Spectrum DERMATOLOGY

NEW PATIENT QUESTIONAIRE

Name:_____ Age:_____ DOB: ___/____/_____ Date: _____

REASON FOR TODAY'S VISIT:

1. _____ 3. _____
2. _____ 4. _____

PAST MEDICAL HISTORY (Check each box that applies)

Condition	Personal	Family	Condition	Personal	Family
Acne	☐	☐	Hay Fever/Allergies	☐	☐
Anxiety	☐	☐	High Blood Pressure	☐	☐
Arthritis	☐	☐	High Cholesterol	☐	☐
Artificial Joints	☐	☐	HIV/AIDS	☐	☐
Asthma	☐	☐	Keloids	☐	☐
Atopic Dermatitis	☐	☐	Liver Disease	☐	☐
Autoimmune	☐	☐	Lung Disease	☐	☐
Explain: _____			Multiple Sclerosis	☐	☐
Bleeding Disorder	☐	☐	Psoriasis	☐	☐
Clotting Disorder	☐	☐	Radiation Treatment	☐	☐
Cancer	☐	☐	Rosacea	☐	☐
Explain: _____			Thyroid Disorder	☐	☐
Crohn's/Colitis	☐	☐	Transplant	☐	☐
Celiac Disease	☐	☐	Other (Including surgeries): _____		
Diabetes	☐	☐	_____		

GENERAL SKIN HEALTH & SKIN CANCER HISTORY

	Yes	No
Have you been to a dermatologist previously?	☐	☐
Have you ever had any moles removed?	☐	☐
If yes, were any "atypical" or "dysplastic"?	☐	☐
Have you ever had a "pre-cancer" or actinic keratosis	☐	☐
Have you ever had a skin cancer?	☐	☐

If yes, please list type (basal cell, squamous cell, melanoma, etc), location, and date:

_____ _____

_____ _____

	Yes	No
Have you ever had a melanoma?	☐	☐
Do you have and 1st degree relatives with a history of melanoma?	☐	☐
Do you have a history of blistering sunburns?	☐	☐
Do you have a history of tanning bed use?	☐	☐
Do you use sunscreen? If yes, what SPF? _____	☐	☐

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Name:_____ Age:_____ DOB: ___/____/_____ Date: _____

OTHER MEDICAL HISTORY

	Yes	No
Have you had any joints replaced within the last 2 years?	☐	☐
Do you have a pacemaker/defibrillator?	☐	☐
Did you have heart surgery as an infant/child?	☐	☐
Do you have an artificial heart valve?	☐	☐
Have you ever had an infected heart valve?	☐	☐
Do you get cold sores? If yes, how often? _____	☐	☐

MEDICATIONS (+supplements, IUDs, patches, etc): **ALLERGIES to MEDICATIONS (list reaction):**

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

OTHER ALLERGIES

	Yes	No
Do you have any allergy to adhesive?	☐	☐
Have you had any issues with local anesthetics (lidocaine, novocaine)?	☐	☐

If Yes, what was your reaction? _____

Preferred Pharmacy (with address): _____

SOCIAL HISTORY

Occupation: _____
_____
Recreational drug use? Yes ☐ No ☐
If yes, details: _____
Do you drink alcohol? Yes ☐ No ☐
If yes, number of drinks/week? _____
Do you smoke/use tobacco? Yes ☐ No ☐
If yes, number of packs/day? _____

FAMILY PLANNING (Females Only)

Are you pregnant, planning a pregnancy, or nursing? Yes ☐ No ☐
Are you using contraception? Yes ☐ No ☐
If yes, list type: _____
Do you have regular periods? Yes ☐ No ☐
If no, please explain: _____

OTHER ITEMS OF INTEREST Please check all that apply. If there is any remaining time during your visit we may discuss these concerns as time allows.

☐ Acne/Rosacea
☐ Acne Scars or other Scars
☐ Age Spots/Dark Spots
☐ Chemical Peels
☐ Skin Rejuvenation
☐ Benign Mole Removal
☐ Skin Product Advice
☐ Botox/Dysport
☐ Supplements
☐ Stress Relief
☐ Diet Modification
☐ Meditation

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GENERAL CONSENT

I am a patient and I have the right to know about my medical condition and what my physician is recommending to me to treat my medical condition. I agree to a physical examination and, if needed, to provide consent on a verbal basis for minor diagnostic or therapeutic procedures such as cryotherapy, skin biopsy, and/or injections. My physician will inform me about the risks, benefits, and alternatives of these minor procedures and will obtain my verbal consent prior to the procedure.

I know there are certain risks involved with most procedures such as pain, swelling, loss of blood, infection, scarring, nerve/muscle damage, allergic reactions, organ injury, heart attack, blood clots, stroke, and death. I also understand things may happen during the procedure which may cause my doctor to have to perform other procedures which he/she might not have planned. If that happens, I want my physician to do those additional procedures if he/she thinks they are needed.

I consent to the examination, use, storage, and disposal by Spectrum Dermatology of any tissue that may be removed during the procedure. If any individual(s) involved in my care is exposed to any of these, I consent to having any bodily fluid(s) and/or tissue submitted for any testing deemed reasonable by my physician. I know and agree that the results of these tests will be made available to any healthcare provider(s) who may have been exposed to such fluids and/or tissue. I consent to the taking and storage of pictures, videos, or electronic images for the purposes of documentation, medical education, or training provided attempts are made to conceal my identity.

I agree my physician has given me the opportunity to ask questions and I have read this entire form.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

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PRIVACY AND SHARING OF INFORMATION

I authorize the clinic and its associated health professionals to collect my personal and medical information as documented above. In addition, I authorize the clinic and its associated health professionals to communicate with my family doctor and/or referring doctor as deemed necessary for my beneficial treatment. I also understand that my personal and medical information is confidential and will only be disclosed to third parties with my permission.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

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Spectrum DERMATOLOGY

FINANCIAL POLICIES

Thank you for choosing Spectrum Dermatology for your skin care needs. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential element of your care. With healthcare costs shifting to patient responsibility, it is essential you understand responsibilities fully. To help you in this, we provide transparent costs of all of our services, with payment expected in full at the time of your visit.

Please read carefully and sign at the bottom to confirm your understanding.

1) **Direct Care Policy: Payment is expected in full at the time of services.**

2) Insurance: Spectrum Dermatology is a direct care (or fee-for-service) dermatology practice. This means patients are responsible for the cost of their visit in full at the time of the appointment. Charges will not be filed through insurance, regardless of your policy. Medicare Part B eligible or enrolled patients must sign a private contract with Spectrum Dermatology in order to receive services and care. Commercially insured patients may request coding documentation for their visit in order to submit for reimbursement from their insurance. This submission would be the sole responsibility of the patient and may incur additional charges for completion of coding documentation.

3) Cancellation and Missed Appointments: We understand that unexpected events, illnesses, etc occur. When this happens, call our office as soon possible to inform us of such issues. In the case of missed appointments or cancellations within 24 hours of the appointment:

    a) Cancelled Appointments- I understand that it is my responsibility to cancel my appointment 24 hours in advance of my appointment time and date, otherwise a $50 fee will be billed to my account.

    b) Missed Appointments- Any missed appointment without notification will require a 100% visit cost deposit in order to reschedule.

4) Other Fees: Occasionally, there may be additional fees for staff time, administrative work, or extra tasks that are done on your behalf. We will inform you beforehand if extra fees are involved. These include but are not limited to: pathology fees (may also be submitted through insurance if desired), forms such as FMLA or disability, prior authorizations, medical coding/billing forms for reimbursement, and administration of certain medications. Specific details regarding these fees will be discussed as needed.

5) Methods of payment accept are: Cash, Credit Card, and personal checks with proper identification (valid Driver's license or photo ID). A $30.00 overdraft charge will be added to the insufficient funds amount of any returned checks.

6) I have read the above financial policies and understand my financial responsibilities as a patient. I understand that failure to make payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees.

7) Some patients may opt to maintain a credit card on file for convenience. The card information is stored with security--the same HIPAA compliant software that protects your confidential medical information. By signing this form you authorize Spectrum Dermatology to bill your card on file. Receipt of any transaction will be forwarded to the email address or home address in our records.

_____
Patient Name

_____ _____
Patient or Guardian Signature Date

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CANCELLATION/MISSED APPOINTMENT/LATE ARRIVAL POLICIES

Your appointment time is reserved just for you. A late cancellation or missed visit leaves a hole in the physician's day that could have been filled by another patient. As such, we require 24 hours' notice for any cancellations or changes to your appointment. We understand that unexpected events, illnesses, etc occur. When this happens, call our office as soon possible to inform us of such issues. Patients who provide less than 24 hours' notice, or miss their appointment, will be charged a cancellation fee.

Cancelled Appointments - I understand that it is my responsibility to cancel my appointment 24 hours in advance of my appointment time and date, otherwise a $50 fee will be billed to my account.

Missed Appointments - Any missed appointment without notification will require a 100% visit cost deposit in order to reschedule.

Late Arrival Policy - At Spectrum Dermatology, we utilize time-based billing and, as such, strive to run on-time for everyone's convenience. We ask that NEW patients arrive at least 10 minutes prior to your scheduled appointment time, and ESTABLISHED patients arrive at least 5 minutes prior to your scheduled appointment time. This will ensure adequate time to check-in and sign applicable forms. If you arrive after these times, any time required to check-in will result in a reduction in your time spent with the physician without a reduction in charges. If you arrive after more than half of your scheduled appointment time has elapsed, you have the option to be seen during the remaining time while being responsible for the full appointment time charges. Alternatively, you may also opt to reschedule for another appointment time during the same day, if available, or may reschedule for a later date. Rescheduling fees may apply.

_____

Patient Name

_____ _____

Patient or Guardian Signature Date

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INSURANCE REIMBURSEMENT POLICIES

Spectrum Dermatology makes no representation that your claim will be reimbursed partially or in its entirety. For privately insured patients, upon request, we can provide the necessary information for you via a coded superbill to file a claim with your insurance company (there may be a small charge to cover the physician's time). Additionally, you will need to print and complete the appropriate reimbursement form and submit to your insurance. If you cannot find the appropriate form for your insurance, you may use the Universal Health Insurance Claim Form and should contact your insurance to make sure no other specific form needs to be completed. All questions regarding your insurance coverage and reimbursement should be directed toward your insurance company or benefits manager.

Please note that by law Medicare and Medicaid patients cannot submit for reimbursement.

_____ _____

Patient/parent/guardian signature Date

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NOTICE OF PRIVACY PRACTICES

Effective Date: December 31, 2020
Last Revised: June 3, 2021

WHAT IS THIS NOTICE OF PRIVACY PRACTICES?

This notice describes ways in which your medical information may be used and disclosed. This notice also explains *your* rights and the obligations *we* have regarding the use and disclosure of medical information. This notice applies to ALL of your records generated and used by Spectrum Dermatology, whether made by the practice or another facility. This notice describes our policies which extend to all areas of our practice, all who work for or with our practice, and any business associates involved in the handling of your medical information. Please review carefully.

YOUR PERSONAL MEDICAL INFORMATION - "PROTECTED HEALTH INFORMATION" (PHI)

Your medical/health information is personal, and we are committed to protecting the information about you. At Spectrum Dermatology, we create paper and electronic records of the care and services/items you receive at our office. We must keep such records to provide you with quality care and to comply with certain legal requirements.

OUR PRACTICES REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

As a medical practice that does not communicate with health insurance companies and other health payers, Spectrum Dermatology is not subject to the federal HIPAA regulations. The practice is subject to various state of Ohio laws which govern medical records. Nonetheless, we have based our internal practices on the HIPAA regulations. Our practices include:

- Ensuring that your protected health information (PHI) is kept private;
- Providing you with our Notice of Privacy Practices that details how we use and disclose your PHI;
- Following the practices detailed in the notice that is currently in effect.

Changes to our Privacy Practices: We reserve the right to change our privacy practices at any time. We will always have a copy of the current notice available in the office. The notice will contain the date of last revision and effective date on the first page (top right hand corner). Each time you visit the office you may request a copy of the current notice in effect.

Handling of Protected Health Information (PHI): This notice will detail how we use and disclose your PHI. Other uses and disclosures of PHI *not* covered by this notice or the laws that apply to us will be made *only with your written permission.* Examples of requests requiring written authorization include release of PHI to:

- Another physician,
- Yourself or a family member,
- A life insurance company.

If you have provided us with your permission to use or disclose your PHI, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose your PHI for the reason covered by your written authorization.

HOW WE USE & DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)

The following categories describe different general ways (with examples) which we use and disclose PHI without a special written authorization from you.

▶ Medical Treatment: We may use your PHI to provide you with medical treatment or services. We may disclose your PHI to other health care professionals who are, were, or may become involved in taking care of you. Examples include sharing your information with: your family doctor that referred you here initially, a friend or family member involved in your care, a doctor we refer you to for a special treatment, or someone who helps pay for your care.

▶ Payment: We may use and disclose your PHI so that the treatment and services that you receive may processed by a third-party such as a credit card processor.

▶ Operational Uses: We do many things that any business would do. We may use and disclose PHI so that we can run our practice more efficiently and make sure that our patients receive quality care. Such uses may include those associated with evaluating the quality of care we give (via internal or external review/audit), training our staff, complying with legal requirements/ lawyers, and other such business operations. When business associates are used, we shall advise them of their continued obligation to maintain the privacy of your medical records.

▶ Appointment, Treatment, Recall Reminders: We may use and disclose PHI to contact you as a reminder that you have an appointment with us or that you are due for an appointment with us. This contact may be via telephone, text, e-mail, postcards, or other means and may involve leaving a message on e-mail, text, voice mail, an answering machine, or with family, etc. Others could pick up such communications.

▶ Marketing/ New and Special Treatments: We may use and disclose PHI to keep you posted about procedures, treatments, or products that you might find of interest. We may also use PHI to inform you about our upcoming events, seminars, and discounts on products/services.

▶ Pathology / Blood work: We may use and disclose PHI to diagnostic labs/ pathology labs in order to send specimens and receive results for you.

▶ Required By Law: We will disclose PHI when required to do so by federal, state or local law. We may also release PHI to a law enforcement official to report or solve crimes and in response to a court order, subpoena, warrant, summons, or similar process.

▶ Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We may also disclose PHI in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We shall attempt in these cases to tell you about the request so you may obtain an order protecting the information requested if you so desire. We may also disclose PHI to defend any member of our practice in any actual or threatened action.

SPECIAL SITUATIONS

▶ To Avert a Serious Threat to Health or Safety: We may use and disclose PHI when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may share PHI with federal officials for national security reasons.

▶ Organ and Tissue Donation: If you are an organ donor, we may release PHI to appropriate organizations to facilitate organ or tissue donation and transplantation.

▶ Disaster relief: We may disclose PHI to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

▶ Workers Compensation: We may release PHI for workers compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.

▶ Public Health Risks: Law or public policy requires us to disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury, or disability;
- To report births and deaths;
- To report child abuse or neglect;
- To report reactions to medications or problems with products;
- To notify a people of recalls of products they may be using;
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
- To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

▶ Investigation and Government Activities: We may disclose PHI to a local, state or federal agency for activities authorized by law. These oversight activities may include audits, investigations, inspections, and licensure. These activities are necessary for the government, health plans, and other regulatory agencies to monitor the health care system, government programs, and compliance with laws.

▶ Coroners, Medical Examiners and Funeral Directors: We may release PHI to a coroner or medical examiner, for example, to help identify a deceased person or determine the cause of death. We may also release PHI to funeral directors as necessary to carry out their duties.

PATIENT RIGHTS REGARDING PROTECTED HEALTH INFORMATION (PHI)

Our practice voluntarily extends to you these rights regarding medical information we maintain about you:

♦ **Right to Inspect and Copy:** You have the right to inspect and have copies of your PHI (including medical and billing records but not psychotherapy notes). Upon proof of an appropriate legal relationship, records of others related to you or under your care (guardian or custodial) may also be disclosed.

To inspect and have a copy of your medical record, you must submit your request in writing to Spectrum Dermatology - Attn: Compliance Officer. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or other supplies (tapes, disks, etc.) associated with your request. We may deny your request in certain very limited circumstances. If we deny your request, we will explain why, and you may request that the denial be reviewed.

♦ **Right to Amend:** If you feel that the medical information we have about you in your record is incorrect or incomplete, then you may ask us to amend the information, following the procedure below. You have the right to request an amendment for as long as the practice maintains your medical record.

To request an amendment, submit the request in writing to Meghan Crute, M.D. You must identify your intended amendment and a reason that supports your request to amend. The information must be dated, signed by you, and notarized.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us;
- Is not part of our records;
- Is not part of the information which you would be permitted to inspect;
- Is accurate and complete.

If we deny amending your PHI, we will tell you why, and we will explain other steps you can take.

♦ **Right to an Accounting of Disclosures:** You have the right to request this "accounting" or list of the disclosures we have made of your PHI to others. The list will *not* include the disclosures detailed above that are for purposes of treatment, payment, and healthcare operations (i.e. those disclosures *not* requiring special authorization from you).

To request this list, you must submit your request in writing to Spectrum Dermatology – Attn: Compliance Officer. You may ask for the "accounting" of those who have seen your PHI in the past 6 years. The first list you request within a twelve (12) month period will be free. For additional lists, we may charge you a fee.

♦ **Right to Request Restrictions:** You have the right to request *in writing* a restriction or limitation on the medical information we use or disclose about you. *We are not required to agree to your request and we may not be able to comply with your request.* For example, you may request a limit on the information we disclose about you to a family member or friend. If we do agree to honor your request, we will comply with your request except in the case of an emergency.

♦ **Right to Request Confidential Communications:** You have the right to request *in writing* that we communicate with you in certain ways or at certain locations. For example, you can ask that we contact you at work instead of home. Or, you may request that we not leave messages on voice mail, e-mail, or the like. We will attempt to accommodate all *reasonable* requests.

♦ **Right to a Paper Copy of This Notice:** You may ask us to give you a copy of this notice at any time.

♦ **Right to Complain:** To file a complaint with the practice, submit your complaint *in writing* to Meghan Crute, M.D. All complaints shall be investigated without repercussion to you. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF SPECTRUM DERMATOLOGY PRIVACY NOTICE

I have received a copy of Spectrum Dermatology's Notice of Privacy Practices.

Signature: _____ **Date: _____**

Patient Name: _____ **Witness: _____**

If not signed by patient, please indicate relationship to patient: _____

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COMMUNICATIONS POLICIES

Voicemail:

Spectrum Dermatology staff may contact you via phone and leave a voicemail on your answering service on any phone number associated with your patient profile. With your permission, we may leave detailed information including personal & protected health information on this voicemail.

☐ I consent to allowing Spectrum Dermatology staff to leave detailed voicemail messages on answering machines associated with any number on my patient profile. This includes but is not limited to demographic information (full name, date of birth, address, etc), appointment details, billing information (including outstanding balances), medical information (including diagnoses, biopsy results, laboratory results, medication specifics, etc) or instructions from your physician.

☐ I understand that this consent is not required to receive treatment at Spectrum Dermatology and can be revoked at any time by sending a written request to Spectrum Dermatology. Otherwise, this consent is valid until a revocation is requested.

By signing below, I understand and consent to Spectrum Dermatology leaving detailed voicemails which may contain personal details or protected health information.

Email and Text Messaging:

☐ I understand that, despite Spectrum Dermatology's best efforts to safeguard these methods of communication, email or standard text communication may not be secure. There is the potential that an email or text message can be intercepted and read by an unintended party. This includes personal health information you do not want other people or parties to be informed of. If this is of concern to you, you should not communicate with our office through email or text messaging. This document constitutes a notice of privacy practices for email and text messaging SMS use. Additionally, you should be aware of and understand that if you use email provided by your employer, any email sent on your employer's system may be viewed by your employer. Spectrum Dermatology cannot and does not guarantee the privacy or security of any emails or text message communications.

☐ I have been informed of and understand the risks and procedures involved with using email and text messaging.

I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of email or text messaging as one form of communication (including personal health information) with my physician, and his/her associates, technicians, and other health care providers.

Signature: _____ Date: _____

Patient Name: _____

If not signed by patient, please indicate relationship to patient: _____

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Spectrum DERMATOLOGY

Credit Card Processing Privacy Policies

Stripe, Jane App, Square, and Other Credit Card Processing. On occasion, you will need to place a credit card on-file to book appointments. You have the right to request to use a different form of payment at the time of your visit if desired (alternate credit card, FSA/HSA account, cash). We currently accept Visa, Mastercard, Discover, and American Express credit cards. This card will not be charged until the time of your visit or if there are cancellation or no show fees that would be applicable. We use Stripe for online payment, analytics, and other business services. Stripe collects identifying information about the devices that connect to its services. Stripe uses this information to operate and improve the services it provides to us, including for fraud detection. You can learn more about Stripe and read its privacy policy at https://stripe.com/privacy. We utilize Square for in-office charges. Their privacy policies can be accessed via the following link https://squareup.com/us/en/legal/general/square-pay-pn.

☐ I have been informed of and understand the credit card processing privacy policies.

Signature: _____ Date: _____

Patient Name: _____

If not signed by patient, please indicate relationship to patient: _____

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