INTEGRATED DERMATOLOGY

Enfield · Simsbury

(Please fill out to the FULLEST and print)

NAME: _____ DOB: ___/___/_____ SEX: M___F___
(LAST) (FIRST) (MIDDLE INITIAL)

ADDRESS: _____

_____
(CITY) (STATE) (ZIP CODE)

EMAIL: _____

EMPLOYER: _____ OCCUPATION: _____

HOME # _____ CELL # _____ WORK # _____
☐Detailed message allowed ☐Detailed message allowed ☐Detailed message allowed

Pharmacy Name: _____ Pharmacy Location: _____

PRIMARY CARE PHYSICIAN:

NAME: _____ LOCATION: _____

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

PRIMARY INSURANCE: _____

ID # _____
POLICY HOLDER (if not self): _____
POLICY HOLDER'S DATE OF BIRTH: _____/_____/_____

SECONDARY INSURANCE: _____

ID # _____ GROUP # _____

POLICY HOLDER: _____ POLICY HOLDER'S DATE OF BIRTH _____

Language:
☐English ☐Spanish ☐French ☐Russian ☐Polish ☐Other_____

Emergency contact: _____ Phone# _____ Relationship: _____

HIPAA (ok to discuss medical information with) contact: _____ Phone# _____

TODAY'S DATE: _____/_____/_____ Initials: _____

Name: _____ Date of Birth: _____ Today's Date: _____

Medications: _____

_____

_____

_____

Allergies:

☐ Food/Environmental: _____

☐ Medication/Drug (Please include the reaction, if known):

_____

_____

Social History

☐ Tobacco: Type/Amount_____ ☐ Alcohol: Amount_____

☐ Tanning Bed Use: Frequency_____

Personal Medical History

☐ Anxiety	☐ Anemia	☐ Asthma	☐ Arthritis
☐ Bleeding Disorder	☐ Celiac Disease	☐ Chronic Bronchitis	☐ Colitis
☐ Congenital Disorder	☐ COPD	☐ Crohn's	☐ Depression
☐ Diabetes	☐ Epilepsy	☐ Emphysema	☐ GERD
☐ Headaches/Migraines	☐ Hearing Impaired	☐ Heart Murmur	☐ Hepatitis
☐ High blood pressure	☐ HIV (AIDS)	☐ High Cholesterol	☐ History of fainting
☐ IBS	☐ Immunosuppressed	☐ Kidney Disease	☐ Muscle Weakness
☐ Seasonal allergies	☐ Sinus Problems	☐ Tuberculosis	☐ Thyroid Disease
☐ Vision impaired	☐ Other: _____		☐ **None**

Events:

☐ History of blood clots: Year_____ ☐ History of Heart Attack: Year_____

☐ History of Stroke: Year_____ ☐ History of Cancer: Type_____

Female Specific:

☐ Family planning: pregnant / plan to conceive / breast feeding

☐ Gynecology Disorders ☐ Irregular Period

Surgical History:

☐ Joint replacement ☐ Cardiac Surgery ☐ Cancer Surgery ☐ Pacemaker Placement

☐ Organ Transplant/Donor ☐ Other_____

Personal Dermatology History

☐ Melanoma	☐ Non-Melanoma Skin Cancer	☐ Atypical Moles	☐ Psoriasis
☐ Hair-loss	☐ Eczema	☐ Chronic Hives	☐ Other_____

Family History

☐ Melanoma	☐ Inflammatory Bowel Disease	☐ Psoriasis	☐ Acne
☐ Cancer	☐ Hair loss	☐ Other_____	

Signature: _____

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Please confirm that we are contracted with your insurance before coming in. If we are not contracted you will be considered self-pay. Calling the number on the back of your insurance card is the easiest way to do this.

Be aware that some insurance companies require an insurance referral from your primary care physician to visit a specialist office. Please consult your benefits before your appointment. If one is required, please call your primary care and have them put one in through the insurance company portal. This is NOT a Dr. to Dr. referral; it goes directly to your insurance company. Provide them with the date of your appointment and the provider you will be seeing. Some insurances require all referrals to be under our supervising physician: Dr, Meagen McCusker

We will require the following information on or before your appointment date:

- Insurance company referral number with the number of visits allowed
- A start and end date of the insurance referral

If you require a referral to see a specialist and do not have one, you may be required to pay at the time of your visit. An example of some other services that may require payment at your visit because they are not covered by insurance are co-payments, co-insurance, cosmetic procedures, skin tag removals and deductibles. All payments can be made by cash or credit/debit card. WE DO NOT ACCEPT CHECKS

Failure to pay a balance due in a timely fashion may result in your inability to receive services from *Integrated Dermatology of Enfield/Simsbury* until the account is paid or payment arrangements have been made.

Your signature below signifies that you understand our referral and financial policy and your responsibility regarding charges incurred at *Integrated Dermatology of Enfield/Simsbury*.

I have read this policy and agree to the terms:

Signature: _____ Date___/___/___

I have read and have received a copy of Integrated Dermatology of Enfield/Simsbury's notice of privacy practices form (Please ask for a copy if you would like one)

Signature: _____ Date___/___/___

(parent or guardian signature *if* minor) Relationship type: _____

INTEGRATED DERMATOLOGY GROUP

NOTICE OF PRIVACY PRACTICES

Effective April 4th 2003

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR RESPONSIBILITIES:

Integrated Dermatology Group is required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to abide by the terms of the Notice currently in effect. We reserve the right to change our privacy practices and make new provisions effective for all information we maintain.

YOUR RIGHTS:

You have the right to: Authorize and Consent to the use and disclosure of protected health information

- Request restrictions on how we use or disclose your medical information.
  We do not have to agree to your request.
  Receive confidential communication to an alternative phone or address.
- Request amendment to your medical information.
- Receive an accounting of disclosures of your medical information not authorized by you and not for purposes of treatment, payment, or health care operations.
- Inspect and copy protected health information.

USES AND DISCLOSURES

Examples of how information may be used for treatment, payment, and health care operations include:

Treatment – We keep a record of each patient visit that includes your tests results, diagnoses, medications, surgeries, therapies, progress and response to care you need.

Payment – We keep a record of the services and supplies provided to deliver your care so we can bill and be paid by you and/or your insurance company.

Health Care Operations – We use medical information to evaluate and improve the quality of care and services we provide, to train and monitor staff and students, and to manage the operation of the practice.

May also use information for appointment reminders, to describe or recommend treatment, alternatives, and to provide information about health-related benefits. Your health information may be shared among Integrated Dermatology

Group representatives and business associates to facilitate treatment, payment, or to manage the business of the practice (health care operations). Business associates who access medical information must follow our requirements to protect the privacy of the information we provide to them.

There are other reasons which permit us to use or disclose medical information, including:

As required by law
For public health activities
To protect victims of abuse, neglect, or domestic violence
For health oversight activities such as inspections
For judicial or administrative proceedings
For law enforcement purposes
To coroners, medical examiners, and funeral directors
For organ donation
To a correctional institution if you are an inmate
For workers' compensation if you are injured at work

Integrated Dermatology Group recognizes and values each individual's right to privacy. This Notice of Privacy Practices provides information on our responsibilities to protect the confidentiality of your health information. This Notice also provides information on how we may use and disclose medical information.

FOR MORE INFORMATION:

If you need clarification or more information on any portion of the Notice,
if you would like to exercise your rights, or if you feel your privacy rights have been violated,
contact the Privacy Offices at (860) 741-2225 or write to the following address:

Integrated Dermatology Group
ATTN: Privacy Officer
113 Elm Street, Suite 304
Enfield, CT 06082

All complaints will be thoroughly investigated, and you will not suffer retaliation for filing a complaint.
You may also file a complaint with the Secretary to the United States Department of Health and Human Services.