APDerm®
MYSTIC VALLEY
DERMATOLOGY ASSOCIATES

General Information

Please fill in all missing information, *verify and/or correct any printed information. Please print legibly.*

Patient's Name: ______________________ **Age:** ______ **Birthdate:** ____________
Last *First* *Middle*

Address: ______________________ **E-mail:** ____________
Street and Apt Number *City* *State* *Zip*

Home Phone: ____________ **Cell Phone:** ____________ **Work Phone:** ____________ **Ext.** ______

Primary contact: *Home*☐ *Work*☐ *Cell*☐ ***Auth. to E-mail:*** Yes☐ No☐ ***Auth. to Leave Voicemail:*** Yes☐ No☐ ***Auth. to Text:*** Yes☐ No☐

Sex: ________ **Marital Status:** ________ **Race:** ________ **Ethnicity:** ________ **Language:** ________

Referring Physician: ______________________ **Phone number:** ____________

Address: ______________________
Street and Suite Number *City* *State* *Zip*

Primary Care Physician: ______________________ **Phone number:** ____________

Address: ______________________
Street and Suite Number *City* *State* *Zip*

Emergency Contact: ______________________ **Relationship to Patient:** ____________

Home Phone: ____________ **Work Phone:** ____________ **Other Phone:** ____________

Parent or Responsible Party: *(If different from patient)* **Name:** ______________________ **Phone:** ____________

Address: ______________________ **Relationship to patient:** ____________
Street and Apt Number *City* *State* *Zip*

Primary Insurance Company: ____________ **Policy #:** ____________ **Group #:** ____________

Name of Subscriber: ____________ **Subscriber Date of Birth:** ____________ **Relationship:** ____________

Secondary Insurance Company: ____________ **Policy #:** ____________ **Group #:** ____________

Name of Subscriber: ____________ **Subscriber Date of Birth:** ____________ **Relationship:** ____________

I hereby authorize and assign my insurance benefits to be paid directly to Mystic Valley Dermatology Associates, P.C. I authorize release of information to facilitate treatment, payment or heath care operations. I give Mystic Valley Dermatology Associates, P.C. permission to treat me and take photographs.

Co-payments and/or outstanding balances are due at the time of your appointment. I agree that I will be financially responsible for any treatment I receive, in the event that my insurance company denies payment due to lack of referral. I will be responsible for a $50 fee in the event that: (1) my check is returned for insufficient funds, or: (2) my account is turned over to a collection agency, or; (3) I fail to show up for my appointment and have not notified your office at least two business days in advance of the appointment. My signature below signifies my understanding and agreement to comply with this policy.

I have read and understand the Notice of Privacy Rights and Practices and MVD Policies.

Signature of Patient
(or responsible party) ______________________ **Date** ____________

Optional: I authorize the following person(s) to have access to my medical and financial information.
This authorization may be revoked in writing at any time.

Name: ______________________ Phone number: ____________

Name: ______________________ Phone number: ____________

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Date: ______________ Name: ______________________________________ DOB: ____________

Phone Number: ____________________ Primary Care Physician: ______________________________

What is the main reason for your visit today? : ____________________ Who recommended this visit? ____________

Would you be interested in any cosmetic and/or esthetic services that we offer here at Mystic Valley Dermatology? ☐ Yes ☐ No

Have you had the Flu Vaccine? ☐ Yes ☐ No

Have you had the Pneumonia Vaccine? ☐ Yes ☐ No

Do you have allergies to medications? ☐ Yes ☐ No

If yes please list drug & reaction: ______________________________

Do you have allergies to latex? ☐ Yes ☐ No

Allergies to other items? (food, pollen, etc.) ☐ Yes ☐ No

If yes please list: ______________________________

Medications: Please list any medications you are currently taking. Include birth control pills, over the counter medications, and herbs:

____

____

____

____

____

____

Are you pregnant? ☐ Yes ☐ No ☐ Not applicable

General Medical History

Please list any medical conditions. Include all conditions with which you have ever been diagnosed, or for which you take medication, even if they are under good control.

Condition	Yes	No	*If yes please specify:*
Cardiac	☐ Yes	☐ No	______
Cardiac valve replacement	☐ Yes	☐ No	______
Respiratory	☐ Yes	☐ No	______
Diabetes	☐ Yes	☐ No	______
Poor healing	☐ Yes	☐ No	______
Keloids/abnormal scars	☐ Yes	☐ No	______
Cancer (other than skin)	☐ Yes	☐ No	______
Glaucoma/Cataracts	☐ Yes	☐ No	______
High blood pressure	☐ Yes	☐ No	______
High cholesterol	☐ Yes	☐ No	______
Neurologic/Stroke	☐ Yes	☐ No	______
Kidney problems	☐ Yes	☐ No	______
Bleeding disorder	☐ Yes	☐ No	______
Psychiatric (anxiety, depression, etc.)	☐ Yes	☐ No	______

Other/Explain further: ______________________________

Surgical History (please list type and year):

____

____

____

Do you have any metal in your body from orthopedic or other surgeries? ☐ Yes ☐ No

If yes, list location/date: ______________________________

____

Do you pre-medicate before a surgical procedure due to an <u>artificial heart valve</u>? ☐ Yes ☐ No

If yes, please list what you pre-medicate with: ______________________________

____

Do you have a pacemaker or defibrillator? ☐ Yes ☐ No

If yes, please specify: ______________________________

____

Have you been diagnosed with Infectious Disease? (HIV, Hepatitis, MRSA, Tuberculosis) ☐ Yes ☐ No

If yes please specify: ______________________________

____

Have you ever smoked tobacco? ☐ Never ☐ in the Past ☐ Currently

How many times in the past year have you had 5 or more drinks in the course of one day? #_____

Occupation: ______________________________

Have you ever been diagnosed with:

Melanoma?	☐ Yes	☐ No
Basal, Squamous Cell or other skin cancer(s)?	☐ Yes	☐ No
Any other skin condition?	☐ Yes	☐ No

If other, please specify: ______________________________

____

How many times in your life have you had a sunburn bad enough to make you blister?

☐ Never ☐ 1 time ☐ 2 or more times

Have you ever used tanning beds?

☐ Never ☐ in the Past ☐ Currently

Has anyone in your immediate family had skin cancer? (parents, siblings, children)

☐ Yes ☐ No ☐ Unknown

If yes, what kind?

☐ Basal or Squamous cell (most common)

☐ Melanoma (less common, but more serious)

☐ Other: ______________________________

Pharmacy Name: ______________________________

Pharmacy Phone: ______________________________

Pharmacy Address: ______________________________

Height: ______________ **Weight**: ______________

PERMISSION FOR VERBAL COMMUNICATION

Mystic Valley Dermatology Associates recognizes that patients may prefer family members or friends to be involved in their care. For example, a patient may want their spouse or adult child to assist with billing questions, to be informed about appointments on their behalf or to be updated of their health status. This form serves as a record of your wishes. Please complete this form if you would like to allow our healthcare team members to discuss your health information with a specific individual. This document does not permit release of any written health information to the individuals named.

____ _____________________________

(Print name of patient or place patient label here) (Date of birth)

Please list the individual(s) that you allow us to speak with about your care:

Family or Friend's Name	Phone Number	Relationship
____	_________________	___________
____	_________________	___________

I acknowledge and understand that:

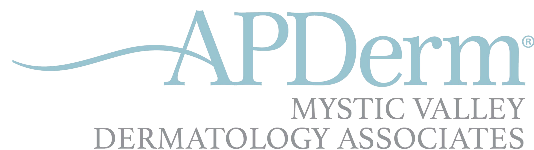
- *I am allowing Mystic Valley Dermatology Associates to share information with the above-named individual(s) only by verbal discussions and that my permission does not give the above-named individual(s) access to my hard-copy or electronic medical record.*
- *The information I allow Mystic Valley Dermatology Associates to share is not limited unless specified: ___________ ____.*
- *My permission will remain in effect for an unlimited amount of time unless another date is listed or I cancel my permission: ________________.*
- *I can change my permission at any time by contacting the dermatology office where I receive care, but that my cancellation will not have an effect on information shared prior to my cancellation.*
- *Information shared with the above-named individual(s) may be further shared by them and not protected under confidentiality and privacy laws.*
- *My permission is voluntary, and Mystic Valley Dermatology Associates may not condition my treatment, payment or eligibility for services on my signature.*
- *If at any time I do not want my healthcare team members to discuss my healthcare information with the above-named individual(s), I must provide written notice to the dermatology office where I receive care or contact the privacy officer at (978) 849-7582 or 526 Main Street, Suite 302, Acton, Massachusetts 01720.*

By signing below, I acknowledge I have read, understand and agree with the information on this form and that all my questions have been answered in a language that I understand.

Patient/Guardian Signature:__________________________Date:_____________________________

Representative's Name: _____________________________Relationship to Patient: ________________

[Type here]



Consent to Treatment

Initial: ____ I authorize and request care by Mystic Valley Dermatology Associates' physician, physician assistant, and/or nurse practitioner (Provider) and their care team. My Provider will recommend the necessary care to treat my condition. This care may include medical, surgical, or diagnostic treatment such as laboratory tests. Recommended care will not be performed until the treatment or service is explained to me and I consent. I understand I may choose another provider at any time to deliver care or to render a second opinion. I understand my care team may include medical students and other clinical trainees. I am aware that I have the option to decline a trainee's involvement in my care at any time by notifying the practice staff or Provider.

Notice of Privacy Practices

Initial:_____ I acknowledge the receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how my protected health information may be used and disclosed by Mystic Valley Dermatology Associates. I understand that Mystic Valley Dermatology Associates may change its privacy practices at any time. I also understand that the current version of the Notice of Privacy Practices is available on Mystic Valley Dermatology Associates website, at each office, or upon my request.

Financial Policy

If you have questions about our financial policy or to pay your bill, please contact our billing department at (978) 371-7010, press 3, press 2. We accept cash, check, Visa, MasterCard, American Express, and Discover.

Insurance: We participate in most insurance plans. At each visit we verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage.

Co-Payments and Deductibles: Co-payment and co-insurance are determined by your insurance. All co-payments must be paid at the time of service. A deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

Referrals: If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to obtain one. If the referral is not sent to us prior to your appointment, you will be responsible for the cost of services rendered.

Non-Covered Services: Some services you receive may not be covered by your insurance. If you and your provider agree that non-covered services are needed or if you request a non-covered service, you will be responsible for full payment of the non-covered service. Aesthetic services are always payable at the time of the visit.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or guardian to their first appointment. To provide treatment to a minor without the presence of a parent or guardian during subsequent visits, a signed consent form must be on file. All copays or monies due are expected to be paid at the time of each service.

Non-Payment and Returned Checks: We understand that temporary financial problems may affect timely payment of your balance. Please communicate your situation with the billing department so that we can assist you in the management of your account. If your account is 90 days past due, your account will be referred to a collection agency. This agency may report your delinquency to a credit bureau. You also may be dismissed from our practice for non-payment. There will be a $50 charge for checks returned for insufficient funds.

Missed Appointments: We ask that you give us at least two business days' (Monday through Friday) notice regarding cancelling/rescheduling. This will enable us to offer your cancelled/rescheduled time to other patients. A fee of $50 may be charged for patients who do not show for their appointment or do not call at least two business days (Monday through Friday) prior to their appointment to cancel and/or reschedule. This charge will be billed to the patient and payment is required prior to scheduling your next appointment.

By signing below, I acknowledge I have read, understand and agree with the above policies and statements, and that all my questions have been answered in a language that I understand.

Print Patient's Name: ____ Date:_____________

Patient/Guardian Signature: ____
Relationship to Patient (if signature is not patient):__________________________

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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

MEMBER ORGANIZATIONS: This Notice applies to Mystic Valley Dermatology Associates, P.C., including its physicians, nurses, and other personnel.

As of April 14th, 2003, we are required under the Health Insurance Portability and Accountability Act (HIPAA) and currently under Massachusetts law to maintain the privacy of your health information, and to provide you with this Notice of Privacy Rights & Practices.

This document explains in detail how we use your Protected Health Information (PHI) which is any information about you that could identify you, your past, present, or future physical or mental health condition(s). Your acknowledgement of receipt of this document will be required the first time you receive services after April 14th, 2003.

Examples of how we can use and disclose your information without your authorization include:

- Treatment – we keep a record of each visit and/or admission. These records may include your test results, diagnoses, medications or other therapies. These records are used and disclosed to allow doctors, nurses, spiritual care and other health care and clinical staff providers to offer high quality care to meet your needs.
- Payment – we maintain a record of and may use and disclose information related to services and supplies you receive at each visit and/or admission, so that we can be paid by you, an insurance company, or a third party. We may tell your health plan and other payors about an upcoming treatment or service, which requires their prior approval and authorization.
- Health Care Operations – we use and disclose your medical information to improve the services we provide, to train staff and students, for business management, and for customer service purposes.

Your information may be shared amongst Mystic Valley Dermatology Associates, P.C. organization, other health care providers, third party payors and or Business Associates to facilitate treatment, payment or health care operations.

ADDITIONAL USES AND DISCLOSURES:

I. There are additional times when we are permitted or required to use/disclosure medical information without your permission. These circumstances are listed below:

- In emergency treatment situations
- To assist incommunicative patients
- For reporting child, elder, or disabled persons neglect
- To avert serious threat to public health or safety
- If required by law
- For law enforcement
- For public health activities (tracking diseases or medical devices)
- For health oversight activities such as fraud investigations
- For certain judicial or administrative proceedings
- For government functions such as national security & intelligence
- For research following an appropriate review or waiver of authorization by an institutional review board to ensure protection of information

NOTICES OF PRIVACY RIGHTS & PRACTICES

II. We may also use information without your permission to:

- Recommend treatment alternatives
- Tell you about health benefits and/or services
- Send or call you with appointment reminders
- To communicate with those involved in your care

Except as otherwise permitted by law, all other uses and disclosures not described above will require your signed authorization. You may revoke any authorization you provide at any time by delivering a written statement directly to the Privacy Officer, except to the extent that we have already taken action in reliance on your authorization.

III. Please know that federal and state laws require special privacy protections for certain highly confidential information about you. In order for us to disclose your Highly Confidential Information for a purpose other than those permitted by law, we must obtain your written authorization.

YOUR RIGHTS: Under HIPAA, you have the right to request in writing:

- Restrictions on how we use and or disclose your medical information.
- Confidential communications to an alternate phone or address other than you home.
- Access to your medical information to review and obtain a copy, subject to federal and state laws (fees may apply).
- An amendment to your medical information if you feel you or your health care provider need to make additions or corrections.
- An accounting of disclosures of your medical information for purposes other than treatment, payment, health care operations or made pursuant to an authorization.
- A paper copy of this notice even if you have received it electronically.
- A revocation of any specific authorization obtained in connection with your privacy, such as for marketing and research.

While we will consider all requests for privacy restrictions carefully, we are not required to agree to any requested restrictions.

OUR RESPONSIBILITIES: We are required by law to maintain the privacy of your medical information, to provide you with written Notice of Privacy Rights and Practices, and to abide by the terms of the Notice currently in effect. We reserve the right to change this Notice and our privacy practices and make the new provisions effective for all information we maintain. Revised Notices will be posted in our facilities and offices, and will be available from your direct treatment provider.

FOR MORE INFORMATION: If you would like further information about your privacy rights, are concerned that we have violated your privacy rights, or disagree with a decision that we made about access to your PHI, you may contact our Privacy Officer at the address and phone number below. You may also file written complaints with the Director, Office for Civil Rights of the U.S. Department of Health and Human Services. Upon request, the Privacy Officer will provide you the correct address for the Director. We will not retaliate against you if you file a complaint with us or with the Director.