WELCOME TO AFFILIATED DERMATOLOGISTS OF VIRGINIA

Date:_______________ Referred by:________________________________ Chart #____________
(_)Dr. (_)Friend (_) Family

Patient's Name____ Primary Dr.____________________
(Last) (First) (Middle)

Date of Birth____________________ SSN___________________________ Marital Status: M D S W

Responsible Party: (_) same as above or_________________________________ Relationship_____________

Address____
(Street) (City) (State) (Zip)

Mailing Address (if different)______________________________ Email Address_________________________

Primary Phone (____)__________________________Alternate Phone(____)____________________________
(_)home (_)cell (_)home (_)cell (_)work

Employer____ Occupation____________________________

Medical Emergency Contact_______________________________ Telephone___________________________

INSURANCE INFORMATION

PRIMARY	**SECONDARY**
COMPANY NAME______________________________	COMPANY NAME______________________________
POLICYHOLDER______________________________	POLICYHOLDER______________________________
POLICYHOLDER'S DATE OF BIRTH__________________	POLICYHOLDER'S DATE OF BIRTH__________________
POLICYHOLDER'S SSN_____________________________	POLICYHOLDER'S SSN_____________________________
RELATIONSHIP TO PATIENT________________________	RELATIONSHIP TO PATIENT________________________
ID #____	ID #____
GROUP #____	GROUP #____

I understand that my insurance policy is a contract between myself and the insurance company and Affiliated Dermatologists of VA (ADOV) is not a party to that contract. I am ultimately responsible for unpaid balances and non-covered services. I am responsible for informing the office of all changes to my information and insurance PRIOR to my appointments. Insurance must be in force and verifiable at time of treatment. If my insurance company requires a referral, it is my responsibility to obtain one PRIOR to my appointment. If I do not have insurance or a referral, I agree to pay in full at the time of the appointment. I hereby assign all insurance benefits for services rendered, otherwise payable to me, directly to ADOV from Medicare or my private insurance. I authorize ADOV to release medical information to my insurance company, its agents or any third party for use in determining my benefits. If my account enters a delinquent status, I agree to pay all costs of collections including attorney fees and court fees. If my account enters court collection status, I understand that I am no longer a patient of record. I understand that the fee for a returned check is $35. AS A COURTESY ONLY, we will attempt to confirm your appointment prior to the date. ADOV cannot guarantee a reminder call. <u>I understand that ADOV charges a minimum fee of $50 for appointments missed or cancelled without 24 hours notice. I agree to pay such fee</u>. ** ADOV will maintain patient records for a minimum of six years following the last visit, barring any exceptions where we may be required to keep them longer.*

By signing below I indicate my understanding and agreement with the policies listed above and authorize Affiliated Dermatologists of Virginia to render treatment to the patient named.

____ ____________________________
Signature of Patient or Responsible Party Date

AFFILIATED DERMATOLOGISTS OF VIRGINIA
MEDICAL HISTORY

Today's Date:	**Patient Name:**
Preferred Pharmacy:	**Date of Birth:**
Location/Phone:	**Chart #:**

Reason for today's visit:____

Do you currently have or have you ever had:

___Bronchitis ___High Blood Pressure ___Irregular Heartbeat ___Thyroid problems
___Emphysema ___Low Blood Pressure ___Pacemaker ___Kidney Problems
___Asthma ___Chest Pain ___Blood clots/phlebitis ___Bladder Problems
___Chronic Cough ___Heart Attack ___MVP ___Stomach Problems
___Morning Cough ___Heart Murmur ___Diabetes ___Hepatitis (A/B/C)
___Bowel Problems ___Glaucoma ___Arthritis/Joint ___HIV/AIDS
___Cancer (type):____

Any other?____ Pregnant? ___Yes ___ No ____n/a

Current prescription medications:____

____

____

Supplements or over the counter medications:____

____

Allergies to: ___Latex ____Food ____Medications **Allergy List**:___________________________________

Any surgeries? ___no ___yes List:____

Have you:
___had a blood transfusion
___been exposed to HIV/AIDS
___had adverse reaction to dental anesthesia

Do you:
___have an artificial joint
___require antibiotics before surgery
___bleed easily
___smoke
___drink alcohol
___use any drugs (other than above)

Have you ever had skin cancer (basal cell, squamous cell, melanoma)? ____yes ___no

If yes, location:____

Have you ever had a mole biopsy? ___yes ___no Location:____

Do you have a family history of melanoma? ___yes ___no Relationship:____________________________

Are you interested in:
___ Botox ____ laser treatment
___ fillers ____ chemical peels

Do you:
___Use tanning bed ___use sunscreen ___tan easily
___ Spray tan/self tan ___burn easily

Current skin care products:____

Signed____ ____
(patient or guardian) /Date **(Provider)/Date**

ADOV/2012/nt

Affiliated Dermatologists of Virginia
HIPAA Consent and Required Government Forms

Name:	**Date of Birth:**	**Chart #**

Our notice of Privacy Practices provides information about how we may use and disclose your protected health information. It contains a section on Patient Rights outlining your rights under the law. You have a right to view our Notice before signing this consent. The terms of our Notice may change. If so, you may obtain a copy by contacting our office.

You have a right to request that we restrict how your protected health information is used or disclosed for treatment, payment and healthcare operations. We are not required to agree to such restriction but if we agree, we will honor that agreement.

By signing this form, you agree to our use and disclosure of your protected health information for treatment, payment and healthcare operations. You have a right to revoke this consent, in writing signed by you. Such a revocation will not affect any disclosures already made in reliance upon your prior consent. This form is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient (or responsible party) understands that:

- Protected health information may be disclosed for purposes of treatment, payment and healthcare operations, or for other purposes permitted or required by law.
- The office has a Notice of Privacy Practices and the patient has the opportunity to review the Notice.
- The office reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the use of their information but the office does not have to agree to the restrictions.
- The patient has the right to revoke this consent in writing and all future disclosures will then cease.
- We will obtain a separate authorization for “subsidized” disclosures, meaning disclosures involving products or services with respect to which the Practice receives remuneration from a third party.

____ ________________________________

Signature (Patient or Responsible Party)/Date ( ) self ( ) resp. party Practice Representative/ Date

Do you give permission to discuss your medical information with anyone else? ( ) Yes ( ) No If yes:

Name	Relationship	Telephone

May we leave personal medical information on your voice mail/answering machine? ( ) Yes ( ) No
If yes, please provide the number we may use to leave the information:_________________________

Recent government regulations require that patients be given the opportunity to self-declare their race, ethnicity and primary language. These categories are predefined by the Office of Management and Budget (OMB). Providing this information is voluntary and does not affect the coordination of your care. We understand this information is sensitive and we hope you will find our process as considerate and efficient as possible.

(_) African American or Black **(_) Asian** **(_) Caucasian** **(_) Native American or Alaskan** **(_) Other** **(_) Unknown** **(_) Patient Declined** ______________________ **Race of Record**	**(_) Hispanic or Latino** **(_) Non-Hispanic or Non-Latino** **(_) Other** **(_) Unknown** **(_) Patient Declined** ______________________ **Ethnicity of Record**	**(_) English** **(_) Chinese** **(_) German** **(_) Italian** **(_) Polish** **(_) Russian** **(_) Spanish** **(_) Other** **(_) Patient Declined** ______________________ **Language of Record**