OAKLAND HILLS
DERMATOLOGY
•General •Cosmetic & Surgical Institute•

www.oaklandhillsdermatology.com

How Can We Assist You Today?

Cosmetics	Dermatology	Products
Acne Program	Acne	Acne Products
Acne Scar Treatment	Actinic Keratosis History	Age Defense Products
Ageless Glow MD	Basal Cell Carcinoma History	Elta
BBL (Broad Band Light)	Cysts	Neocutis
Botox	Dry Skin	Neotensil
Chemical Peel	Eczema	Latisse
Cosmetic Consultation	Full body Exam	Rosacea Products
Dark & Age Spots	Hair Loss	Skin Better
Dermaplane	Melanoma History	Skin Medica
Earlobe Repair	Mohs Surgery	Spot Correctors
Eyelash Enhancement	Moles & Mole Removal	Sunless Tanning Products
Fillers (Juvederm, Vollure, Voluma)	Nails	Tan Towels
Laser Hair Reduction	Poison Ivy	Wrinkle Reducing Products
Laser Skin Resurfacing	Precancerous Mole History	Other:
Laser Skin Tightening	Psoriasis	
Lip Enhancement	Psoriasis Light Treatment-Excimer	
Liposuction	Rashes	
Microdermabrasion	Rosacea	
Micro-Needling	Skin Cancer	
Non-surgical Liposuction (Coolsculpting)	Squamous Cell Carcinoma History	
Photo-rejuvenation	Varicose Vein Treatment	
Tattoo Removal	Warts	
Visia (Photo Image)	Other:	
Vein Treatment		
Other:		

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History and Intake Form

Name____

Date of Birth____________________ **SSN**_________________________

Address____

City______________________________ **State** _______ **Zip**__________

Home Phone____________________ **Cell Phone**_____________________

Email____________________________________ **Sex** **Male / Female**

Who Referred You? ____

Primary Care Physician _____________________________________

Primary Care Phone # ______________________________________

I give permission to give information concerning my health & well-being to the following:

Name	Relationship	Phone
________________	________________	________________
________________	________________	________________
________________	________________	________________

If we need to get in touch with you regarding test results, what is the best way to reach you? (Please circle) HOME CELL WORK EMAIL

Race
White/Caucasian
Black/African American
Asian
American Indian/Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity
Hispanic/Latino
Non-Hispanic/Latino

Marital Status
Single
Married
Divorced
Domestic Partner
Separated
Widowed

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Patient Name:________________________

Past Medical History *(please circle all that apply)*

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis (Type ______)
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None

Other ____

Past Surgical History *(please circle all that apply)*

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None

Other ____

Skin Disease History *(please circle all that apply)*

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Rosacea
None

Other ____

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Difficulties with bleeding or clotting? Yes No

Difficulties with scarring or keloids? Yes No

Do you wear Sunscreen? Yes No
If yes, what SPF? __________

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ____
Any other family history ____

Medications (Please enter all current medications, strengths and times a day taken)

____

____

____

Allergies (Please enter all allergies)

____

____

Social History (Please circle one)

Cigarette Smoking
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use
None
<1 drink per day
1-2 drinks per day
+3 drinks per day

Language
English
Spanish
Other_________________

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Pharmacy Name ____

Street____

City______________________________State__________ Zip____________

Phone______________________________

Occupation and Workplace______________________________________

Were you screened for Tuberculosis this year?	Yes	No
Was your test negative?	Yes	No
If your test was positive, did you get a chest x-ray?	Yes	No
Was the chest x-ray negative?	Yes	No
Do you have diabetes?	Yes	No
If yes, have you had a foot exam in the last year?	Yes	No
If yes, what was your most recent Hemoglobin A1C?	________	
Have you had the flu shot in the last year?	Yes	No
When was your flu shot given?	________	
Have you had a pneumonia shot in the last 5 years?	Yes	No
Have you ever had a shingles vaccination?	Yes	No
Have you fallen in the past year?	Yes	No

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REVIEW OF SYSTEMS:

Please circle "YES" or "NO" to indicate if you have any of the following symptoms or circumstances

Problems with bleeding	YES	NO
Problems with healing	YES	NO
Problems with scarring (hypertrophic or keloid)	YES	NO
Rash	YES	NO
Immunosuppression	YES	NO
Hay fever	YES	NO
Chest pain	YES	NO
Fever or chills	YES	NO
Night Sweats	YES	NO
Unintentional weight loss	YES	NO
Thyroid problems	YES	NO
Sore throat	YES	NO
Blurry vision	YES	NO
Bloody urine	YES	NO
Joint aches	YES	NO
Muscle weakness	YES	NO
Neck stiffness	YES	NO
Headaches	YES	NO
Seizures	YES	NO
Cough	YES	NO
Wheezing	YES	NO
Anxiety	YES	NO
Depression	YES	NO
Allergy to adhesive	YES	NO
Allergy to Lidocaine	YES	NO
Allergy to topical antibiotic ointments	YES	NO
Artificial heart valve	YES	NO
Artificial joints with past two years	YES	NO
Blood thinners	YES	NO
Defibrillator	YES	NO
MRSA history	YES	NO
Pacemaker	YES	NO
Premedication prior to procedures	YES	NO
Rapid heartbeat with Epinephrine	YES	NO
Pregnancy or planning a pregnancy	YES	NO
Breastfeeding	YES	NO
Traveled out of the country in the last 21 days	YES	NO

Other: ______________________________

NOTICE OF PRIVACY POLICY

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

At Oakland Hills Dermatology, we are committed to treating and using Protected Health Information (PHI) about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective July 1, 2010 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Oakland Hills Dermatology, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment.
This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve

Understanding what is in your record and how your health information is used helps you to: Ensure its accuracy, better understand who, what, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Patient Health Information Rights

Although your health record is the physical property of Oakland Hills Dermatology, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy our health record
- Amend your health record
- Obtain an accounting of disclosure of your health Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibility

Oakland Hills Dermatology is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate reasonable request you may have to communicate health information by alternative means or alternative locations

CONSENT FOR DERMATOLOGIC TREATMENT

The providers of Oakland Hills Dermatology have an obligation to discuss with you, your condition and the recommended surgical procedure to be performed. This discussion is intended to ensure you are completely informed and had the opportunity to make a reasonable decision whether or not to consent to the procedure.

There are many diagnoses in Dermatology to be listed, below are a few that are seen in our office:
• Acne Vulgaris • Acrochordons • Angioma/Telangiectasia(s) • Condyloma Acuminatum • Epi Cyst • Flat Warts • Contact Derm • Seborrheic Keratosis • Molluscum Contagiosum • Verruca Vulgaris • Plantar Warts • Actinic Keratosis • Psoriasis • Eczema

There are several methods used to treat the different diagnoses in addition to shave and or excision removal:

1. Cryosurgery- is the treatment of lesions with the application of a cold substance. The cold substance (liquid nitrogen) is used to destroy the lesion.
2. Chemical- is the treatment of lesions with the application of a chemical. The chemical is used to destroy the lesion.
3. Injection / Dermajet- a low dose steroid medication is used by injecting into the affected areas for treatment.
4. UVB - is light therapy to treat your condition.

The physician and/or associates have explained to my satisfaction the following:

1. There is no single treatment that can guarantee successful treatments
2. Treatments may require 1 or more methods or combinations of several treatment options
3. Multiple treatments may be required
4. The treated area(s) may develop new lesions
5. There may be a recurrence to the treated areas
6. The treated area(s) may leave a scar(s)/ indention or atrophy
7. Blisters may occur with treatments with the exception of Acne

Call the office if you see signs of infection, pus, redness or increasing pain or have any further questions.

If you are coming in for the removal of skin tags, this is not a covered procedure by insurance companies with the exception of Blue Cross MESSA. You are responsible for the cost of having these lesions removed. The cost to you will be:

1. $50.00 for lesions 1 -1 O
2. $100.00 for lesions 11-20
3. $150.00 for lesions 21 -30 (tags over 30 will be charged at $5.00 each)

The treatment of angiomas / telangiectasia(s) are same price as skin tags (multiple treatments can be needed).

LESION REMOVAL: Any lesion removed that is considered cosmetic will be given a quote price by the physician and is due at time of service. *Any lesion removed is sent to an independent /laboratory.* There are two parts in billing for a lesion removed. The outside lab prepares the lesion. The second part is for a diagnosis, which may be billed by the outside laboratory or from our office. You must contact the lab in regards to their billing:

- Outside lab fee - $109.00
- Office fee - $75.00 (diagnosis *read* only)

Some insurance carriers may consider treatment for your diagnosis as cosmetic; you may contact your carrier to verify benefits before consenting to treatment. Any balance, after insurance payment is made, such as co-payment, un-met deductibles or a non-covered service is the patient's responsibility.

My signature below signifies my willingness to proceed with treatment, fully realizing the issues identified above. If after one year *my* treatment needs to be continued, I understand I will need to resign a new consent.

____ ________________________
Patient/Parent/Guardian Signature Date

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change, we will make a revised notice available to you.

We will use patient health information for regular health operations: For example: Member of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in patient health records to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

Business associates: There are some services provided in our organization through contacts and business associates. Examples include physician services in the emergency department, hospital and urgent care facility, radiology referrals, laboratory tests, and billing services associated with these associates. When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard the information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another responsible person, for the purposes of continuing care. For example: A specialist we referred you to may not have your correct telephone number and need to reschedule an appointment

Organ procurement organization: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking of transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment or other health related services that may be of interest to you.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health for legal authorities charged with preventing or controlling disease, injury or disability. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem: If you have any questions and would like additional information, you may contact the practice at:

OAKLAND HILLS DERMATOLOGY
2251 N. SQUIRREL RD., SUITE 200
AUBURN HILLS, MI 48326
PHONE: 248-858-2255

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy officer or with the office for Civil Rights U.S. Department of Health.

I hereby acknowledge that I received a copy of Oakland Hills Dermatology notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I will be offered a revised copy at my next appointment if the Notice of Privacy Practices has been amended.

____ ________________________

Patient/Parent/Guardian Signature Date

OUR PRACTICE INFORMATION AND FINANCIAL POLICY

Our entire staff is dedicated to providing our patients with the highest quality of care and service. It is in this spirit that we are providing you with this important information. All patients must complete our patient information forms and provide a valid state issued ID before seeing the provider. If a provider in any of our offices has not seen you within the past 3 years or if you have been seen for cosmetic procedures only, you are considered a new dermatology patient and will be billed accordingly. Full payment is expected at the time of service, unless other prior arrangements have been made. We accept cash, checks, MasterCard/Visa, Discover, American Express and Care Credit. We accept cash and credit only for cosmetic procedures and products over $200 (all sales are final). With so many health insurance companies and contracts available today, it is very difficult for our staff to know exactly what your individual contract covers. Therefore, to avoid any financial "surprises" relating to the *specialized services* you receive at Oakland Hills Dermatology, please review your insurance policy for specific terms, conditions and coverage limitations.

Insurance:

We will only accept assignment of benefits with insurance plans in which we participate. Complete health insurance information is required to process insurance claims on your behalf. All patients are required to provide all current policy information. Insurance carriers have a filing time limit. If we do not have your correct insurance information before the filing time limit you will be responsible for all charges. Any remaining balances (such as co-pays. deductibles and non-covered services) are your responsibility. Please note that all procedures done in a Dermatology office are considered surgery. Your policy may have a separate deductible for surgery. It is ultimately your responsibility to know what is covered through your policy. If we do not participate in your plan, you will be responsible for any NON-COVERED services under your policy and/or charges that may exceed your policies customary fee schedule. As a patient you have the right to refuse treatment.

Minor Patients:

The parent/guardian accompanying the minor is responsible for payment. After their first visit with a parent /guardian, an unaccompanied minor must have a written consent authorizing other treatments. A parent/guardian must accompany minors for all biopsy/ surgical procedures. Return Policy: Unopened products may be returned within 30 days of purchase. No returns are accepted on makeup.

No Show Fee

If you do not show up for a scheduled appointment, you will be charged a No Show fee of $25.00. In order to avoid the No Show fee, we ask that you contact our office to reschedule or cancel your reserved appointment.

Checks & Collections Services

Returned checks will be assessed a fee of $25.00. Balances over 60 days without pre-approved payment arrangements will be turned over to a third party collection agency. When turned over to an outside agency for collection, collection costs of 50 % (Fifty Percent) will be applied to your current balance on your account.

Cosmetic Packages:

All cosmetic sales are final. Cosmetic packages will be honored for 1 year. If the package is broken by the patient for any reason, they will be charged at a single procedure price, plus charged for any products that were included. No show fees for cosmetics packages range from $50- $100 (depending on procedure).

By my signature below, I acknowledge my understanding of all points in your financial policy. I authorize the release of medical information for the purpose of processing insurance claims on my behalf. I authorize payment of medical benefits directly to the provider for services provided to me. A copy of this authorization shall be considered as valid as an original signature.

______________________________	______________________________	________________
Patient/Parent/Guardian Signature	Relationship to Patient	Date

____
Print Name of Patient/Parent/Guardian