New Patient

Name:_____ Age:_____ Pt#_____ Date:_____

WT:_____ HT:____ P:___ BP:____ R:____

Allergies:_____ Current Meds:_____

Reason(s) For Today's Visit

CC_____ 4)_____

2)_____ 5)_____

3)_____ 6)_____

History of Present Illness(HPI):[Location, Appearance, Duration, Improving or Getting Worse, Painful or not, Itching or not, Other]

_____

_____

Applicable ROS: Current or Past Problems With

	No	Yes(if yes explain)		No	Yes(if yes explain)
General Health			Arthritis/Muscle/Joints		
Eyes			Skin/Breast		
Ears/Nose/Throat/Mouth			Headaches/Seizures		
Heart			Psychological Disorders		
Lungs			Thyroid/Diabetes		
Stomach/Bowel			Blood/Bleeding Disorder		
Kidneys/Bladder			Allergic/Immunologic		

Additional Comments _____

_____

Females: are you pregnant? ___yes ___no Planning to Become Pregnant? ___yes ___no

Applicable Family and Social History: Mother Living/Deceased___ age___ Father Living / Deceased___ age___

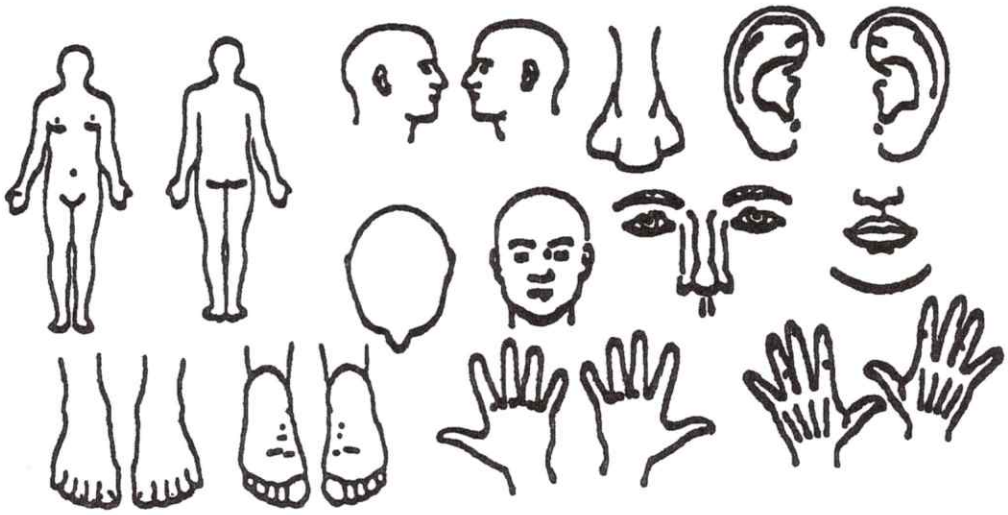
Which of the following medical conditions have occurred in your family:

Disease	Mother	Father	Blood Relative	Disease	Mother	Father	Blood Relative
Skin Cancer	O	O	O	Arthritis	O	O	O
Malignant Melanoma	O	O	O	Allergies	O	O	O
Internal Malignancy	O	O	O	Asthma	O	O	O
Other Cancers	O	O	O	Diabetes	O	O	O
Other Tumors	O	O	O	Eczema	O	O	O
Tuberculosis	O	O	O	Psoriasis	O	O	O
Lung Disease	O	O	O	Heart Disease	O	O	O

Reviewed_____ Date_____ Update_____

Physician Signature

Objective (Physical Exam)



Assessment/Diagnosis:

Test Results: _____

Recommendations/Treatment Plan:

Physician Signature: _____ Date: _____

MidMichigan Dermatology
Registration Information

Date: _____ Cell Phone: _____ Home Phone: _____

Patient: _____

Last Name First Name Middle Initial

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

Circle one: Single Married Widowed Separated Divorced Other

Email: _____

Responsible Party (if minor): _____

Home Address: _____

House number / P O Box Street

_____

City State Zip code

Name of Employer: _____

Business Address: _____

Occupation: _____ Business Phone: _____

Purpose of Visit: _____

Drug Store Name: _____ Drug Store Phone: _____

In case of emergency, who should be notified? _____ Phone: _____

My signature acknowledges that the patient does **NOT** have Medicare or Medicaid insurance plan

Signature: _____ Date: _____

This office only participates and bills for certain insurance plans, and only bills primary insurance. Payment is otherwise expected at the time of service. My signature acknowledges that if my insurance is not one of the plans this office participates with that payment will be made at the time of service. If my insurance is accepted, I acknowledge that anything not covered by my insurance will be my responsibility. I plan to pay for services with: Cash _____ Check _____ Charge Card _____

Signature: _____

Insurance Information for Those Insurance That This Office Participates With

Insurance Company Name _____

Policy Number _____

Policyholder's Name _____ Date of Birth _____

NOTIFICATION

In the event that a MidMichigan Dermatology health care worker sustains an accidental exposure to my blood or body fluids by puncture or contact with open skin or mucous membrane, I understand that my blood may be tested for HIV or other infectious diseases without further consent. I further understand that HIV is an abbreviation for Human Immunodeficiency Virus, the name of the virus now thought to be the cause of AIDS.

_____ _____

Signature of Patient Signature of Witness

_____ _____

Signature of Closest Relative or Legal Guardian (if applicable) Date Witnessed

_____

Date Signed

_____

Relationship

Mid Michigan Dermatology
Patient Authorization, Assignment, and Agreement for Hospital, Physician, and/or Surgeon Services Performed

_____
Patient Name (Please Print)

Authorization

I hereby authorize Mid Michigan Dermatology, it's Owner, President or designees, physician and/or surgeon to release to my insurance company and/or third-party payor(s) and/or external review agency(s) such information contained in my patient records as is necessary for the payment of insurance benefits without regard to any limitation placed on dates, history of illness or diagnosis and therapeutic information, including any testing and/or treatment for AIDS, AIDS-Related Complex (ARC) or HIV infection (MI 1989 Public Act 174). This authorization expires upon full payment of insurance benefits unless previously revoked, and may be revoked at any time except to the extent that action has been taken by the hospital, physician, surgeon in reliance thereon. I certify information furnished for claims to be true and correct.

Assignment

I assign to Mid Michigan Dermatology, it's Owner, President or designees, physicians and/or surgeons all rights to benefits, insurance proceeds, settlement payments, or judgements I may be entitled to, for services rendered and authorize them to submit a claim for payment on my behalf to my insurance company.

Agreement

I understand that the health insurance plan in which I am enrolled may require prior authorization or approval for coverage of treatment. In the case that coverage for the outpatient services has been requested and subsequently denied by the insurance company, I understand that if I elect to have these services performed, I will be liable for all of the respective charges that are incurred.

_____ _____
Signature of Patient Date Signature of Witness Date

_____
Signature Parent or Guardian Date

MIDMICHIGAN DERMATOLOGY

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name_____ Birthdate_____

Signature_____

Date_____

Below is For Office Use Only

Documentation of Failure to Obtain Signed Acknowledgement

I presented this Acknowledgement of Receipt of Notice of Privacy Practices Form

to_____

[ ] The patient (parent or guardian) refused to provide a signature when requested.

[ ] Communication barriers prohibited obtaining the Acknowledgement.

[ ] An Emergency situation prevented us from obtaining acknowledgement.

[ ] Other (Please specify)

_____

_____

Office Personnel Signature Date

MIDMICHIGAN DERMATOLOGY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATON ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPROTANT TO US. THIS NOTICE TAKES EFFECT ON APRIL 14, 2003 AND REMAINS INEFFECT UNTIL WE REPLACE IT.

OUR OBLIGATION:

We are required by federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the terms of the notice while it is in effect.

We have the right to change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law. We also have the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

USES AND DISCLOSURES OF MEDICAL INFORMATION:

We use and disclose medical information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your medical information to a physician or other healthcare provider providing treatment to you. We may disclose medical information about you to doctors, nurses, medical assistants, technicians, medical students, or other people involved in your diagnosis, management and/or treatment.

Payment: We may use or disclose your medical information for payment purposes.

Healthcare Operations: We may use and disclose your medical information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, accreditations, certification, licensing or credentialing activities.

We may also use and disclose medical information for the following purposes:

Required By Law: We may use or disclose your medical information when required to do so by law.

Abuse of Neglect: We may use or disclose your medical information to appropriate authorities if we reasonably believe that there is a possibility of abuse, neglect, domestic violence or victim of crime.

Notification: We may disclose your medical information to notify or help notify a family member, personal representative, friend or other person responsible for your care, of your location, general condition, or death. If you are present, we will get your permission if possible before we disclose, or give you the opportunity to refuse permission. In case of emergency we will disclose the health information that is directly necessary for your healthcare, according to our professional judgment. We will also use our professional judgment to make reasonable inferences of your best interest in allowing someone to pick up prescriptions, medicine, medical supplies, x-rays, lab results, or other medical information for you.

Family and Friends: We may disclose your medical information to a family member, friend, or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so. We will disclose medical information and treatment options only to parents or guardians of minor children unless you give us prior written authorization to disclose to another party.

Appointment Reminders: We may use or disclose your healthcare information to provide your with appointment reminders (such as voicemail messages, answering machines, postcards, letters, or messages left with other members of your family).

Marketing Health Related Services: We may notify our patients via mail or phone about various procedures or products that we provide and have available. We do not share patient names or addresses with any outside vendors for their marketing purposes.

Your Authorization: In addition to our use of your medical information as delineated you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Unless you give us a written authorization we will not use or disclose your medical information for any reason except those described in this notice.

YOUR INDIVIDUAL RIGHTS:

Access: You have the right to look at or get copies of your medical information. You may request that we provide copies in a format other than photocopies. We will use the format you request unless it is not practical for us to do so. You must make your request in writing. You may get the form to request access by using the contact information listed at the end of this notice. You may also request access by sending a letter. If you request copies, we will charge you $1.00 for each page, $20.00 per hour for staff time to locate and copy your medical information, and postage, if you want the copies mailed to you. If you request an alternative format, we will charge a cost-base fee for providing your medical information in that format.

Disclosure Accounting: You have the right to request a list of instances where we or our business associates disclosed your medical information for purposes other than treatment, payment, healthcare operations and other specified exceptions. If requested more than once in a 12-month period, we may charge you a cost- base fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do we will make every attempt to abide by our agreement (except in case of emergency).

Alternative Communications: You have the right to request that we communicate with you about your medical information by different means or to different locations. Your request must be in writing and must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location your request.

Amendment: You have the right to request that we amend your medical information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you received this notice electronically, you are entitled and have the right to request and to receive this notice in written form.

QUESTIONS AND CIMPLAINTS:

If you have any questions about this notice or want more information please contact us. We support your right to the privacy of your medical information. Contact Officer: Dr. Albert Peterson (989) 832-7915
If you have a complaint or are concerned that we may have violated your privacy rights please let us know. You may request and submit a complaint form directly to the Contact Officer at: 5103 Eastman Ave. Suite 255 Midland, Michigan 48640.
You may also submit a written complaint to the U.S. Department of Health and Human Services. WE will provide you with their address to file your complaint with them upon request.