

NAME _____

BIRTHDATE ___/___/___

MEDICAL HISTORY:

PLEASE CHECK ANY OF THESE PROBLEMS YOU NOW HAVE OR HAVE HAD:

- | | | |
|---|--|--|
| <input type="checkbox"/> Asthma, emphysema | <input type="checkbox"/> Thyroid disease | <input type="checkbox"/> Nervous /emotional |
| <input type="checkbox"/> Hay fever | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Bleeding disorder |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Anemia /blood disorder |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney /bladder problem |
| <input type="checkbox"/> Skin cancer | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Other skin disease | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Liver disorder | <input type="checkbox"/> Seizures | <input type="checkbox"/> Poor wound healing |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Fainting spells | <input type="checkbox"/> Blood transfusions |
| <input type="checkbox"/> Prostate problems | <input type="checkbox"/> Headaches | <input type="checkbox"/> Eye or ear disorder |
| <input type="checkbox"/> Stomach Ulcer | | |

WOMEN:

- | | |
|---|--|
| <input type="checkbox"/> Vaginal Infections | <input type="checkbox"/> Menstrual problems |
| <input type="checkbox"/> Presently Pregnant | <input type="checkbox"/> Last menstrual period _____ |

Please list all medications you are taking (including aspirin, birth control pills, laxatives, etc.)

Vitamins, herbs, supplements (dosages): _____

Special diet: _____

Are you allergic to any medication, food, clothing, metal, insects, etc.?

YES NO

Please list them: _____

Previous operations & year: _____

Personal history: Do you or did you:

Smoke Drink alcohol Work outdoors

Work with harmful chemicals

Spend a lot of recreational time in the sun (golf, fishing, etc.)

Family History:

Skin cancer Allergies Eczema Psoriasis Hayfever

Bleeding or clotting disorders

Any other problems or conditions we should know about?: _____

PLEASE PRINT AND COMPLETE ALL ENTRIES

Patient Name Last _____ First _____ MI _____		AZ Address Street _____ Apt. # _____		City _____	State _____	Zip _____
Home Telephone _____		Relation to Insured: () 0- Same () 2- Child () 1- Spouse () 3- Other		Social Security Number _____		Patient's Sex () Male () Female
Cell: _____						Patient's Date of Birth _____/_____/_____
Employment Status: () 1- Empl FT () 4- Not Empl () 2- Retired () 5- Student FT		Patient's Status () 1- Married () 4- Other () 6- Separated () 2- Single () 5- Widowed () 7- Divorced		Primary Care Physician Last _____ First _____		Telephone: _____
Summer Residence Telephone _____		Summer Residence Address Street _____ City _____ State _____ Zip _____		Nearest relative not living with you Name _____ Telephone Number _____		
Parent/Guardian Information of Minor Name _____ SS# _____ Date of Birth _____ Male Female		Patient's OR Guardian's Employer _____		Employer's Telephone _____		

INSURANCE INFORMATION

Primary Insurance Name	Address _____ City _____ State _____ Zip _____	Insurance Telephone () _____
Policyholder's Name	Policyholder's Birthday & Sex _____/_____/_____ M F	Policyholder's Social Security #
Policyholder's Employer	Employer's Address _____	Employer's Telephone
Insured's ID Number	Group Number	Effective Date/ Co-Pay
Secondary Insurance Name	Address _____ City _____ State _____ Zip _____	Insurance Telephone () _____
Policyholder's Name	Policyholder's Birthday & Sex _____/_____/_____ M F	Policyholder's Social Security #
Insured's ID Number	Group Number	Effective Date/ Co-Pay

RELEASE INFORMATION

YES NO

I give my permission to any representative of this organization to leave my personal medical information ie: pathology results, surgery information, etc., on the recording machine of the telephone number I listed above.

YES NO

I give my permission to any representative of this organization to give any medical information regarding myself to:
 (Indicate below the name of the person(s) and their relationship to you, to whom you authorize your medical information to be released.)

Name

Name

Name

Relationship

Relationship

Relationship

SIGNED: _____

DATE: _____



Alta Dermatology Group

130 S. 63rd St. · Suite 114 · Building 3 · Mesa, Arizona 85206
Ph (480) 981-2888 Fax (480)654-0599

OUR MISSION STATEMENT

Our mission is to respond to our community's dermatologic health care needs. All services will be provided by a committed staff, providing as accessible and cost effective health care as possible.

OUR FINANCIAL POLICY

If you are covered by a plan that we contract with as a participating provider we will file all claims to your insurance carrier for all covered services. Due to the large number of insurance plans and policies we only file selected secondary insurances. Please ask the front desk or contact the billing department for a list of secondary insurance plans we submit claims to. We encourage our Medicare patients to contact their supplemental insurances to set-up coordination of benefits (also known as auto crossover) as we do not file all Medicare supplement insurances.

As for minors, the parent or guardian accompanying the patient is responsible for all charges (please refer to the paragraphs below for more detailed information). For unaccompanied minors, non-emergency treatment will be denied unless written consent is provided by the parent or guardian and the minor is an established patient. All charges that are the patient's responsibility are due at the time of service.

Unless cancelled at least 24 hours in advance, our policy is to charge for a missed appointment/surgery at the rate of an office visit. Please help us serve you better by keeping scheduled appointments and or canceling at least 24 hours in advance.

For your convenience we accept cash, checks, Visa and MasterCard. A fee of \$40.00 will be charged for any checks returned by the bank.

******PLEASE INITIAL EACH ITEM BELOW***

I hereby authorize my insurance company to make payment directly to: Alta Dermatology Group

_____ I understand that I am financially responsible for any co-payments, coinsurances, deductibles and all charges which are not covered by my insurance. All co-pays, coinsurances, deductibles are due at the time services are rendered.

_____ I understand that I am responsible for all charges if it is determined that the information I have provided is not correct and that it is my responsibility to notify Alta Dermatology Group if there are any changes to my insurance and or contact information.

_____ I understand that for amounts due after insurance has processed the claim Alta Dermatology Group will only send 2 consecutive statements at 30 day intervals and the balance is due in full during that

period. Furthermore, I understand that if my account remains delinquent past 60 days, it will be turned over to a collection agency and NO additional contact will be made by Alta Dermatology Group.

Your signature below signifies that you have read each item, initialed each line, and understand your responsibilities to Alta Dermatology Group.

Signature of patient/guardian

Date

Printed name of Patient or Responsible Party

Staff Witness

Exhibit 4

ALTA DERMATOLOGY GROUP

**RECEIPT OF NOTICE OF PRIVACY PRACTICES
WRITTEN ACKNOWLEDGEMENT FORM**

I, _____, have received a copy of Alta Dermatology Group's
Notice of Privacy Practices.

Signature of Patient

___/___/___
Date

Printed Name _____

Effective Date: April 14, 2003

Exhibit 3

ALTA DERMATOLOGY GROUP

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that these laws are complicated, but we must provide you with the following important information:

- How we may use and disclose your IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all times, and you may request a copy of our most current Notice at any time.

IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Alta Dermatology Group Privacy Officer or Staff

WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. Treatment. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood, urine or pathologies) and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many of the people who work for our practice – including, but not limited to, our doctors and nurses – may use or disclose your IIHI to others who may assist in your care, such as your spouse, children or parents. Finally, we may also disclose your IIHI to other health care providers for purposes related to your treatment.

2. Payment. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if you insurer will cover, or pay for, your treatment. We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly for services and items. We may disclose your IIHI to other health care providers and entities to assist in their billing and collection efforts.

3. Health Care Operations. Our practice may use and disclose your IIHI to operate our business. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your IIHI to evaluate the quality of care you received from us, or to conduct cost-management and business planning activities for our practice. We may disclose your IIHI to other health care providers and entities to assist in their health care operations.

OPTIONAL

4. Appointment Reminders. Our practice may use and disclose your IIHI to contact you and remind you of your appointment. This may include mailing or leaving a message on your answering machine.

OPTIONAL

5. Treatment options. Our practice may use and disclose your IIHI to inform you of potential treatment options or alternatives.

OPTIONAL

6. Health-related Benefits and Services. Our practice may use and disclose your IIHI to inform you of health-related benefits or services that may be of interest to you.

OPTIONAL

7. Release of Information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medication information.

8. Disclosures Required by Law. Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOUR IIHI IN CERTAIN SPECIAL CIRCUMSTANCES

The following categories describe unique scenarios in which we may use or disclose our identifiable health information.

1. Public Health Risks. Our practice may disclose your IIHI to public health authorities that are authorized by law to collect information for the purpose of:

- Maintaining vital records, such as births and deaths.
- Reporting child abuse or neglect.
- Preventing or controlling disease, injury or disability.
- Notifying a person regarding potential exposure of a communicable disease
- Notifying a person regarding a potential risk for spreading or contracting a disease or condition
- Reporting reactions to drugs or problems with products or devices
- Notifying individuals if a product or device they may be using has been recalled

- Notifying appropriate government agency (ies) and authority (ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information if the patient agrees or we are required or authorized by law to disclose this information.
- Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

2. Health Oversight Activities. Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and health care system in general.

3. Lawsuits and Similar Proceeding. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We may also disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

4. Law Enforcement. We may release IIHI if asked to do so by a law enforcement official:

- Regarding a crime victim in certain situations, if we are unable to obtain the person's agreement.
- Concerning a death we believe has resulted in criminal conduct.
- Regarding criminal conduct at our offices.
- In response to a warrant, summons, court order, subpoena or similar legal process.
- To identify/locate a suspect, material witness, fugitive or missing person.
- In an emergency, to report a crime (including the location or victim(s) of the crime, or the description, identity or location of the perpetrator)

OPTIONAL

5. Deceased Patients. Our practice may release IIHI to a medical examiner or coroner to identify a deceased individual or to identify the cause of death. If necessary, we may also release information in order for funeral directors for perform their jobs.

OPTIONAL

6. Organ and tissue donation. Our practice may release your IIHI to organizations that handle organ, eye or tissue procurement or transplantation, including organ donation banks, as necessary to facilitate organ or tissue donation and transplantation if you are an organ donor.

OPTIONAL

7. Research. Our practice may use and disclose your IIHI for research purposes in certain limited circumstances. We will obtain your written authorization to use your IIHI for research purposes except when an Internal Revenue Board or Privacy Board has determined that the waiver of your authorization satisfies the following: (i) the use or disclosure involves no more than a minimal risk to your privacy based on the following: (A) an adequate plan to protect the identifiers from improper use and disclosure; (B) an adequate plan to destroy the identifiers at the earliest opportunity consistent with the research (unless there is a health or research justification for retaining the identifiers or such retention is otherwise required by law); and (C) adequate written assurances that the PHI will not be re-used or disclosed to any other person or entity (except as required by law) for authorized oversight of the research study, or for other research for which the use or disclosure would otherwise be permitted; (ii) the research could not practicably be conducted without the waiver; and (iii) the research could not practicably be conducted without access to and use of the PHI.

8. Serious Threats to Health or Safety. Our practice may use and disclose your IIHI when necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. Under these circumstances, we will only make disclosures to a person or organization able to help prevent the threat.

9. Military. Our practice may disclose your IIHI if you are a member of the U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.

10. National Security. Our practice may disclose your IIHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your IIHI to federal offices in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

11. Inmates. Our practice may disclose your IIHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official. Disclosure for these purposes would be necessary: (a) for the institution to provide health care services to you, (b) for the safety and security of the institution, and/or (c) to protect your health and safety or the health and safety of other individuals.

12. Worker's Compensation. Our practice may release your IIHI for workers' compensation and similar programs.

E. YOUR RIGHTS REGARDING YOUR IIHI

You have the following rights regarding the IIHI that we maintain about you:

1. Confidential Communications. You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. In order to request a type of confidential communication, you must make a written request to Privacy Officer of Alta Dermatology Group, 130 S. 63rd St. Building 3, Suite 114, Mesa, AZ 85206-1634 specifying the requested method of contact, or the location where you wish to be contacted. Our practice will accommodate reasonable requests. You do not need to give the reason for your request.

2. Requesting Restrictions. You have the right to request a restriction in our use or disclosure of your IIHI for treatment, payment or health care operations. Additionally, you have the right to request that we restrict our disclosure of other IIHI to only certain individuals involved in your care or the payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you. In order to request a restriction in our use or disclosure of you TINT, you must make our request in writing to Privacy Officer of Alta Dermatology Group, 130 S. 63d St. Building 3, Suite 114, Mesa, AZ 85206-1634.

Your request must describe in a clear and concise fashion:

- The information you wish restricted;
- Whether you are requesting to limit our practice's use, disclosure or both; and
- To whom you want the limits to apply.

3. Inspection and Copies. You have the right to inspect and obtain a copy of the IIHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to Privacy Officer of Alta Dermatology Group, 130 S. 63d St. Building 3, Suite 114, Mesa, AZ 85206-1634 in order to inspect and/or obtain a copy of your IIHI. Our practice may charge a fee for the

costs of copying, mailing, labor and supplies associated with your request. Our practice may deny your request to inspect and/or copy in certain limited circumstances; however, you may request a review of our denial. Another licensed health care professional chose by use will conduct reviews.

4. Amendment. You may ask use to amend your health information if you believe it is incorrect or incomplete, and you may request an amendment for as long as the information is kept by or for our practice. To request an amendment, your request must be made in writing and submitted to Privacy Officer of Alta Dermatology Group, 130 S. 63d St. Building 3, Suite 114, Mesa, AZ 85206-1634, 480-981-2888. You must provide us with a reason that supports your request (and the reason supporting your request) in writing. Also, we may deny your request if you ask us to amend information that is in our opinion (a) accurate and complete; (b) not part of the IIHI kept by or for the practice; (c) not part of the IIHI which you would be permitted to inspect and copy; or (d) not created by our practice, unless the individual or entity that created the information is not available to amend the information.

5. Accounting of Disclosures. All of our patients have the right to request and “accounting of disclosures”. An “accounting of disclosures” is a list of certain non-routine disclosures our practice has had of your IIHI for non-treatment, non-payment or non-operations purpose. Use of your IIHI as part of the routine patient care in our practice is not required to be documented. For example, the doctor sharing information with the nurse; or the billing department using your information to file your insurance claim. In order to obtain an accounting of disclosures, you must submit your written request to Privacy Officer of Alta Dermatology Group, 130 S. 63d St. Building 3, Suite 114, Mesa, AZ 85206-1634. All requests for an “accounting of disclosures” must state a time and period, which may not be longer than six (6) years from the date of disclosure and may not include dates before April 14, 2003. The first list your request within a 12-month period is free of charge, but our practice may charge you for additional lists within the same 12-month period. Our practice will notify you of the costs involved with additional requests, and you may withdraw your request before you incur any costs.

6. Right to a Paper Copy of This Notice. You are entitled to receive a paper copy of our notice of privacy practices. You may ask us to give you a copy of this notice at any time. To obtain a copy of this notice, contact Privacy Officer of Alta Dermatology Group, 130 S. 63d St. Building 3, Suite 114, Mesa, AZ 85206-1634 or make your requests at the front desk.

7. Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact a Privacy Official at 480 981-2888. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

8. Right to Provide and Authorization for Other Uses and Disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law. Any authorization you provide to use regarding the use and disclosure of your IIHI may be revoked at any time in writing. After you revoke your authorization, we will no longer use or disclose your IIHI for the reasons described in the authorization. Please note, we are required to retain records of your care.

Again, if you have any questions regarding this notice or our health information privacy policies, please contact Privacy Officer 480 981-2888.

