Cape Cod Dermatology, LLC

Welcome to our Practice *5/1/2020*

Thank you for choosing our office for your dermatologic care. We are dedicated to providing you and your family with the highest quality of care, in a comfortable and professional environment. Please familiarize yourself with the policies of this office. This form must be read and signed before treatment is rendered. Please ask questions if you do not understand any of these policies.

APPOINTMENTS

In order to provide quality, effective care, we utilize an appointment schedule. Our office hours are Monday through Friday 8 am to 5 pm. Our phones are answered from 9 -12 and 1:30 - 4. If you reach our voice mail always leave us a message as we check these frequently. We aim to give you all the time and attention you require while you are in our office. However, if you are more than 5 minutes late for your appointment, we may need to reschedule you to allow enough time for your treatment. All children under the age of 18 must be accompanied by a responsible adult.

INDEPENDENT CONTRACTORS

Dr. Sasha Girouard and Dr. Elizabeth Tocci are directly employed by Cape Cod Healthcare and practice on Cape Cod Dermatology LLC's premise solely as independent contractors.

CANCELLATION POLICY

Kindly give 24 hours for cancelled appointments. Cape Cod Dermatology, LLC charges a $75 fee for missed appointments. Each patient is allowed to miss one appointment after which the fee will be charged for all subsequent missed appointment. Repeated missed appointments may result in dismissal from the practice.

FINANCIAL AGREEMENT

- Insurance cards must be presented at every visit.
- Insurance co-payments are expected at the time of service.
- If REFERRALS are required by your insurance company: Obtaining an insurance referral is the responsibility of the patient. Failure to get an insurance referral will result in the patient being billed for the services rendered by Cape Cod Dermatology, LLC.
- All self-pay charges are expected to be paid at the time of service, unless prior arrangements have been made with the billing office.
- Cape Cod Dermatology, LLC will take reasonable efforts to get your insurance claim processed. However, if the insurance company rejects the claim the financial responsibility becomes that of the patient.

PATIENT PORTAL ACCESS AGREEMENT

Cape Cod Dermatology, LLC provides access to a patient portal as a courtesy in partnership with Modernizing Medicine for the exclusive use of its patients. The portal offers secure viewing and communication as a service to our patients who wish to view parts of their records and communicate with our staff. While we believe that the IT infrastructure and data are safe and secure, it does not guarantee unforeseen adverse events cannot occur. Secure messaging can be a valuable communications tool, but has certain risks as does all evolving technology. The portal user also agrees to the following:

- Do not use portal communication if there is an emergency. Dial 911 or go to the Emergency Room.
- The user agrees to provide factual and correct information.
- We will usually respond to non-urgent emails within 48 hours. Do NOT use the patient portal for urgent problems – please call the office.
- If you think someone has acquired your password, you should promptly go to the Patient Portal and change it.
- I will to notify Cape Cod Dermatology, LLC if there is a change in my email account or I feel that my secure password has been breached. I agree not to hold Cape Cod Dermatology, LLC or any of its staff liable for network infractions beyond its reasonable control.
- Cape Cod Dermatology, LLC is not responsible for a breach of private medical information if: the patient using the portal is using a computer workstation or device that could be compromised, if the patient discloses his/her portal password, or if said breach occurs due to any other outside factors beyond Cape Cod Dermatology, LLC's reasonable control.

Cape Cod Dermatology, LLC

- I understand the risks associated with online communications between my physician and patient. I acknowledge that using the patient portal is entirely voluntary and will not impact the quality of care I receive from Cape Cod Dermatology, LLC.

NOTICE OF PRIVACY PRACTICES

Cape Cod Dermatology, LLC strives to give you the highest quality health care and to have a relationship with you that is built on trust. This trust includes our commitment to respect the privacy and confidentiality of your protected personal health care information. Cape Cod Dermatology, LLC retains the right to use and share your protected health information for the following purposes:

- Treatment: to help coordinate and manage care with your providers (physicians, hospitals and other caregivers). For example, we may discuss your treatment plan with your physician or surgeon.
- Payment: Cape Cod Dermatology, LLC will use and share your personal health information as necessary to bill and collect payment for the health care services provided to you. For example, if you have health insurance, your health care provider will share your medical information with your insurance company (for example, Blue Cross Blue Shield or Medicare). We have indirect treatment relationships with your providers (such as laboratories & pharmacies) and may have to disclose your personal health information for the purposes of treatment, payment, or health care operations.
- Cape Cod Dermatology, LLC may use and share your personal health information with its business associates for activities that are known as health care operations. For example, Cape Cod Dermatology, LLC will share your information with Cape Cod Healthcare as required for auditing purposes. For example, Cape Cod Dermatology, LLC may utilize off site data backup and shredding companies. Business associates of Cape Cod Dermatology, LLC are required to protect your personal health information.
- As required by state and federal laws and regulations and for required public health reporting.
- As authorized by and as necessary to comply with workers compensation laws.
- Cape Cod Dermatology, LLC may use your health information to obtain your telephone number and/or address to contact you about scheduled or cancelled appointments, registration/insurance updates, billing or payment matters, surgical appointments, test results, and/or other matters related to your care as a patient. You have the right to request in writing for restrictions on the use of your contact information (for example, you may request that voicemail and/or other messages not be left at your contact number).

Your additional rights regarding your protected health information:

- Under ordinary circumstances, uses and disclosures not described in this Notice of Privacy Practices require your authorization.
- You have the right to restrict disclosures of your personal health information to your health plan when you pay out of pocket in full for your health care visit. Please note that a request for information restriction must be accompanied by a written request at the time of your office visit in addition to payment in full for said visit.
- Cape Cod Dermatology, LLC will notify you in the event of a breach of unsecured personal health information.
- You have the right to a copy of your medical record. Requests for medical records must be made in writing. Cape Cod Dermatology, LLC will respond to your request within 14 business days.
- If you are asked to and give written permission for the use and/or disclosure of your health information, you may withdraw such consent at any time in writing except to the extent that Cape Cod Dermatology, LLC has already acted upon your previously provided consent.
- Cape Cod Dermatology, LLC retains the right to change its privacy practices and the terms of this notice at any time. Cape Cod Dermatology, LLC retains the right to make the new notice provisions effective for all protected health information it retains.

  You may request a copy of the current notice at any time by contacting the office.

Cape Cod Dermatology, LLC

Contact Information

Last Name: _____First: _____M.I.: _____

Gender: _____ Date of Birth: _____ SS# _____

Mailing Address: _____

Street Address (if Different): _____

City: _____ State: _____ Zip: _____

Home: _____ Cell: _____ Work: _____

Email address (please print carefully): _____

Please note: Appointments will be confirmed via phone, email and/or text unless you have requested otherwise.

Responsible Party (if not self): _____

If Minor: Parent/Legal Guardian Names: _____

Primary Care Physician: _____

What is your main reason for today's visit?_____

_____

Insurance

1st Insurance: _____ Member ID# _____

Subscriber: _____ Date of Birth: _____

2nd Insurance: _____ Member ID# _____

Subscriber: _____ Date of Birth: _____

3rd Insurance: _____ Member ID# _____

Subscriber: _____ Date of Birth: _____

Cape Cod Dermatology, LLC

PATIENT AGREEMENT

Patient Name:_____Date of Birth: _____

1ST Insurance: _____ Member ID: _____

2ND Insurance: _____ Member ID: _____

New Patient Agreement

By signing below, I agree that I have familiarized myself with the policies of this office and all of my questions have been answered. I acknowledge that I have received a copy of Cape Cod Dermatology, LLCs *Welcome to our Practice* Letter dated 5/1/2020 outlining practice policies and my responsibilities relating to scheduling, cancelling and keeping timely appointments. I understand that appointments will be confirmed via phone, email and/or text unless I have requested otherwise. I understand that Dr. Girouard and Dr. Tocci are independent contractors practicing on site. I understand and agree that I am financially responsible for all rejected or non-covered services, and all co-pays and deductibles. I agree to access the patient portal in a secure manner. I know my rights regarding my protected health information.

Request for Payment

By signing below, I request payment of all eligible and authorized insurance benefits including but not limited to Medicare, Medicaid, Supplemental, Medigap, Commercial, and Private for me or on my behalf for any services provided by Dr. Fiske, Dr. Girouard, Dr Tocci, or Bri Schreiner, PA-C or at Cape Cod Dermatology, LLC be paid directly to Cape Cod Dermatology, LLC.

Release of Information

By signing below, I authorize the release of any medical or other information necessary to Medicare, Medicaid, Supplemental, Medigap, Commercial, and Private Insurance and its agents any information needed to determine these benefits or benefits for related services.

Signature: _____Date: _____

Note: A photocopy of this signature may by be used in lieu of original

Messages

Initial just one option, yes or no below. I authorize messages via text, email, voice message or answering machine with medical information such as lab/biopsy results, prescription information, or billing/insurance**.**

YES I DO authorize such messages to be left _____ *Initial*

NO I DO NOT authorize such messages to be left _____ *Initial*

Communication Permission

If desired, please list below a Relative or Friend that you would give permission to inform or discuss your Medical Information, Biopsy results, Plan of Care, or billing/insurance.

Name: _____

Relationship: _____ Phone Number: _____

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Required for Meaningful Use by The Federal Government

Preferred Language (please choose one or write in response):

☐ English ☐ Portuguese ☐ Spanish ☐ Other: _____

Ethnicity (please choose one or write in response):

☐ Latino/Hispanic ☐ Not Latino/Hispanic ☐ Other: _____ ☐ Prefer Not to Say

Race (please choose one or write in response):

☐ Caucasian (White)
☐ American Indian or Alaskan Native
☐ Asian
☐ Native Hawaiian or Pacific Islander
☐ Black or African American
☐ Prefer Not to Say
☐ Native American
☐ Other

Pharmacy

Current Pharmacy Name and Address: _____

_____

Medications (Please list all current prescription medications as well as over-the-counter, vitamins, herbs & supplements)

Name of Medication	Dose	Frequency	Route (oral, IV, etc.)

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Allergies (Please enter all allergies including drug, food, substance allergies, i.e. Latex)

Allergic to:	Describe reaction

Past Medical History (Please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ Benign Prostatic Hyperplasia
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems

Other: _____

Past Surgeries (please include dates): _____

_____

Skin Disease History (Please check all that apply)

- ☐ Acne
- ☐ Actinic Keratoses (pre-cancers)
- ☐ 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
- ☐ NONE

Other: _____

If positive personal history of melanoma, please indicate date of diagnosis and treatment course:

_____

Skin Protection (Do you wear sunscreen?) ☐ YES Indicate SPF here _____ ☐ NO

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Family Dermatology History

Do you have a family history of Melanoma? ☐ YES ☐ NO

If yes, which relative(s)? _____

Do you have a family history of squamous cell carcinoma or basal cell carcinoma? ☐ YES ☐ NO

If yes, which relative(s)? _____

Other Dermatology Family History (That you feel we should be aware of)

_____

Social History

Smoking Habits:

☐ Currently Smoke ☐ Never Smoked ☐ Former Smoker Quit on: _____

Alcohol Use:

☐ None ☐ less than 1 drink per day ☐ 1-2 drinks per day ☐ 3 or more drinks per day

Review of Systems

Are you currently or recently experiencing any of the following? (Please check all that apply)

☐ New or changing moles
☐ New skin growths
☐ Recent hives
☐ Rash
☐ Malaise
☐ Fever or chills
☐ Night sweats
☐ Problems with scarring (keloids, etc.)
☐ Immunosuppression

Other Symptoms: _____

ALERTS (Please check all that apply)

☐ Allergy to Adhesive
☐ Allergy to Lidocaine
☐ Allergy to topical antibiotics
☐ Artificial heart valve
☐ Artificial joint replacement
☐ Blood Thinners
☐ Defibrillator
☐ MRSA
☐ Pacemaker
☐ Require antibiotics prior to a surgical procedure
☐ Rapid heart beat with epinephrine
☐ Pregnant or currently trying to get pregnant

Vaccines

Have you had the pneumonia vaccine ☐ YES Indicate date most recent vaccine _____ ☐ NO

Have you had the influenza vaccine ☐ YES Indicate date most recent vaccine _____ ☐ NO