OMNI
DERMATOLOGY

Patient Name
Last:________________________________ First:________________________________ MI:__________
Parent(s)/Guardian(s) Name: Not Applicable ▢
Last:________________________________ First: ______________________________ Relation:____________

Last:________________________________ First: ______________________________ Relation:____________

Social Security #: Date of Birth: Sex: M ☐ F ☐

Address:
Street:____ Apt/Unit #:___________
City:__________________________________ State: ________________ Zip Code: ________________

Phone Numbers:
Home:____________________________________ Cell: ____
Email: ____
Confirm appointments by: Text ☐ Email ☐ Phone ☐

Demographics: Marital Status: Divorced▢ Widowed▢
Language:______________________________ Race:____________________________ Married▢ Single▢

Guarantor Information: (Parent/Guardian and/or to whom billing statements are sent)

Check this box if it is the same as patients information ▢

Full Name:____ Date of Birth:______________
Street:____ Apt/Unit #:___________
City:__________________________________ State: ________________ Zip Code: _________________
Phone:____________________________________ Relation:____

Emergency Contact:
Full Name:____ Relation:________________________
Home Phone: __________________________________ Cell Phone:________________________________

Billing and Insurance Information ***only fill out if you are **NOT** the primary insurance holder***

	Primary	***Secondary***	***Additional***
Policy Holder Name			
Policy/ID Number			
Group Number			
Policy Holder DOB			

PATIENT MEDICAL HISTORY

Patient Name: ____

Doctors/Specialists (Please list doctors, first & last name, who need to be informed about your appointments)

____

Reason for Visit: ____

Pharmacy Name & Crossroads: ____

Medications: ____

Allergies: ____

Have you received a shingles Vaccine? ☐ Yes ☐ No ☐ Unsure

Are you pregnant? ☐ Yes ☐ No If yes, how far along are you? ___________________________________

Are you positive for: HIV ☐ Yes ☐ No AIDS ☐ Yes ☐ No

Are you positive for: Hepatitis ☐ Yes ☐ No *If yes, please specify which type* ______________________

Past Medical History: Place a check mark for your answers *If all are Negative then check here: ☐

☐ Anxiety	☐ Diverticulitis	☐ Kidney Stones
☐ Arthritis	☐ Fibromyalgia	☐ Liver Disease
☐ Asthma	☐ Gout	☐ Osteoporosis
☐ COPD	☐ High Cholesterol	☐ Blood Clots in Lungs
☐ Cancer: ___________	☐ High Blood Pressure	☐ Reflux Disease
☐ Heart Disease	☐ Hyperthyroidism	☐ Stroke
☐ Depression	☐ Hypothyroidism	☐ Tuberculosis
☐ Diabetes	☐ Kidney Disease	☐ Other: ___________________

Surgical History with Month & Year:

____

Family History ☐ Rashes ☐ Skin Cancer ☐ Melanoma If yes, then whom: ______________________________

Social History: Place a check next to your answers

Do you Smoke: Former ☐ Current ☐ Never ☐

If yes how much: Less than 1/4 PPD ☐ 1/4 PPD ☐ 1/2 PPD ☐ 1 PPD ☐ More ☐

Do you drink Alcohol: Never ☐ Occasionally ☐ Moderately ☐ Heavily ☐

Are you: Single ☐ Married ☐ Divorced ☐ Widowed ☐

How long have you lived in AZ: ________________

Do you use Sun block regularly? Yes ☐ No ☐

Have you traveled outside of the U.S. recently? Yes ☐ No ☐ If yes, where did you travel to? _________________

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PATIENT MEDICAL HISTORY (CONT'D)

Please Circle Any Positives:

**If all of the following are negative please check here ☐

Review of Symptoms:

General: Fever ☐ Chills ☐ Nausea ☐ Fatigue ☐

Skin: Itching ☐ Burning ☐ Tenderness ☐ Hair Loss ☐ Nail Problems ☐

Eyes: Itching ☐ Redness ☐ Dryness ☐

Mouth: Ulcers ☐ Rash ☐ Pain ☐

Nose: Sinus Problems ☐ Nose Bleeds ☐

Pulmonary: Asthma ☐ Shortness of Breath ☐ Coughing Blood ☐

Cardiovascular: Leg Swelling ☐

Genitourinary: Abnormal Discharge ☐ Pain with Urination ☐

Musculoskeletal: Weakness ☐ Joint Pain ☐ Joint Swelling ☐

Neurological: Numbness ☐ Tingling ☐ Headaches ☐

Endocrine: Change in Voice ☐ Heat or Cold Intolerance ☐ Weight Gain/Loss ☐

Psychological: Depression ☐ Anxiety ☐ High Stress ☐

Hematologic: Anemia ☐ Bleeding Disorder ☐ Taking Blood Thinners ☐

Allergic/Immunologic: Seasonal Allergies ☐ Autoimmune Disease ☐

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Consent to Treat Patient *without* Parent/Legal Guardian Present

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from parent or legal guardian. If the minor arrives with someone other than a parent or legal guardian, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's Name: ____ DOB: ________________

For those occasions when you may not be with your child, **please list those individuals who may give us consent** to see your child:

____ __________________________

Name Relationship to Minor

____ __________________________

Name Relationship to Minor

LIMITATIONS:

Identify any specific limitations on the kinds of medical services for which this authorization is given. (If none, write "none".)

____

☐ Check here if you wish to give consent for the minor to receive medical care **without an accompanying adult**, which shall be in effect for:

☐ Date ________________________ ***ONLY***

☐ **Indefinitely**, until revoked by verbal or written communication.

AUTHORIZATION:

I request and authorize Omni Dermatology and its personnel to deliver routine medical care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware the adult presenting the child is responsible for payment of patient portion at the time of service.

I have legal right to preauthorize Omni Dermatology and its personnel to deliver routine medical treatment and services to my child. Routine medical care and treatment may include, but are not limited to: skin evaluations, acne treatment, injections, lab work, laser treatment, and wart treatment.

I have read, understand, and give my consent as stipulated. My signature means that I have read this form and/or have had it read to me and explained in the language that I understand.

____ __________________________

Parent or Legal Guardian Signature Date

____ __________________________

Parent or Legal Guardian Printed Name Relationship

NOTICE OF PRIVACY PRACTICES

To our patients: 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 health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Our commitment to your privacy

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. We realize that these laws are complicated, but we must provide you with the following important information.

Use and Disclosure of Your Health Information in Certain Special Circumstances

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. 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. We will only make disclosure to a person or organization able to help prevent the threat.
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of law enforcement official.
8. For Workers Compensation and similar programs.

Your rights regarding your health information:

1. You can request a restriction in our use or disclosure of your health information for treatment, payment, or health care operation. Additionally, you have the right to request that we restrict our disclosure of your health information 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.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have the right to review the Notice of Privacy Practices prior to signing this consent. Omni Dermatology and its providers reserve the right to revise this Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Omni Dermatology Privacy Officer at 4801 E. McDowell Rd. Ste 150, Phoenix, AZ 85008.

With my consent, Omni Dermatology and it providers and staff may call my home or to other designated location and leave a message on a voice mail or in person in reference to any items that assist the practice in carry out TPO; such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Omni Dermatology and its providers and staff may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

By signing this form, I am consenting to Omni Dermatology's providers and staff to use and disclosure of my Personal Health Information to carry out treatment, payment and healthcare operations. I have also read the Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Omni Dermatology may decline to provide treatment to me.

I herby acknowledge that I have been presented with a copy of Omni Dermatology Notice of Privacy Practice

________________________ ________________________ ________________

Patient's Name Signature Date

Updated Omni Dermatology Office Policy

All patients must have a valid credit/debit card on file to be seen by a provider.
Your credit/debit card is kept securely offsite by our electronic medical record system and encrypted at the highest level.
It will be used to settle any balances owed on your account for services rendered including co-pays, deductibles, co-insurance and no show fees of $50 that will be withdrawn the same day as the no show.
Before your card is ever charged you will receive a notification at least 5 days prior. You will then be able to login to your patient portal and see an explanation of your bill and charges.
If you have any questions regarding your bill or would like to use a different form of payment besides your card on file you can call 623-478-8000 and ask for the billing department.
This policy will help streamline the billing, statement, and payment process for all parties involved.
In addition, it will help in our continuing effort to be a completely paperless office.
We thank you for your understanding in this matter and look forward to continuing to provide you with the best dermatological care in the valley.

CREDIT CARD AUTHORIZATION CONSENT

I authorize Omni Dermatology to keep my credit card on file and charge for future payments that become due resulting from my treatment. This includes payments for co-pays as well as any balances resulting from insurance deductibles and/or co-insurance. I understand I will receive a notification at least 5 days prior to my credit card being charged for balances owed. I understand that if I would like to use a different payment method, I can change my card on file at any time or pay with cash in person before the 5-day period expires. If I do nothing, then I understand my outstanding balance will be charged to my card on file to settle my balance owed. For any questions regarding this policy please call 623-478-8000 to speak with the billing department.

____ ____________

Signature Date

____

Patient Name (Printed)

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HIPAA CONSENT TO LEAVE MESSAGE

Patient Name: ____ DOB: ________________

I wish to be called at home ☐ other ☐ (check all that apply) regarding my care and follow up. The best telephone numbers(s) to reach me are:

Home Phone: __________________________Other Phone: ____________________________

I do ☐ I do not ☐ want relevant medical information (i.e. lab results, biopsy results) on my answering machine or voice mail.

I do ☐ I do not ☐ want relevant medical information shared with the person who may answer the telephone. The name(s) of the individual(s) with whom you may leave pertinent information are:

____
____
____
____

____ ______________
Patient Signature Date

PHOTOGRAPHY PERMIT

I hereby authorize the appropriate personnel of Omni Dermatology and its providers and staff to take digital pictures of my skin condition.

I hereby state that it has been fully explained to me that said pictures are taken for the

purpose of medical record documentation, location for treatment options, and for the showing to the duly licensed physicians, nurse practitioners, and authorized paramedical personnel should treatment be needed in the future. These photos are a vital part of your chart and are HIPAA compliant.

I further state that at the time of the execution of the consent, that I am fully aware of the pictures to be taken and the uses, as above described, to which they are to be put, and that all questions with respect to the taking of the pictures and the use there of have been fully explained to me and to my complete satisfaction by personnel of Omni Dermatology.

____ ________________________

Signature Date

MEDICATION HISTORY AUTHORITY

We are implementing a new Electronic Medical Records (EMR) program that will **automatically import your medication history from third party sources (i.e. pharmacies)**. In order to transfer your current and past medications to the new system we must have your authority.

By signing below I hereby certify Omni Dermatology to transfer my medication history.

____ ________________________

Signature Date

____

Patient Name (printed)

Financial Policy

______(initial) I understand that I am financially responsible for charges for services rendered on my behalf or on behalf of my dependent, regardless of if they are covered by my insurance company, Medicare and/or supplemental policy.

______(initial) Payment is required at the time services are rendered. Omni Dermatology Inc. is allowed by contract with your insurance company to collect the copayment and/or co-insurance and any unmet deductible at the time of service. The amount collected is estimated based on benefit information available. Specific policy information is often limited or unavailable until after a claim has been filed.

______(initial) Insurance coverage is not a guarantee of payment. I understand I am responsible for any remaining balance not covered by my insurance company, Medicare and/or supplemental policy. It is my responsibility to contact them if I have questions regarding my benefits and coverage.

______(initial) I understand that my insurance company, Medicare and/or supplemental policy may have a preferred lab for blood work. It is my responsibility to know which preferred lab I can use, and to inform my provider at the time of service.

______(initial) I understand that a fee may be assessed for returned checks.

______(initial) I understand and agree that it is my responsibility to know if my insurance requires a referral/authorization from my primary care physician and that it is up to me to obtain the referral/authorization. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

By signing below, I certify that I have read the above information and my questions concerning these policies have been answered. My signature also certifies my understanding and agreement with the above information.

Patient Printed Name:	Patient Date of Birth:
Parent/Legal Guardian Printed Name:	Relationship:
Signature:	Date: