



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.

Notice of Practice Policy

I have received a copy of Cape Cod Dermatology, LLC’s Practice Policy.

I hereby agree and acknowledge:

- 1) Financial Agreement: Patient or guarantor is financially responsible for all non-covered services, co-pays and deductibles.
- 2) Appointment and Cancellation Policy: Late arrivals may be rescheduled, missed appointments or appointments cancelled within 24 hours may be charged. Repeated missed appointments may result in dismissal from the practice.
- 3) Independent contractor: Dr. Elizabeth Tocci is directly employed and insured by Cape Cod Healthcare.
- 4) Patient Portal: An optional patient portal is available for use as a courtesy in partnership with Modernizing Medicine. Use of the patient portal is entirely voluntary and will not impact the quality of care received.
- 5) Patient Portal Safety: Patient portal is NOT for emergencies. Portal must be accessed on a secure network and password must be protected.
- 6) Privacy Policy: Cape Cod Dermatology, LLC will use and share my personal health information as outlined in the Notice of Privacy Practices printed on the Practice Policy.
- 7) Additional Rights regarding my protected health information are found on the Practice Policy.

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.



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

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

Pharmacy

Current Pharmacy Name and Address: _____

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

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

Past Medical History (Please check all that apply)

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Lymphoma |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> COPD | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Diabetes | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Benign Prostatic Hyperplasia | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> GERD | <input type="checkbox"/> Lung Cancer | <input type="checkbox"/> Other: |

Other: _____

Past Surgeries (please include dates): _____

Skin Disease History (Please check all that apply)

- | | | |
|--|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Poison Ivy |
| <input type="checkbox"/> Actinic Keratoses (pre-cancers) | <input type="checkbox"/> Eczema | <input type="checkbox"/> Precancerous Moles |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Melanoma | <input type="checkbox"/> 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



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)? _____

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

Other Dermatology Family History (That you feel we should know)

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)

- | | | |
|--|--|---|
| <input type="checkbox"/> New or changing moles | <input type="checkbox"/> Rash | <input type="checkbox"/> Night sweats |
| <input type="checkbox"/> New skin growths | <input type="checkbox"/> Malaise | <input type="checkbox"/> Problems with scarring (keloids, etc.) |
| <input type="checkbox"/> Recent hives | <input type="checkbox"/> Fever or chills | <input type="checkbox"/> Immunosuppression |

Other Symptoms: _____

ALERTS (Please check all that apply)

- | | |
|---|--|
| <input type="checkbox"/> Allergy to Adhesive | <input type="checkbox"/> Defibrillator |
| <input type="checkbox"/> Allergy to Lidocaine | <input type="checkbox"/> MRSA |
| <input type="checkbox"/> Allergy to topical antibiotics | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Require antibiotics prior to a surgical procedure |
| <input type="checkbox"/> Artificial joint replacement | <input type="checkbox"/> Rapid heartbeat with epinephrine |
| <input type="checkbox"/> Blood Thinners | <input type="checkbox"/> Pregnant or currently trying to get pregnant |



Practice Policy Statement

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. 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 Contractor

Dr. Elizabeth Tocci is directly employed and insured by Cape Cod Healthcare. She practices at Cape Cod Dermatology LLC's premises solely as an independent contractor.

Cancellation Policy

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

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.

CAPE COD DERMATOLOGY



CAPE COD DERMATOLOGY

134 Ansel Hallet Rd, West Yarmouth, MA 02673

(508) 771-9779

CAPECODDERM.ORG

Practice Policy



Patient Portal Safety

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. Use of your patient portal is entirely voluntary and will not impact the quality of care received from Cape Cod Dermatology, LLC.
URL [HTTPS://CCD.EMA.MD](https://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 agrees to the following:

- Do not use portal communication if there is an emergency. Dial 911 or go to the Emergency Room.
- We will usually respond to non-urgent emails within 48 hours. Do NOT use the patient portal for urgent problems – please call the office.
- 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.
- 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).

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 quote 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.

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, 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).