PATIENT INFORMATION SHEET

Name: _____ Today's Date: ___/___/___
Last First M.I.
Sex: _____ SS#: _____ Marital Status: Single____ Married ____ Other ____
Date of Birth: _____/_____/_____ Age: _____
Address: _____
Street Apt# City State Zip
Phone: _____
Home Cell Work
Email Address: _____
Preferred contact method: ___ Home __Cell
Name of Employer: _____ Address: _____
*How did you hear about us: _____

Parent, Spouse, or Responsible Party (If different from patient)
Name: _____
Last First M.I.
Sex: _____ SS#: _____ Date of Birth: ____/____/____ Age: _____
Address: _____
Street Apt# City State Zip
Phone: _____
Home Work Cell
Name of Employer: _____ Address:_____

Primary Ins Name: _____
Policy Holder Name: _____ Date of Birth: ___/___/____
ID#:_____ Group#:_____ Relationship to Patient: _____
Secondary Ins Name: _____
Policy Holder Name: _____ Date of Birth: ___/___/____
ID#:_____ Group#:_____ Relationship to Patient:_____

Please note we are out of network with Medicare, Medicaid and TennCare and are unable to file a claim with those insurances. We can provide necessary documentation for you to file on your own, if desired. Please ask about our Private Pay rates.

Primary Care Physician: _____ Phone #:_____
Referred by: _____ Phone #:_____
Emergency contact: _____ Phone #:_____
Pharmacy #:_____

By signing below, I authorize the release of medical information to my primary care or referring physician, to consultants for claim processing or prescriptions. I also authorize payment of medical benefits to the physician. I understand payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, **all applicable deductibles, co-payments, and coinsurance will be collected at the time of service. Any fees for non-covered services will also be collected at the time services are rendered.** I understand that there is a **$50 NO SHOW FEE** for all missed appointments that are not cancelled or rescheduled, with the exception of cosmetic procedures. Appointments for cosmetic procedures that are not cancelled 24-hours prior to your scheduled time, a **$100 NO SHOW FEE** will apply. Any collection fees incurred in the collection of your account are your responsibility. Your signature below signifies your understanding and willingness to comply with our above policies.

Patient or Responsible Party Signature: _____ Date:_____

Patient Responsibility and Consent to Treat

As you are aware, our office files only specific insurance companies for our patients as a courtesy. Filing of insurance claims for you does not relieve the patient of the financial responsibility for the services rendered by our physician. We take great pride in caring for our patients and insuring quality medical care is given. However, the insurance company will only pay for services that are covered under your insurance policy, with no exception. Our office will bill you for any uncovered services provided as well as any co-insurance, co-pay, or deductible amount. It is the patient's responsibility to know your insurance coverage. If you do not have your insurance information available at the time of service, the full office visit fee will be due at the time of service. **NO EXCEPTIONS**. We will later file that date of service for you and upon receipt of an insurance payment will refund any overpayment due to you.

Dr. Baker is trained and board certified in Family Medicine, but has spent his entire career devoted to the treatment of cosmetic and medical skin related conditions, including laser surgery. His training does give him some advantages in the treatment of many pediatric conditions and in various surgical techniques. In the event that a difficult, rare or resistant skin disorder is persistent, a second medical opinion may become necessary, and if recommended, or a transfer of care is necessary, your patience and cooperation is appreciated.

Dr. Baker and his staff believe in prompt, quality medical care. We make it a priority to see urgent need patients as quickly as possible, often the next business day. We also make it a goal to see our patients as close to their appointment time as possible, taking great pride in the timeliness of our care, although emergencies and surgical complications do occur on occasion which may delay your care. This does mean, however, that we require the same desire for punctuality from our patients. There is a **$50 NO SHOW FEE** that will be billed to the patient for visits that are not cancelled or rescheduled 48 hours prior to the appointment time. This is to ensure that we can provide you timely care in an efficient manner. We appreciate your business and we are dedicated to providing quality medical service.

I understand the above policy and will take financial responsibility for my bill if my insurance does not cover the services performed.

Signature_____ Date _____

My permission is given today for any medical treatment including, but not limited to, examination, injections, diagnostic testing or medical procedures as deemed advisable by the members of Dermatology Realm and Family Practice.

Signature_____ Date _____

Medical History

Patient: _____ Date _____

Allergic to any medications? Reactions to anesthesia? O No O Yes If yes, please list:
1. _____ 2. _____

List all medications you are taking and reason for taking them:
_____
_____
_____

Do you have now (or ever had) one of the following conditions: (Please select Y/N)

Lungs	Yes	No	Other systemic:	Yes	No
Bronchitis	O	O	Diabetes	O	O
Emphysema	O	O	Thyroid	O	O
Asthma	O	O	Kidney	O	O
Vascular			Cancer	O	O
Hypertension	O	O	Hepatitis	O	O
Heart Disease	O	O	Arthritis	O	O
Blood Clots	O	O	HIV	O	O
Bleed Easily	O	O			
Skin Diseases			Skin Cancer		
Lupus	O	O	Melanoma	O	O
Psoriasis	O	O	Squamous	O	O
Eczema	O	O	Basal	O	O

Please list other medical conditions not noted:
_____
_____

Family History of skin diseases or cancers? O No O Yes If yes, please list:
1. _____ 2. _____

When exposed to sun, do you: O Tan only O Tan and Burn O Burn only

Frequency of tanning bed or outside tanning: ___ times a O week O month O year

Do you smoke? O No O Yes If yes, how much? _____ packs a day

Do you drink alcohol? O No O Yes If yes, how much? _____ drinks a day / week

I will notify the staff of any changes to this form when they occur:

Patient Signature: _____ Date: _____

Please inform a member of our staff if your insurance requires a specific lab.

DERMATOLOGY REALM NOTICE OF PRIVACY PRACTICES

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.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control of your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Following are examples of uses and disclosures of your PHI that we are permitted to make. These examples are not meant to be exhaustive, but to describe types of uses and disclosures.

Treatment – We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other healthcare providers who may be involved in your care and treatment.

Special Notices – We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests to provide information about health-related benefits and services offered by our office. You will have the right to opt out of such special notices and each such notice will include instructions for opting out. The use of your PHI for marketing purposes will require specific authorization from you.

Payment – Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits. If you pay out of pocket for a procedure that could be covered by insurance you have the right to restrict the disclosure of your PHI.

Healthcare Operations – We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to, business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization – The practice may elect to use a health information organization, or other such organization, to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare – Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person, that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures – We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceeding; law enforcement purposes; criminal activity; military activity; national security; worker's compensation; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule. Others uses and disclosures not described in this Notice of Privacy Practices will be made only with your authorization.

Dermatology Realm

PATIENT RIGHTS AND RESPONSIBILITIES

While you are a patient of Dermatology Realm and Family Practice your rights and responsibilities include:

You have the right to:

- Receive a copy of this Notice of Privacy Practices.
- Authorize other use and disclosure. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use of disclosure indicated in the authorization.
- Inspect and copy your PHI and request an amendment to your protected health information.
- Request a listing of disclosures that we have made of your PHI to entities outside of our office.
- Receive a written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.
- Expect the necessary health services to the best of our ability.
- Privacy and confidentiality. All treatment records are confidential unless you have given permission for release of this information.
- Be treated with dignity and respect.
- Be provided with information concerning your diagnosis, treatment, and prognosis in terms that are understandable to you. When it is not medically advisable to give such information to the patient, this information may be made available to the designated person acting on the patient's behalf.
- Review your medical record with a doctor.
- Be made aware of unusually lengthy delays in being seen by the health care provider at your appointment time.
- Refuse treatment and be informed what might happen if you do.

You have the responsibility to:

- Provide information about your health, past illnesses, hospitalizations and use of medications.
- Follow the care prescribed for you by the doctor.
- Ask questions if you do not understand instructions.
- Express concerns or complaints in a constructive manner
- Respect the rights of other patients and staff and be understanding if delays are encountered.
- Keep all scheduled appointments on time or call in a timely manner to reschedule them.
- Provide ALL insurance information, know terms and limits of your coverage and inform staff of any changes.
- Pay your bill in a timely manner or talk with our billing department regarding payment plan if necessary.

Privacy Complaints – You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at 901-362-7170, ext 3. We will not retaliate against you for filing a complaint.

Effective Date: August 1, 2013 Publication Date: August 1, 2013

ACKNOWLEDGEMENT OF RECEIPT OF
HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of Dermatology Realm's HIPAA Notice of Privacy Practices and hereby give consent to release my Protected Health Information (PHI) as detailed in the Notice of Privacy Practices. I understand I have the right request restrictions on the usage and disclosure of my PHI and that any requests must be made in writing. I may also cancel this agreement at any time.

_____ _____
Patient signature Date

Or

_____ _____
Signature of representative Date

Authority of representative to sign for patient:
Parent ___ Guardian ___ Power of Attorney ___ other ___

I hereby authorize this office to release information regarding my PHI to include account status, test results, scheduled appointments and information regarding my healthcare to the persons I have listed below:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Consent to Arbitration

General-Arbitration.indd | Rev 080523

MEDICAL PROFESSIONAL LIABILITY ARBITRATION AND PRIVACY AGREEMENT

In consideration of the agreement of Dermatology Realm, the Surgeon(s) of Dermatology Realm, and the staff under contract with Dermatology Realm (including those individuals under lease service agreement from any third party staffing entity) herein called the “Providers”, to render certain medical and surgical services for hereinafter named patient, the providers and patient do hereby agree as follows:

(1) It is understood that any dispute as to medical malpractice, that is as to whether any medical service rendered under this contract were unnecessary or unauthorized or were improperly, negligently or incompetently rendered, will be determined by submission to arbitration as provided by the laws of the State of Tennessee, TN Code Ann. § 29-5-302 (1980), and not by a lawsuit or resort to court process except as the law of the State of Tennessee provides for judicial review of arbitration proceeding, both parties to this contract, by entering into it, are giving up their right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

(2) In the event of any claim, demand, controversy, civil action or dispute, including but not limited to personal injury, malpractice, or any tort, whether brought in tort, contract or otherwise, by Patient, his dependents, whether or not minors, heirs at law, or person representatives, against Doctor or any of Doctor’s officers, directors, shareholders, agents, representatives, employees, successors in interest, assigns, staff physicians or associates agreeing in writing to be bound by this arbitration provisions of the agreement (“Affiliates”) THE SOLE METHOD FOR RESOLVING SUCH DISPUTE SHALL BE BY BINDING ARBITRATION ADMINISTERED BY THE AMERICAN ARBITRATION ASSOCIATION in accordance with the Commercial Arbitration Rules of the American Arbitration Association. The parties hereby agree that they shall submit their controversy to a sole Arbitrator who is a medical doctor and a member of the American Academy of Cosmetic Surgery or the American Society of Cosmetic Breast Surgery, who shall decide the controversy based on the evidence presented. The arbitrator will be agreed upon by mutual consent of the parties. It is agreed that all parties relevant to a full and complete settlement of any dispute subject to this agreement may be interviewed or joined.

(3) The prevailing party in any arbitration pursuant to this agreement shall be responsible for all costs, including reasonable attorneys’ fees and the arbitrators’ fees, in prosecuting or defending the claim in arbitration, but not to exceed $2,000.00 in amount. Furthermore, if any action is initiated or undertaken to set aside or otherwise attack this arbitration agreement or award, or to compel arbitration, the prevailing party in the court action shall be entitled to all costs of such action, including reasonable attorney’s fees as may be fixed by the court.

(4) Any party initiating arbitration under this agreement shall file with his/her petition a bond or cash surety in the amount equal to One Thousand Dollars ($1,000.00), which shall provide security for attorney’s fees and costs in the event that the moving party should not prevail.

Consent to Arbitration

(5) In the event that any provision of this agreement shall be void or unenforceable for any reason whatsoever, then such provision or provisions shall be stricken and shall be of no force and effect. The remaining provisions of this agreement, however, shall continue in full force and effect, and to the extent required, shall be modified to preserve their validity.

(6) This agreement shall not limit the ability of the physician, in the exercise of his professional judgment, to refer the patient to other physicians or to decline further medical treatment to the patient.

(7) Further, it is understood that a patient's medical information will be considered private, and will only be released after a signed request. Even though HIPAA statues do allow for covered medical entities to release information to other covered entities, the privacy standard of the Providers is stricter, and private information will NOT be released to other HIPAA entities without the permission of the patient. Likewise, the patient agrees to protect the trade and reputation of the Providers by extending a similar level of consideration. Only permissible avenue of dispute resolution is this binding arbitration process, and the patient agrees to make no statements, public or private, written or oral, which would harm the trade of the Providers. A violation will result in damages of no less than $20,000.00. By statute, the results of any Arbitration finding may become a matter of public record.

(8) This agreement shall be construed in accordance with and governed by the law of the State of Tennessee.

THIS IS A BINDING LEGAL DOCUMENT, WHICH MAY HAVE AN IMPORTANT EFFECT ON YOUR LEGAL RIGHTS. THIS AGREEMENT PROVIDES THAT ALL MEDICAL CONTROVERSIES SHALL BE DECIDED BY AN ABITRATOR AGREED UPON MUTUALLY. CONSULT YOUR ATTORNEY ON ANY QUESTIONS YOU MAY HAVE. NOTICE: BY SIGNING THIS CONTRACT YOU ARE AGREEING TO HAVE ANY ISSUE OF MEDICAL MALPRACTICE DECIDED BY NEUTRAL ARBITRATION AND YOU ARE GIVING UP YOUR RIGHT TO A JURY OR COURT TRIAL. SEE ARTICLE ONE (1) OF THIS CONTRACT.

I, _____, of lawful age, being first duly sworn, upon oath, state that I am the patient above named; that I have read the foregoing MEDICAL ARBITRATION AGREEMENT; that I am familiar with the contents thereof and understand the same; and have been afforded the opportunity for legal counsel prior to the signing thereof.

_____ _____

Patient Signature Date