HAYDEL DERMATOLOGY
PATIENT INFORMATION

PATIENT INFORMATION

Name:____
Last First Middle

Mailing Address:____
Street City State Zip

SS#______________ Date of Birth:__________ Age:____ Sex:_____ Marital Status:____ Race:_______ Language:______________

Home Phone:______________________________ Cell Phone:______________________________

Place of Employment:______________________________ Work Phone:______________________________

Email:______________________________

PARENT OR RESPONSIBLE PARTY

Name:____
Last First Middle

Mailing Address:____
Street City State Zip

SS#__________________ Date of Birth:______________

Home Phone:______________________________ Cell Phone:______________________________

Place of Employment:______________________________ Work Phone:______________________________

INSURANCE INFORMATION (Please present insurance card and license at the time of check in)

Primary Insurance Name______________________
Name of Insured______________________
SS#______________ Date of Birth______________
Policy#______________ Group#__________
Employer Name______________________
Employer Phone#______________________
Relationship to Patient______________________

Secondary Insurance Name______________________
Name of Insured______________________
SS#______________ Date of Birth______________
Policy#______________ Group#__________
Employer Name______________________
Employer Phone#______________________
Relationship to Patient______________________

Emergency Contact____
Name Phone Number Relationship

Pharmacy of choice______________________________ Phone number______________________

Referred By______________________________ Primary Care Physician______________________

How did you hear about our office?____

The above information is accurate and complete to the best of my knowledge and is only for use in my treatment, billing and processing of insurance benefits, for which I am entitled. I will not hold Haydel Dermatology responsible for any errors or omissions that I may have made in the completion of this form.

I authorize the release of medical information to my primary care or referring physician, to consultants if and needed as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Haydel Dermatology.

Patient or Responsible Party Signature ____Date__________

Co-pay, deductible, non-covered services and cosmetic services are due at the time of service. We accept payment in the form of cash, check, visa or mastercard, and care credit.

HAYDEL DERMATOLOGY MEDICAL HISTORY

Patient: ______________________________ Date ____/____/____
Reason for today's visit: ______________________________

Are you allergic to any medications? □Yes □ No If yes, list below:
1.__________ 2.__________ 3.__________
Have you ever had dental anesthesia (Novocaine)? □Yes □ No Any bad reaction? □Yes □No

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):
1. __________ 3.__________ 5.__________
2. __________ 4. __________ 6.__________

Do you have now, or have you ever had diseases or conditions of: (please check yes or no)

Lungs:	**YES**	**NO**
Bronchitis	□	□
Emphysema	□	□
Asthma	□	□
Shortness of Breath	□	□

Cardiovascular:	**YES**	**NO**
High Blood Pressure	□	□
Chest Pain	□	□
Heart Attack	□	□
Heart Murmur	□	□
Irregular Heartbeat	□	□
Inflammation of vein	□	□
Blood clots	□	□
Pacemaker/defibrillator	□	□

Other Systemic:	**YES**	**NO**
Diabetes	□	□
Excessive thirst/hunger	□	□
Amputation	□	□
Thyroid	□	□
Kidney	□	□
Dialysis	□	□
Gastrointestinal	□	□
Stomach absorptive disorder	□	□
Chrohn's Disease/Ulcerative Colitis	□	□
Arthritis/Joint Deformity	□	□
Joint Pain	□	□
Limited Motion	□	□
Artificial Joint	□	□
Convulsions, Epilepsy or Seizures	□	□
Fainting	□	□

Have you had or have you been exposed to HIV (AIDS)? □Yes □No
List any other diseases or conditions: ______________________________
List surgical procedures you have had in the last 6 months: ______________________________

Skin:	**YES**	**NO**
Do you get hives?	□	□
Do you have a history of fever blisters?	□	□
Have you ever had skin cancer?	□	□
Has anyone in you family had melanoma?	□	□
Do you have a history of any specific skin diseases?	□	□
Have you ever taken Accutane?	□	□
Do you develop keloids (scars) after surgery?	□	□
Do you bleed easily?	□	□
Are you on blood thinners?	□	□
Do you get nausea, vomiting, diarrhea or yeast infections from taking oral antibiotics?	□	□

Do you develop skin rashes in reaction to □Medications □ Food □ Poison Ivy □Bandages □ Topical Neosporin □ Other ______________

Social History:
Do you drink alcohol? □ Yes □ No If YES, _____ drinks per day
Do you use IV drugs? □ Yes □ No If YES, what? __________ How often? __________
Do you smoke? □ Yes □ No If YES, how much? ______________

(Women) Are you pregnant? □ Yes □ No Due date: ___/___/___
What is your occupation? ______________
Do you have a history or tendency of fainting during medical procedures? □ YES □ NO
CAN LAB TEST RESULTS BE LEFT ON YOUR ANSWERING MACHINE? □ YES □ NO

NOTE: ALL BIOPSIES ARE SENT TO DR. T. NICOTRI, A SKIN PATHOLOGIST; *SEPARATE CHARGES WILL BE INCURRED FROM HIS OFFICE.* PLEASE INQUIRE AT FRONT DESK IF YOUR INSURANCE IS ACCEPTED BY DR. NICOTRI.

Financial Policy

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication. We are committed to providing you with the best possible medical care. The following is our financial policy:

PAYMENT:

1. **All co-payments, coinsurance and deductibles are due and payable at the time of service**, regardless of who brings the patient in for the appointment. Sitters, grandparents, divorced parents, etc., must be prepared to pay at the time of service. Haydel Dermatology accepts cash, checks, debit cards, MasterCard, VISA and Care Credit.
2. Overpayments will be refunded after all charges have been processed and paid by your insurance company. A refund check will be written and mailed within 30 days of your written or verbal refund request.

INSURANCE

1. Our office participates with a variety of insurance plans. It is your responsibility to:
   a.) Bring your insurance card to each visit and notify us of any changes.
   b.) Know your co-payment, coinsurance, and deductible amounts and be prepared to pay this amount at the time of service
   c.) Know your insurance company benefits (physical exam coverage, diagnostic testing co-payment amounts and pre-certification requirements, etc.)
   d.) If you are enrolled in a Managed Care Insurance Plan (HMO) it is YOUR responsibility to obtain or ensure a referral is supplied to our office from your PCP or primary care physician prior to the time of your appointment. Without this referral, you cannot be seen by our physicians.
2. If your insurance coverage is through a plan that we do not participate with, our office is happy to file the claim for you upon request as a courtesy. However, you are responsible for payment in full at the time of service and you will be reimbursed upon payment being received from your insurance company in the event that the payment is not made directly to you.
3. We file secondary insurance claims as a courtesy. If your secondary insurance has not paid within 60 days of our first filing, you automatically become responsible for the balance of unpaid charges.

Returned Checks

The charge for a returned check is $25.00 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You may be placed on a "CASH AND CREDIT CARD ONLY" basis following any returned check. If payment for an insufficient check is not made within 10 business days, your check will be turned over to the District Attorney's Office and you will be responsible for all court cost that may be involved.

PATIENT AUTHORIZATION

I consent to treatment, including biopsies, necessary for the care of the below named patient. I understand that I will receive a separate bill from Skin Dx, Lab Corporation, or Delta Pathology (pathologist) for each skin specimen processed. (By law, Dr. Sarah Haydel is required to send skin specimens to a pathologist for biopsies and surgeries).

I have read and fully understand the above consent for treatment of biopsies and Haydel Dermatology's financial policy.

____

Patient's Name or Guardian's Name Printed Date

____

Patient's Signature or Guardian's Signature Date

Haydel Dermatology
Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a Notice of Privacy Practices by Haydel Dermatology that provides a complete description of the uses and disclosures of certain health information.

By signing this form, I consent to the use and disclosure of protected health information about me for the purpose of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already made in reliance on my prior consent.

____

Name (print)

____

Patient's Signature (or Guardian, if a minor):

____

Date

Haydel Dermatology
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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, and the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

• Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
• Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
• The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

• Most uses and disclosure of psychotherapy notes;
• Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
• Disclosures that constitute a sale of PHI under HIPAA; and
• Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 4, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information.

Compliance Officer:
Dawn Falgoust
Haydel Dermatology
578 Valhi Blvd
Houma, LA 70360
(985)223-3871
dawn@haydeldermatology.com

Sarah Haydel, MD
578 Valhi Blvd.
Houma, LA 70360
(985) 223-3871

REQUEST FOR CONFIDENTIAL COMMUNICATION

Date:______________

Name of Patient:________________________________

Date of Birth: __/__/____

Please list below anyone to whom we can disclose your medical information.

Name	**Relationship**
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________
________________________________	______________

________________________________ ______________

Patient Signature

Sarah Haydel, MD
578 Valhi Blvd.
Houma, LA 70360
(985) 223-3871

Credit Card Policy

Haydel Dermatology has implemented a credit card policy. You will be asked for a credit card number at the time you check in and the information will be held SECURELY until your insurances have paid their portion and notified us of the amount your share. At that time, any remaining balance owed by you that is $100 or less will be charged to your credit card and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, coinsurance, and deductibles will still be due at the time of service.

If you have any questions about this payment method, do not hesitate to ask.

I AUTHORIZE HAYDEL DERMATIOLOGY TO CHARGE OUTSTANDING BALANCES ON MY ACCOUNT TO THE FOLLOWING CREDIT CARD OR DEBIT CARD:

VISA / MASTERCARD / DISCOVER (CIRCLE ONE)

ACCOUNT NUMBER: ______________________________

CVV CODE (3 DIGIT CODE ON BACK OF CARD): __________ **EXP. DATE:** __________

NAME ON CARD (PLEASE PRINT) ______________________________

SIGNATURE: ______________________________ **DATE:** ______