THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA, PLLC

3700 JOSEPH SIEWICK DR. SUITE 404/402, FAIRFAX, VA 22033
(703)620-8900 FAX: (703)620-2288

MINOR PATIENT REGISTRATION FORM

Child's Name: ____
First Middle Last

Child's Date of Birth ____/____/____ Child's Sex: Male / Female
Month Day Year

Home Address: ____
Street # Street Name Apt #

____
City State Zip

Legal Guardian or
Parent Name: ______________________________ Parent Birth Date _____/_____/______
First Middle Last Month Day Year

Home Phone: ( ) ______________Work Phone: ( ) _______________Cell Phone: ( ) _______________

Referring Physician ______________________________City________________________Phone______________

Primary Physician________________________________City________________________Phone______________

In case of Emergency, who should be notified? __________________________________ Phone______________

INSURANCE INFORMATION (Please present Insurance card at time of check-in)

Primary Ins. Co.________________________________

Policyholder's Name_____________________________

Insured's ID/Policy #_____________________________

Group # ______________________________________

Relationship of Patient to Policyholder _____________

Secondary Ins. Co. ________________________________

Policyholder's Name______________________________

Insured's ID/Policy #______________________________

Group # ____

Relationship of Patient to Policyholder _______________

Do we have your permission to:

Leave a message on your answering machine at home? YES / NO
Leave a message at your place of employment? YES / NO
Discuss the child's medical condition with any member of your household? YES / NO
If Yes, whom: ________________________ Relationship to patient: ________________

In order to establish optimal relations with our patients and avoid misunderstandings regarding out payment policies, please note: IT IS THE POLICY OF THIS OFFICE THAT THE ADULT PRESENTING THE CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF "THE PATIENT PORTION" AT THE TIME OF SERVICE. Your signature below indicates that you understand and accept this policy.

____ _______/______/______
Signature of Parent / Legal Guardian Date

Please present insurance cards and photo ID to the receptionist so copies can be made.

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MEDICAL HISTORY

Patient Name:____ **Date:**____/______/______

What skin issue are you here for: ____

Are you ALLERGIC to LATEX? YES / NO If Yes, explain reaction:________________________

Are you ALLERGIC to any medicines? YES / NO If Yes, please list:

MEDICATION ALLERGY	REACTION
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________
____________________________	______________________________

MEDICATIONS and SUPPLEMENTS/HERBALS you are currently taking : NONE

1____________________________	5______________________________
2____________________________	6______________________________
3____________________________	7______________________________
4____________________________	8______________________________

Do you have any MEDICAL PROBLEMS / SURGICAL HISTORY? (Not Skin) YES / NO If Yes, please list:

____

____

History of SKIN PROBLEMS?: NONE List:____

Have you ever had a SKIN CANCER? YES / NO If YES, Circle Type:

MELANOMA / BASAL CELL CARCINOMA / SQUAMOUS CELL CARCINOMA

Is there a FAMILY HISTORY of MELANOMA: YES / NO Who?________________

Is there a FAMILY HISTORY of Other SKIN CANCER : YES / NO

Do you CURRENTLY have any Fevers, Chills or Sweats? YES / NO

CURRENT OCCUPATION: ______________________________________

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PATIENT FINANCIAL POLICY AND SIGNATURES ON FILE

Patient Name:____ Date _____/_____/______

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.

PAYMENT POLICIES:
MEDICARE: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible, paying for the co-payment and charges for non-covered /cosmetic services. If we participate with your secondary/supplemental carriers we will file a claim for you. However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. I authorize any holder of medical or other information about me to be released to the Social Security Administration, Center for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PPO, HMO, TRICARE, OR OTHER MANAGED CARE PATIENTS: If **we participate (are contracted)** with an **insurance plan** under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic service. In the event that we are not aware that a particular service is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

NON-MEDICARE PATIENTS WHO HAVE INSURANCE COVERAGE WITH A CARRIER THAT WE DO NOT HAVE A CONTRACT (PARTICIPATE) WITH: Patients covered by private, commercial plans in which our physicians are not members will be responsible for payment in full at the time of service, regardless of the benefits and payment policies of your carrier. We will *NOT* file claims directly with your insurance company. Patients may elect to independently seek reimbursement from their carrier, if so we can provide you documentation of the services performed.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient or Responsible Party Signature_________________________________ Date _____/_____/______

If you have a **SUPPLEMENTAL POLICY** to which your **MEDICARE** carrier automatically "crosses over": I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related service.

Patient or Responsible Party Signature _________________________________Date _____/_____/______

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HIPAA CONSENT AGREEMENT AND NON DISCRIMINATION POLICY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement in order to the use and disclose individually identifiable health information (IIHI), as long as it is only shared with others who are treating you or supporting us in providing you quality health care.

However, it is Important to have your consent to allow us to use and/or disclose your IIHI to health care plans to ensure accurate and timely payments for the services we render. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. Please refer to our Privacy Notice (this document is available from the front desk) for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements:

I have been offered an opportunity to review a Privacy Notice and I understand my rights regarding individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

The obligation to notify patients if there is a breach of their Protected Health Information (PHI) has been clarified under the new rule. The subjective "harm" standard in the interim final rule has been eliminated. Under the "harm" standard, a breach did not occur unless the access, use, or disclosure posed "a significant risk of financial, reputational, or other harm to an individual." Now, any acquisition, access, use, or disclosure of unsecured PHI not permitted under HIPAA is presumed to be a breach unless it is determined that there is a low probability that the PHI has been compromised based on a four-factor risk assessment:

1. The nature and extent of PHI involved;
2. The unauthorized person who used the PHI or to whom the disclosure was made;
3. Whether PHI was actually acquired or viewed; and
4. The extent to which the risk to PHI has been mitigated (e.g., assurances from trusted third parties that the information was destroyed).

Individuals have a right to access and to obtain a copy of PHI within 30 days of their request. Under the new rule, if an individual requests a copy of PHI that is maintained electronically, the provider must, with limited exception, give the individual access to the PHI in an electronic format.

At an individual's request, a health care provider may not disclose the individual's PHI to a health plan, if the disclosure is not required by law, the request relates to payment or health care operations, and the individual has paid for the item or service out of pocket in full. If an individual makes such a request, providers will want to document the request and ensure that the patient understands that no claims will be submitted by the provider to the patient's insurer. Providers will also need to employ some method to flag medical records with respect to the PHI that has been restricted.

Under the new rule, providers may disclose PHI to family members of a decedent who were involved in the person's care prior to his or her death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the covered entity.

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HIPAA CONSENT AGREEMENT AND NON DISCRIMINATION POLICY CONTINUED

The law allows us to make disclosures for payment purposes, treatment and permitted disclosures to patients in exchange for a reasonable fee.

OUR OFFICE DOES NOT AND WILL NOT SELL YOUR HEALTH INFORMATION TO ANYONE. Federal law requires us to tell you that your individual authorization is required before any information is sold.

OUR OFFICE DOES NOT AND WILL NOT CONDUCT FUNDRASING ACTIVITIES. Federal law requires us to tell you that you would have the opportunity to opt-out of receiving fundraising communications.

The new rule permits a provider to combine an authorization for the disclosure of PHI for research purposes that requires the signing of that form for the patient to be treated with an authorization for the use of PHI for other purposes that does not include the same conditions, provided that the authorization allows the individual to opt in to the unconditioned activities, and the research does not involve the use or disclosure of psychotherapy notes. These authorizations may also encompass future research, which was not permitted under the existing rules.

The definition of "marketing" has been modified to encompass communications by a provider for purposes of treatment and health care operations about health-related products or services if the provider receives financial remuneration for making the communication from or on behalf of the third party whose product or service is being described. A provider must obtain an individual's written authorization prior to sending marketing communications to the individual.

Clinical Skin Center Notice: Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law, and Clinical Skin Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Clinical Skin Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In accordance with Affordable Care Act section 1557. We provide free aids and services to people with disabilities to communicate effectively such as qualified sign language interpreters, written information in other formats, and language services to people whose primary language is not English. If you need these services, you can contact the office manager, Ms. C. Chapman.

If you believe the Clinical Skin Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, or fax. Assistance in these matters is available to you if you need it. Contact: Ms. C Chapman, Clinical Skin Center, 3700 Joseph Siewick Dr. #404 Fairfax, VA 22033. 703-620-8900.

You can also file a complaint with U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the online Office for Civil Rights Complaint Portal, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. 800-368-1019.

Signature:___________________________ Date:_____________