ADVANCED DERMATOLOGY ASSOCIATES OF SUSSEX COUNTY, P.C.

Please clearly complete the following **patient** information:

Patients Full Name: _____

Address**:**_____

City, State: _____ Zip Code: _____

Home Phone #:_____ Cell Phone #:_____

SSN: _____--_____--_____ Date of Birth:_____ Age:_____ Sex: M□ □ F□ □

Married □ Single □ Divorced □□ Widow □

Primary Care Physician's Name, Address, Phone #: _____

_____

Pharmacy Name & Phone #:_____

Patient Employer:_____ Work Phone #: _____

Employer Address: _____

City, State: _____ Zip Code:_____

Occupation:_____

Insurance Information:

Primary Insurance:_____

Policy Holder Name: _____ **Date of Birth**: _____

SSN: _____--_____--_____ **Relationship to Patient**: _____

Ins. Address:_____

ID #_____ Group #_____

Secondary Insurance:_____ID#_____

Name of Insured:_____ Date of Birth:_____

Emergency Contact Information:

Name:_____ Relationship:_____ Phone #: _____

Advanced Dermatology Assoc. of Sussex County, P.C.

Medical History

Patient name: _____ Age: _____ Date of birth: ____/____/____

Allergies:
Current Medications:
Medical Problems:

Reason for today's visit: (chief complaint)
_____
_____
_____
_____

Current or past problems with: (Review of systems)

	YES	**NO**	**(If YES explain)**
General Health (Fever, Weight loss)	□	□	_____
Eyes	□	□	_____
Ears/Nose/Throat/Mouth	□	□	_____
Heart	□	□	_____
Lungs	□	□	_____
Stomach/bowel	□	□	_____
Kidney	□	□	_____
Arthritis/muscles/joints	□	□	_____
Headaches/seizures	□	□	_____
Psychological disorder	□	□	_____
Thyroid/diabetes	□	□	_____
Blood/bleeding disorder	□	□	_____
Allergic/immunologic	□	□	_____
Blood transfusions	□	□	_____
HIV	□	□	_____
Hepatitis B/C	□	□	_____

Skin:

Have you ever had skin cancer? □ YES □ NO
Has anyone in your family had skin cancer? □ YES □ NO
Do you have a history of any specific skin diseases? □ YES □ NO If **YES**, _____
Do you have problem with healing? □ YES □ NO
Do you develop keloids (scars) after surgery? □ YES □ NO
Do you bleed easily? □ YES □ NO
Do you develop skin rashes in reaction to □ Medications □ Food □ Environment □ Bandages
□ Topical Neosporin □ Other _____

_____ ___/___/___
Physician Signature Date

Advanced Dermatology Assoc. of Sussex County, P.C.

Family History: (Past family & Social history)

Mother: living/deceased _____ age____ Father: living/deceased_____ age ____

Medical Problems (Mother): Medical Problems (Father):

_____ _____

_____ _____

How many children do you have?____ age(s) _____

Social History:

Do you drink alcohol? □ YES □ NO If YES _____ drinks per day

Do you smoke? □ YES □ NO If YES, how much: _____

Do you use IV drugs? □ YES □ NO If YES, what? _____How Often? _____

Please answer the following questions:

(Women) Are you pregnant? □YES □ NO Due Date: ___/___/___

What is your occupation? _____

Completed by:

□ Patient

□ Parent/ Guardian _____ ___/___/___

□ Medical Assistant _____ Signed by Patient Date

_____ ___/___/___

Reviewed by Date

Advanced Dermatology Associates of Sussex County, PC
1 Centre Street
Sparta, NJ 07871
P: 973-729-3945 F: 973-729-7441

AUTHORIZATION FOR TREATMENT

By my signature below, I authorize evaluation and/or treatment by the providers at Advanced Dermatology.

- I understand that many dermatological conditions are chronic and require ongoing care which may result in multiple visits.
- I understand that all medications may have side effects and there are risks to any medication prescribed.
- Dermatologists frequently diagnose skin growths by performing a biopsy and may treat skin growths by freezing, cauterizing, and/or injection.
- I understand that there are risks to any procedure and these risks include, but are not limited to: temporary or permanent discoloration, blistering, pain, bleeding, infection, and scarring.
- I consent to having these procedures done as part of my care and treatment.

Patient or Responsible Party's Signature: _____ Date: _____

Patient or Responsible Party's Printed Name: _____

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below I acknowledge that I have been provided with an opportunity to review the Notice of Privacy Practices.

I give my permission to the staff and physicians to communicate my lab, biopsy results, treatment, payment and/or follow-up messages as described below:

I can be reached at the following phone number:_____

or a message may be left as described below (please check all that apply)

___ Home phone

___ Cell phone

___Work phone

___ Other _____

If I am not there, you may share the information with:

Name:_____

Relationship: _____

Phone Number: _____

I understand that I must write to Advanced Dermatology Associates of Sussex County to change or revoke any of my preferences indicated above. No verbal instructions will be accepted.

_____

Signature of Patient/Guardian Date

This authorization and consent shall remain in effect for this visit and all future visits to this office and will be updated every three years

Advanced Dermatology Associates of Sussex County, PC
1 Centre St
Sparta, NJ 07871
P: 973-729-3945 F: 973-729-7441

OFFICE & FINANCIAL POLICIES

Welcome to our office. In order to provide you with the best care possible, your understanding of our policies is essential. To ensure smooth operation of the practice, our office, patient and financial policies are outlined below:

INSURANCE: We participate in several insurance plans and will be happy to bill on your behalf whenever medically applicable, as long as we are a contracted provider with your insurance company. It is your responsibility to provide this office with accurate insurance information and to notify us of any changes in health insurance coverage. Please note that insurance coverage is a contract BETWEEN YOU and YOUR INSURANCE COMPANY—NOT between the doctor and your insurance company. The insurance companies are increasingly reminding us that they have NO obligation to pay the provider for services. Verification of benefits is not a guarantee of coverage. If your insurance carrier denies payment for services rendered, you will be financially responsible. **If your insurance plan requires a referral it is your responsibility to obtain the referral and have it sent prior to your appointment. Please bring your current insurance card to every appointment.** Please consult the office staff before treatment is rendered if you have any questions.

KNOW YOUR BENEFITS: Each insurance company, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurance company, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have related to your own benefits with them.

COPAYMENTS: All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. If you arrive for your visit without your co-pay, you may be asked to reschedule.

NON-COVERED SERVICES: Advanced Dermatology may provide services that may not be covered as a benefit of your specific insurance plan. Patients or Guarantors are financially responsible for any and all services provided that are not covered. **It is your responsibility to know and understand your specific insurance plan and what benefits are provided**.

PRIVATE PAY/SELF PAY/COSMETIC: Payment in full is due at the time of visit for all cosmetic services and for patients without medical insurance.

PATIENT BALANCES: Most insurance companies have a deductible or co-pay/co-insurance which YOU are responsible for. Any balance must be paid before or at the time of your next appointment unless otherwise arranged in advance by our billing staff.

RETURNED CHECKS: There is a $25 fee for returned checks. If your check is returned from the bank, we may not accept an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

NONPAYMENT: Any outstanding account not paid after 60 days will be assessed a 12% finance charge. If there is still a balance on your account after three billing cycles, the unpaid balance may be turned over to a collection agency. Patients sent to collections may be discharged from the practice unless their balance is paid in full.

NO SHOW, CANCELLATION AND LATENESS POLICY: If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of 24 hour notice. There will be a $25 fee for missed appointments. If you arrive more than 20 minutes late you may be asked to reschedule.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, pathology and lab samples are sent out to the appropriate lab according to your insurance to the best of our knowledge. These services are billed independently of Advanced Dermatology. You may receive a bill from the outside lab and will be responsible for payment to that facility.

MINOR PATIENTS: Patients under the age of 18 must be accompanied by a parent or guardian at the time of service. Please understand that it is not our position to get in the middle of family struggles over which party is responsible for the doctor's fees. Responsibility for payment of minors' fees rests with the parent/guardian who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of Advanced Dermatology

By signing below I acknowledge that I have read, understand and agree to abide by the policies of this practice.

Patient or Responsible Party's signature:_____ Date Signed:_____

Patient's Printed Name:_____

Responsible Party's Printed Name (only if applicable):_____

This shall remain in effect for this visit and all future visits to this office and will be updated every three years

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.
THIS PAGE IS YOURS TO KEEP; PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: **MARCH 19, 2007**
PRIVACY OFFICER: **ANTHONY J. PAPADOPOULOS, MD**

ADVANCED DERMATOLOGY ASSOCIATES OF SUSSEX COUNTY
1 CENTRE STREET, SPARTA, NJ 07871
PHONE: **973-729-3945** FAX: **973-729-7441**

WE CARE ABOUT OUR PATIENTS' PRIVACY AND STRIVE TO PROTECT THE CONFIDENTIALITY OF YOUR MEDICAL INFORMATION AT THIS PRACTICE.
NEW FEDERAL LEGISLATION REQUIRES THAT WE ISSUE THIS OFFICIAL NOTICE OF YOUR PRIVACY PRACTICES.

YOU HAVE THE RIGHT TO CONFIDENTIALITY OF YOUR MEDICAL INFORMATION, AND THIS PRACTICE IS REQUIRED BY LAW TO MAINTAIN THE PRIVACY OF THAT INFORMATION.

THIS PRACTICE IS REQUIRED TO ABIDE BY THE TERMS OF THE NOTICE OF PRIVACY PRACTICES CURRENTLY IN EFFECT, AND TO PROVIDE NOTICE OF ITS LEGAL DUTIES AND PRIVACY PRACTICES WITH RESPECT TO PROTECTED HEALTH INFORMATION. IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT THE PRIVACY OFFICER AT THIS PRACTICE.

HOW WE MAY DISCLOSE YOUR MEDICAL INFORMATION

THE FOLLOWING CATEGORIES DESCRIBE DIFFERENT WAYS THAT WE MAY USE AND DISCLOSE MEDICAL INFORMATION WITHOUT YOUR SPECIFIC CONSENT OR AUTHORIZATION. EXAMPLES ARE PROVIDED FOR EACH CATEGORY OF USES OR DISCLOSURES. NOT ALL POSSIBLE USES OR DISCLOSURES ARE LISTED.

TREATMENT: WE MAY USE MEDICAL INFORMATION ABOUT YOU TO PROVIDE YOU WITH MEDICAL TREATMENT OR SERVICES. **EXAMPLE:** *IN TREATING YOU FOR A SPECIFIC CONDITION, WE MAY NEED TO KNOW IF YOU HAVE ALLERGIES THAT COULD INFLUENCE WHICH MEDICATIONS WE PRESCRIBE FOR THE TREATMENT PROCESS.*

PAYMENT: WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU SO THAT THE TREATMENT AND SERVICES YOU RECEIVE FROM US MAY BE BILLED AND PAYMENT MAY BE COLLECTED FROM YOU, AN INSURANCE COMPANY OR A THIRD PARTY. **EXAMPLE**: *WE MAY NEED TO SEND YOUR PROTECTED HEALTH INFORMATION, SUCH AS YOUR NAME, ADDRESS, OFFICE VISIT DATE, AND CODES IDENTIFYING YOUR DIAGNOSIS AND TREATMENT TO YOUR INSURANCE* COMPANY FOR PAYMENT.

HEALTH CARE OPERATIONS: WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR HEALTH CARE OPERATIONS TO ASSURE THAT YOU RECEIVE QUALITY CARE. **EXAMPLE:** *WE MAY USE MEDICAL INFORMATION TO REVIEW OUR TREATMENT AND SERVICES AND EVALUATE THE PERFORMANCE OF OUR STAFF IN CARING FOR YOU.*

OTHER USES OR DISCLOSURES THAT CAN BE MADE WITHOUT YOUR CONSENT OR AUTHORIZATION.

- AS REQUIRED DURING AN INVESTIGATION BY LAW ENFORCEMENT AGENCIES.
- TO AVERT A SERIOUS THREAT TO PUBLIC HEALTH OR SAFETY.
- AS REQUIRED BY MILITARY COMMAND AUTHORITIES FOR THEIR MEDICAL RECORDS.
- TO WORKERS' COMPENSATION OR SIMILAR PROGRAMS FOR PROCESSING OF CLAIMS.
- IN RESPONSE TO A LEGAL PROCEEDING.
- TO A CORONER OR MEDICAL EXAMINER FOR IDENTIFICATION OF A BODY.
- IF AN INMATE, TO THE CORRECTIONAL INSTITUTION OF LAW ENFORCEMENT OFFICIAL.
- AS REQUIRED BY THE US FOOD AND DRUG ADMINISTRATION. (FDA)
- OTHER HEALTHCARE PROVIDER'S TREATMENT ACTIVITIES.
- OTHER COVERED ENTITLES' HEALTHCARE OPERATIONS ACTIVITIES. (TO THE EXTENT PERMITTED UNDER HIPAA)
- USES AND DISCLOSURES REQUIRED BY LAW.
- USES AND DISCLOSURES IN DOMESTIC VIOLENCE OR NEGLECT SITUATIONS.
- HEALTH OVERSIGHT ACTIVITIES.
- OTHER PUBLIC HEALTH ACTIVITIES.

WE MAY CONTACT YOU TO PROVIDE APPOINTMENT REMINDERS OR INFORMATION ABOUT TREATMENT ALTERNATIVES OR OTHER HEALTH-RELATED BENEFITS AND SERVICES THAT MAY BE OF INTEREST TO YOU.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION REQUIRING YOUR WRITTEN AUTHORIZATION

OTHER USES AND DISCLOSURES OF MEDICAL INFORMATION NOT COVERED BY THIS NOTICE OR THE LAWS THAT APPLY TO US WILL BE MADE ONLY WITH YOUR WRITTEN AUTHORIZATION. IF YOU GIVE US AUTHORIZATION TO USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU, YOU MAY REVOKE THAT AUTHORIZATION, IN WRITING AT ANY TIME. IF YOU REVOKE YOUR AUTHORIZATION WE WILL THEREAFTER NO LONGER USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU FOR THE REASONS COVERED BY YOUR WRITTEN AUTHORIZATION. WE ARE UNABLE TO TAKE BACK ANY DISCLOSURES WE HAVE ALREADY MADE WITH YOUR AUTHORIZATION, AND WE ARE REQUIRED TO RETAIN OUR RECORDS OF THE CARE WE HAVE PROVIDED YOU.

YOUR INDIVIDUAL RIGHTS REGARDING DISCLOSURES AND CHANGES TO YOUR MEDICAL INFORMATION

RIGHT TO REQUEST RESTRICTIONS: YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OR LIMITATION ON THE MEDICAL INFORMATION WE USE OR DISCLOSE ABOUT YOU FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS OR TO SOMEONE WHO IS INVOLVED IN YOUR CARE OR THE PAYMENT FOR YOUR CARE. WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST. IF WE DO AGREE, WE WILL COMPLY WITH YOUR REQUEST UNLESS THE INFORMATION IS NEEDED TO PROVIDE YOU WITH EMERGENCY TREATMENT. TO REQUEST RESTRICTIONS, YOU MUST SUBMIT YOUR REQUEST IN WRITING TO THE PRIVACY OFFICER AT THIS PRACTICE. IN YOUR REQUEST, YOU MUST TELL US WHAT INFORMATION YOU WANT TO LIMIT.

Right to an Accounting of Non-Standard Disclosures: You have the right to request a list of the disclosures we made of medical information about you. O request this list, you must submit your request to the Privacy Officer at this practice. Your request must state the time period for which you want to receive a list of disclosures that is no longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (on the paper or electronically). The first list you request within a 12-month period will be free. For additional lists, we reserve the right to charge you for the cost of providing the list.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept. To request an amendment, your request must be made in writing and submitted to the Privacy Officer at this practice. In addition, you must provide a reason that supports your request. 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 the information was not created by us. Is not part of the medical information is kept at this practice, is not part of the information which you would be permitted to inspect and copy, or which we deem to be accurate and complete. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebut. Statements of disagreement and any corresponding rebuttals will be kept on file and sent out with any future authorized requests for information pertaining to the appropriate portion of your record.

Your individual Rights Regarding Access to Medical Information

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually this includes medical and billing records but does not include psychotherapy notes, information compiled for use in a civil, criminal, or administrative action or proceeding, and protected health information to which access is prohibited by law. To inspect and copy medical information that may be used to make decisions about you, you must submit your request in writing to the Privacy Officer at this practice. If you request a copy of the information we reserve the right to charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy in a certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Another licensed health care professional chosen by this practice will review your request and the denial. The person conducting the review will not be the person who denied your request. We will comply with the outcome of the review.

Right to a paper copy of this notice: You have the right to a paper copy of your current Notice of Privacy Practices at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy. To obtain a paper copy of the current Notice, please request one in writing from the Privacy Officer at this practice.

Right to Request Confidential Communications: You have the right to request how we should send communications to you about medical matters, and where you would like those communications sent. To request confidential communications, you must make your request to the Privacy Officer at this practice. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted. We reserve the right to deny a request if it imposes an unreasonable burden on the practice.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with the Privacy Officer at this practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing. You will not be penalized or discriminated against for filing a complaint.

Who will follow this notice?

Any health care professional authorized to enter information into your medical record, all employees, staff and other personnel at this practice who may need access to your information must abide by this Notice. All subsidiaries, business associates (e.g. a billing service), sites and locations of this practice may share medical information with each other for treatment, payment purposes or health care operation described in this notice. Except where treatment is involved, only the minimum necessary information needed to accomplish the task will be shared.

Changes To This Notice

We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. We will post a copy of the current Notice, with the effective date on the posted copy.