NEW PATIENT FORMS

Date: ____________________________

First Name: ____________________________ Middle Initial: ____ Last Name: ____________________________________
Date of birth:_________________________ Gender: ________________
Street Address: ___________________________________ City: _______________________ State:______ Zip:___________
Preferred phone number: _____________________________________(please circle type: home work mobile)
(If you would like to receive appointment reminders via text message at the above number, check box ☐)
please note phone number must be a mobile phone number to receive reminders via text message
Secondary phone number: _________________________________ (please circle type: home work mobile)
E-mail address:____
(To receive appointment reminders via e-mail, check here ☐ To join the patient portal, check here ☐)
Occupation: ____
Emergency contact name and phone number: ____

Insurance

Primary Insurance
Subscriber name and date of birth (if other than self):
____
Insurance Carrier:_________________________________
ID:____
Group:____

Secondary Insurance (if applicable):
Subscriber name and date of birth (if other than self):
____
Insurance Carrier:_________________________________
ID:____
Group:____

Account Responsibility:
Name of responsible party:_____________________________________
Relationship to patient:____
Address (if other than patient address):____

CONSENT TO LEAVE MEDICAL INFORMATION ON VOICEMAIL

Dr. Watnick, Dr. Mohammadi, Dr. Sklar, or their delegates may need to leave a message on your answering machine regarding your results or any other medical information pertaining to your medical care.

PLEASE CIRCLE ONE OPTION: YES LEAVE A VOICEMAIL / NO DO NOT LEAVE A VOICEMAIL

Signature:____ **Date:**_____________________

Phone number to leave message(if yes circled above): ____

INSURANCE AUTHORIZATION

I hereby authorize Dr. Watnick, Dr. Mohammadi, and Dr. Sklar to provide my information to my insurance carriers concerning my treatment and hereby assign to the physicians all payments for all medical services rendered to me or my dependents. I understand I am responsible for any deductibles, co-pays, or amount not covered by my insurance and that it is my responsibility to know my insurance coverage. If any unpaid balance is sent to a collection agency, I understand that I will be responsible for any charges insured from the collection agency.

Signature:____ **Date:**____________________

VERIFICATION OF CORRECT INFORMATION & NO SHOW POLICY ACKNLOWGEMENT

I hereby attest that all information listed above has been reviewed by myself and is correct. I understand that I will be charged a fee of $25.00 for any no show appointments and appointments cancelled with less than 24 hours notice.

Signature:____ **Date:**___________________

WEST BLOOMFIELD
DERMATOLOGY AND MOHS SURGERY

Medical History

Reason for your visit today: Please circle all that apply

Skin check   Change in mole   Rash   Warts   Acne   Botox/Filler   Mohs Surgery

Other (Please explain):______________________________

Primary Care Physician: ______________________________

Who referred you to this office:______________________________

Medical History: Please circle yes or no for the following

Anxiety or depression	YES/NO	Hearing loss	YES/NO
Arthritis	YES/NO	Heart disease	YES/NO
Asthma	YES/NO	HIV/AIDS	YES/NO
Atrial fibrillation	YES/NO	High cholesterol	YES/NO
Bleeding Disorder	YES/NO	Thyroid condition	YES/NO
Cancer (type:____________)	YES/NO	Inflammatory Bowel Disease	YES/NO
Chronic obstructive lung disease	YES/NO	Kidney disease	YES/NO
Diabetes mellitus	YES/NO	Liver Disease/Hepatitis/Jaundice	YES/NO
Eczema or Atopic Dermatitis	YES/NO	Psoriasis	YES/NO
Elevated blood pressure	YES/NO	Radiation therapy	YES/NO
Family history of skin cancer (list relatives: ____________ ____________)	YES/NO	Rheumatologic Disease (Lupus, Raynaud's, Rheumatoid arthritis, psoriatic arthritis, etc.)	YES/NO
Hay fever, Asthma, or Hives	YES/NO	Personal history of skin cancer (circle) Basal Cell/Squamous Cell/Melanoma	YES/NO
Stroke/TIA	YES/NO		

Please list any other medical conditions not included above:______________________________

____

Past Surgeries: Please circle yes or no for the following

Kidney transplant	YES/NO	Joint replacement please specify if yes:____________ ____________	YES/NO
Pacemaker/defibrillator	YES/NO	Other surgeries (please list):____________ ____________ ____________	
Skin Biopsy	YES/NO		

Personal History: Please circle one response to each question below

Smoking Status:	Immunizations:	Alcohol Use: How many times in the past year have you had 4 or more drinks in a day?
Never Smoker Current Smoker Former Smoker	Influenza:Yes/No/Prefer not to answer Pneumonia:Yes/No/Prefer not to answer COVID:Yes/No/Prefer not to answer	0 1 2 3 4 5 or more

Artificial heart valve	YES/NO	Pregnancy or planning pregnancy	YES/NO
Blood thinners	YES/NO	Problems with bleeding	YES/NO
MRSA	YES/NO	Problems with healing	YES/NO
Premedication prior to procedures	YES/NO	Problems with scarring	YES/NO
Rapid heart beat with epinephrine	YES/NO	Immunosuppression	YES/NO

Patient Signature:______________________________ Date:____________

WEST BLOOMFIELD
DERMATOLOGY AND MOHS SURGERY

Medications, Pharmacy Information, Medical History

MEDICATIONS: Please list your medications below:

Name of medication	Dosage	Frequency

DRUG ALLERGIES: Please circle yes or no to the allergies below

Adhesive YES/NO Lidocaine YES/NO Topical Antibiotics YES/NO

Please list any other allergies below:

____

____

____

PREFERRED PHARMACY

Name:____________________ Phone Number:____________________

Address:____

Financial Agreement

Due to ongoing insurance policy changes, it is no longer an easy task to monitor each individual policy. Insurance companies offer many different types of health coverage. Most of the plans require the patient to pay a deductible, copay and/or coinsurance charges. The amount of your copay, coinsurance and deductible depends on your individual insurance policy. Ultimately, it is **YOUR responsibility to understand your individual coverage.** Therefore, we strongly encourage you to check with your insurance company prior to any office procedure.

Please be advised that all costs incurred during your office visit that are not paid by your insurance company will be your responsibility to pay.

Deductible

Most insurance plans require a patient to pay an annual deductible. The patient must pay their health care provider/s for services totaling the deductible amount *before* the insurance company will begin to pay. Your insurance company will not pay any charges until you have met your *current yearly deductible.*

Copay/Coinsurance

Many insurance plans require the patient to pay a percentage of their health care costs. This amount is your coinsurance and is payable to the health care provider. You may also have a set amount you pay at each visit; this amount is your copay. If a service is not covered by the insurance plan, by law, the patient is usually responsible for the full amount.

Please Note

The billing staff will charge you according to the information provided by your insurance company. When we receive payment, if your insurance company has determined you owe additional charges, *as required by law*, you will be billed. All outstanding balances must be paid *prior* to your next visit.

I agree to pay for all charges not covered by insurance; this includes copays, coinsurance and deductibles. I have read and understand the above information and agree to pay West Bloomfield Dermatology as stated above.

Patient Signature: ______________________________Date:______________
Parent/Guardian Signature:__________________________Date:______________

Acknowledgement of privacy policy

I acknowledge that I have received the Notice of Privacy Practice for West Bloomfield Dermatology and Mohs Surgery.

_______________________________________ ________________

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:____

Authorization to release medical information to someone other than myself

Please circle YES or NO below:

NO- I do NOT authorize Dr. Watnick, Dr. Mohammadi, Dr. Sklar, or their delegates to release any of my medical information to anyone other than myself.

YES- I authorize Dr. Watnick, Dr. Mohammadi, Dr. Sklar, or their delegates to discuss all personal health information in my file with the following person(s):

____

(please list name, relationship to patient, and contact phone number for authorized individual(s))

Signature:_____________________________________ Date______________

West Bloomfield Dermatology Guidelines During COVID 19

To our Patients:
West Bloomfield Dermatology is taking every precaution to ensure your safety during this pandemic.
Appointment reminder phone calls state that patients must wear masks and that patients should cancel their appointment if they have any COVID 19 symptoms. In addition, patients should come alone if possible.
All patients and staff must wear masks at all times.
No staff will be in the office if they have any COVID 19 symptoms.
Personal Protective equipment will be worn by staff.
Exam rooms, equipment, knobs, pens, etc., will be cleaned with disinfectant between each patient visit.
Waiting room chairs will be socially distanced.

We realize that with all of these measures there is still no 100% guarantee that transmission could not occur. But we feel very confident that we are doing everything possible to substantially decrease the risk to our patients. We would like you to agree to these guidelines and measures.
Sincerely,
The Staff at West Bloomfield Dermatology

Patient Signature:____ Date:__________________

HIPAA NOTICE OF PRIVACY PRACTICES
West Bloomfield Dermatology and Mohs Surgery
5839 W. Maple Road Suite 109
West Bloomfield, MI 48322

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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment of health care operations (TP) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

1) **Uses and Disclosures of Protected Health Information**

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining payment for services rendered might require that your relevant protected health information be disclosed to the health plan to obtain approval.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment.
We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures Will be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken any action in reliance on the use or disclosure indicated in the authorization.

<u>Your Rights</u>
Following is a statement of your rights with respect to your protected health information

You have the right to inspect and copy your protected health information, Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceedings, and protected health information that is subject to law that prohibits access to protected health information

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints
You may complain to us or to the Secretary 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 our Privacy Officers, in writing, of your complaint at the address below. We will not retaliate against you for filing a complaint.

West Bloomfield Dermatology and Mohs Surgery- 5839 W. Maple Road Suite 109, West Bloomfield, MI 48322

This notice becomes effective January 1, 2021