PLEASE READ THIS FIRST

Highlands Dermatology and Surgical Associates

112 North Walnut
Cookeville, TN 38501
931-520-1414

Thank you for choosing our office for your dermatology needs. Please complete the enclosed information sheet. **If there is sufficient time before your appointment, you may mail this back to our office.** If not, keep it until your appointment time and bring it with you to your visit.

Directions: From Interstate 40, take exit 286. Go north on South Willow Ave. toward Cookeville Hospital and TTU. Turn right on Second St. You will be heading east on Second Street. You will cross Whitney Ave., Hickory Ave., Oak Ave., Cedar St. and Peachtree Ave. Second St. will end on Walnut Ave. We are on the right hand corner of Second and Walnut. Our building is brick with a black canopy over the door.

You may also take exit 287. Go north on Jefferson Ave. all the way through the square. Take a left on 1st St. Stay on 1st and cross the railroad tracks at the four way stop. Take a right on Walnut Ave. We are the second building on the left.

Insurance Information: We are participating providers with traditional Medicare. We also participate in several Medicare Advantage plans and commercial health plans. We will file with secondary/supplemental carriers for Medicare patients. Please verify with your insurance if we are in their network and if they require an authorization prior to your appointment. All copays will be expected at time of service. All others will be expected to pay at time of service unless prior arrangements have been made. We will give you forms to file with your insurance company for reimbursement. Even though we do not file, we will need to make a copy of your most current insurance cards in the event that your insurance company has questions about your claim.

Items to bring: Current list of all medications, current insurance cards, and the enclosed information sheet.

Our Policy: We ask that you call 24 hours in advance to cancel any appointment. If you are going to be 15 minutes or more late, you will need to reschedule your appointment.

Any child under 18 must have a parent or legal guardian or they will not be seen.

***Return patients:** We are sending these out to every patient who needs to update their chart. We must have these forms completed in order to complete your visit. By completing these forms at home, it will make your next office visit an even shorter one. Please don't forget to bring a current list of all medications and your most recent insurance cards.

THE BACK OF THIS FORM CONTAINS OUR
PROVIDERS' HIPAA NOTICE OF PRIVACY PRACTICES

HIPAA Notice of Privacy Practices

112 North Walnut Avenue • P.O. Box 1210 • Cookeville, TN 38503
931-520-1414

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 or health care operations (TPO) 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 my identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

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 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 practices 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 care 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 approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

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 your 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; Organ Donation; Research; Criminal Activity; Military Activity and National Security; Worker's 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 an action in reliance on the use or disclosure indicated in the authorization.

Your Rights: 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 complied in reasonable anticipation of, or use in civil, criminal, or administrative action or proceeding, 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 your physician believes it is in 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 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 an 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 contact of your complaint. You will not be penalized for filing a complaint.

This notice was published and becomes effective on/or before April 14, 2003.

We are required by law to maintain the privacy of, and provide individuals with, this notice or our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 931-520-1414.

Chart # _____

HIGHLANDS DERMATOLOGY & SURGICAL ASSOCIATES

Name _____ **Birthdate** _____ **Sex** ____**M** ____**F**

Address _____ **City, State, Zip** _____

Primary phone # _____ **Is this a cell phone?** _____**Yes** _____ **No**

Secondary phone # _____ **Emergency Contact #** _____

___Employed ___ Retired ___Student Employer _____**Emp phone #**_____

Marital Status ____**S** _____**M** _____**W** _____**D Spouse Name**_____

Responsible Party (If different from patient)

Name _____ **Birthdate**_____ **Sex**____**M**____**F**

Relationship to patient_____ **Phone #** _____

Address_____ **City, State, Zip**_____

Primary Ins. Co. _____ **Contract ID** _____ **Grp #**_____

Secondary Ins. Co. _____ **Contract ID** _____ **Grp #**_____

HIPAA Compliance: (WHO CAN WE TALK TO ABOUT YOUR HEALTHCARE. IF NO NAMES ARE LISTED, WE WILL ONLY SPEAK TO YOU ABOUT YOUR HEALTHCARE)

Spouse: _____ **Yes** _____**No Name**_____

Emergency contact: _____ **Yes** _____**No Name**_____

Primary Care Doctor: _____**Yes** _____**No Name**_____

Other: ____**Yes** _____**No Name**_____ **Relationship**_____

Name_____ **Relationship**_____

_____ **No One (THIS MEANS WE WILL SPEAK TO *YOU ONLY!*)**

Do we have permission to:

Call you regarding test results, appointments, insurance, etc. ? _____ **Yes** _____ **No**

Leave a message on your answering machine/voicemail? _____ **Yes** _____ **No**

Leave a message if someone else answers the phone? _____ **Yes** _____ **No**

Call you at work? Work # _____ _____ **Yes** _____ **No**

***Release of Information Authorization*: I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I permit a copy of this authorization to be used in place of the original and payment be made to me or the provider on my behalf.**
My signature on this form also acknowledges that I have received a copy of Highlands Dermatology & Surgical Associates Notice of Privacy Practices.

_____ _____

Patient Signature (guardian if patient under 18) **Date**

MEDICARE PATIENT FORM ONLY

Medicare Secondary Payer Questionnaire:

Patient Name _____ Medicare # _____

Please answer the following questions:

___ Yes ___ No Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job?
___ Yes ___ No Are you covered by an HMO/PPO which makes Medicare secondary?
___ Yes ___ No Is this illness covered by the VA (Veteran's Administration)?
___ Yes ___ No Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
___ Yes ___ No Is this illness due to an accident? If yes, work ___ or automobile ___ ?
___ Yes ___ No Is patient disabled (under age 65) and covered by Large Group Health Plan?

Please sign so we may have your Medicare authorization on file:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare benefits apply.

_____ _____
Signature as it appears on Medicare Card Date

Please sign so we may have your Supplemental Authorization on file:

If you have a suppemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file.

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the listed MEDIGAP carrier any information needed to determine these benefits or the benefits payable for the related services.

_____ _____
Signature as it appears on Medigap Card Date

HIGHLANDS DERMATOLOGY & SURGICAL ASSOCIATES

Chart #: _____

Medical, Social, Family History, and Review of Systems

First: _____ Middle Initial: _____ Last: _____ Jr/Sr: _____

Date of Birth: _____

Family Doctor: _____ Referring Doctor: _____ Pharmacy: _____

I accept the complete skin exam. (circle) Yes No
I authorize Highlands Dermatology to electronically import my medications. (circle) Yes No

Past Medical History: Please check Yes or No		
Do you have a history of:	Y	N
Anxiety		
Arthritis		
Asthma		
Atrial Fibrillation (Irregular Heartbeat)		
Stroke		
COPD		
Coronary Artery Disease		
Depression		
Diabetes		
Hypertension (High Blood Pressure)		
End Stage Renal Disease		
Seizures		
Hearing Loss		
HIV / AIDS		
Hyperthyroidism (overactive thyroid)		
Hypothyroidism (underactive thyroid)		
Hepatitis		
Leukemia		
Lymphoma		
Radiation Treatment		
Bone Marrow Transplant		
Cancer (other than skin) - type:		

Past Surgical History: Please check Yes or No		
	Y	N
Heart: Cornoary Artery Bypass Surgery		
Kidney: Kidney Transplant		
Liver: Hepatectomy		
Heart: Biological Valve Replacement		
Heart: Mechanical Valve Replacement		
Liver: Shunt		
Spleen (Splenectomy)		
Skin Biopsy		
Kidney: Nephrectomy		
Joint Replacement: Hip LEFT		
Joint Replacement: Knee LEFT		
Joint Replacement: Hip RIGHT		
Joint Replacement: Knee RIGHT		
Heart: Heart Transplant		
Liver: Liver Transplant		
Defibrillator		
Pacemaker		
Other:		

Skin Disease History: Please check Yes or No		
Do you have a history of:	Y	N
Acne		
Actinic Keratosis		
Dry Skin		
Basal Cell Carcinoma		
Poison Ivy		
Precancerous Moles		
Eczema		
Other:		
Do you wear sunscreen?		
If Yes, what SPF?		
tanning Salon Use - current		
Tanning Salon Use - history of		

Asthma		
Hay Fever / Allergies		
Melanoma		
Flaking or Itchy Scalp		
Psoriasis		
Squamous Cell Carcinoma		
Blistering Sunburns		
Family History of Melanoma		
If Yes, which relative?		
Family History of non-Melanoma Skin Cancer		
If Yes, which relative?		

*****PLEASE CONTINUE ON REVERSE SIDE*****

Medical, Social, Family History, and Review of Systems

PRESCRIPTIONS AND OVER-THE-COUNTER MEDICATIONS (dosage and frequency):

MEDICATION ALLERGIES (and reaction):

Social History: Please check Yes or No

Smoking Status: (circle one)
Never smoker *Former smoker*
Current every day smoker *Current occasional smoker*
If current smoker, how many packs per day?
If former smoker, date you stopped?

	Y	N
Do you drink alcohol?		
If Yes, number of drinks per day:		
How many times in the past year have you had 5 or more drinks in a days (for men), or 4 or more drinks in a day (for women) or any adult older than 65?		

	Y	N
Have you received the flu vaccine this season?		
If no, why not? Medical reasons _____ I do not want one _____		
For patients 65 and older: (check one) Received a pneumococcal vaccine _____ Did not receive a pneumococcal vaccine _____		

Review of Systems: (Past Several Months) Please check Yes or No

	Y	N		Y	N
******* Returning Patient *******			******* New Patient *******		
Recent fever			immunosuppression		
Rash			problems with healing		
sore throat			fever or chills		
Muscle aches			unintentional weight loss		
			joint aches		
			Swollen lymph nodes		
			muscle weakness		
			thyroid problems		
			Sore throat		
			Muscle Aches		

I certify that I have read and understand the above questions and acknowledge that questions have been answered to the best of my knowledge. This health form will expire three (3) years from the date signed and will require a new form to be completed.

Patient's Signature _____ Date _____

Highlands Dermatology & Surgical Associates
PATIENT FINANCIAL POLICY

Participating Insurance Plans

We are participating providers in the traditional Medicare program. We will file with secondary/supplemental carriers for Medicare patients. We also participate in several Medicare HMO's and commercial health plans. Please call your insurance company to verify if we are in network with your plan.

Non-Participating Plans and Self Pay

If you have insurance that we do not participate in, we will be happy to file the claim to your carrier. However, payment in full is expected at time of service.

We are not in network with any TennCare/Medicaid plans and do not file claims for these carriers unless they are your secondary insurance.

If you do not have medical insurance, payment for all services is expected at the time of your visit.

Patients are responsible for payment of their annual deductible, coinsurance, and copayment amounts.

Payment Options

We accept checks, Visa MasterCard, Discover, American Express, and Care Credit. There is a $25 charge for any returned checks.

Also, please be aware that we DO NOT accept cash.

Patient Balances

Statements are mailed for any outstanding patient balance. Payments are accepted by mail, phone, or in person.

In the event your account balance is not paid within 90 days, it may be placed with a collection agency, and you will be responsible for the collection fees, court costs, and legal fees.

No Shows and Missed Appointments

Our policy is to charge for missed appointments. If you do not show up for an appointment or cancel with less than 24 hour notice, there may be a missed appointment fee of up to $150. This charge will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.

_____ I have read and understand the financial policy of HDSA.

_____ _____

Patient Signature Date

Aug 2019

Chart: _____

Patient Consent for Medical Photography

Patient Name:_____ Date:_____

I consent for medical photographs to be made of me (or my child/person for whom I am legal guardian). I understand that the information may be used in my medical record, for purposes of medical teaching, or for publication in medical textbooks or journals as I have designated below. By consenting to these medical photographs I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may contact:

Highlands Dermatology & Surgical Associates
112 North Walnut Avenue
Cookeville, TN 38501
931-520-1414

By signing this form below I confirm that this consent form has been explained to me in terms I understand.

1) I consent for these photographs to be used in medical publications, including medical journals, textbooks, and electronic publications. I understand that the image may be seen by members of the general public, in addition to scientists and medical researchers that regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

_____(Signature) _____(Witness)

2) I agree for my image to be shown for teaching purposes AND to be used for my medical record, but NOT FOR medical publication:

_____(Signature) _____(Witness)

3) I agree to use of my image for medical records ONLY:

_____(Signature) _____(Witness)

For patient between the ages of 7-18 years, a signature below indicates that the information in this consent form has been explained to me, and I assent to use of my images as outlined above:

_____(Signature of patient) _____(Witness)