Cape Cod Dermatology, LLC **134 Ansel Hallet Road West Yarmouth, MA 02673-2582 P: (508) 771-9779 F: (508) 771-4355**

Practice Policy Statement – 7/20/2023

Please acknowledge receipt of this notice after your review. See Below.

Thank you for choosing our office for your dermatologic care. We are dedicated to provide 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. Elizabeth Tocci is directly employed by Cape Cod Healthcare and practices on Cape Cod Dermatology LLC's premise solely as independent contractor.

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 patients will be given a Good Faith Estimate in advance of their appointment. Charges are expected to be paid at the time of service, unless prior arrangements have been made with the billing office.
- We 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.

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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. URL CCD.EMA.MD

The Patient Portal provides access to the following services:

- Fill out paperwork for faster check-in
- Send messages to staff
- Request prescription refills
- View your medical records and results
- Pay bills online

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.
- You should never use a public computer to access your patient portal. Protect your password. If you think someone has acquired your password, you should change it immediately.
- 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.
- Cape Cod Dermatology, LLC is not responsible for a breach of private medical information should the breach occur beyond Cape Cod Dermatology, LLC's reasonable control. (For ex: using an insecure network, compromised device, patient discloses his/her portal password).
- I understand the risks associated with online communications. 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.

Patient Agreement

By signing below, I acknowledge that I have reviewed Cape Cod Dermatology, LLCs Practice Policy Statement dated 7/20/2023 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 Dr. Tocci is an independent contractor 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 agree to follow the policies of this office. A copy of this statement is available upon request or can be viewed at www.capecodderm.org.

Signature: ____ Date: _______________________

Note: My typed signature constitutes proof that all parties involved have agreed to the terms of the above policy statement. A photocopy of this document may be used in lieu of original.

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NOTICE OF PRIVACY PRACTICES – 7/20/2023

Please acknowledge receipt of this notice after your review. See Below.

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, we will share your information with Cape Cod Healthcare as required for auditing purposes. For example, we may utilize off site data backup and shredding companies. Our business associates 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 (PHI):

- 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 PHI 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 paid in full office 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.

By signing below, I acknowledge that I have reviewed Cape Cod Dermatology, LLC's *Notice of Privacy Practices* dated 7/20/2023. A copy of this notice is available upon request or can be viewed at www.capecodderm.org.

Signature: ____ Date: _________________________

Note: My typed signature constitutes proof that all parties involved have agreed to the terms of the above policy statement. A photocopy of this document may be used in lieu of original.

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Contact Information

Last Name	First Name	MI	Date of Birth	Gender

Identifies as Male - Identifies as Female - Transgender Male/Trans Man (FTM) Transgender Female/Trans Woman (MTF) - Genderqueer - Other	He, Him, His - She, Her, Hers They, Them, Their
Gender Identity – Please Circle	Patient Preferred Pronouns

Mailing Address/Street Address	City	State	Zip

If Minor, Parent/Legal Guardian Name (s)/ Relationship	Address if different

	Mobile - Home - Work		Mobile - Home - Work
Primary Telephone	Please Circle Type	Secondary Telephone	Please Circle Type

Email address	Primary Care Physician

Emergency Contact Name	Emergency Contact Phone

Insurance

1st Insurance: _______________________________ Member ID# _________________________________

Subscriber: ____ Date of Birth: _______________________

2nd Insurance: _______________________________ Member ID# _________________________________

Subscriber: ____ Date of Birth: _______________________

Consent 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 Tocci, or Bri Schreiner, PA-C or at Cape Cod Dermatology, LLC be paid directly to Cape Cod Dermatology, LLC.

Consent to Release 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: ___________________

My typed signature constitutes proof that I have agreed to the terms above. A photocopy of this document may be used in lieu of original.

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What is your main reason for your new patient visit? (What are your concerns/symptoms)

____

Consent to speak/share your PHI with a friend/relative *PHI is your protected health information such as your Medical Information, Biopsy results, Plan of Care, or to answer billing/insurance questions.*

Name of relative/friend	Relationship	Phone

Consent to leave messages *ALL appointments will be confirmed via phone, email and text unless you request otherwise.*

***Do you** authorize detailed messages to be left/sent via text, email, voice message or answering machine with medical information such as lab/biopsy results, prescription information, or to answer a billing/insurance question?*

If yes initial here:	**If no initial here:**
YES I authorize detailed messages	**NO I DO NOT** authorize detailed messages

Required for Meaningful Use by The Federal Government

Occupation (before retirement if applicable): ____

City/State of birth: ____

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.)

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

Allergic to:	Describe reaction

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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:

____

____

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

Have you had the COVID-19 vaccine ☐ YES Indicate date most recent vaccine ___________ ☐ NO

Manufacturer: ☐ Moderna ☐ Pfizer ☐ J & J

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

Tobacco 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 heartbeat with epinephrine
☐ Pregnant or currently trying to get pregnant