PHYSICIAN: ______________________________

Patient Information

______________________________ (First, Middle, Last Name) ______________ (Date of Birth)

______________________________ (Address) ______________________________ (City, State, Zip Code)

______________________________ (Email Address) ______________________________ (Social Security Number)

(Home Number) check if preferred (Work Number) check if preferred (Cell Number) check if preferred

Marital Status: ☐Single ☐ Married ☐ Divorced ☐ Widowed
Gender: ☐ Male ☐ Female
Preferred Language: ☐ English ☐ Other______________________
Race: ☐ White ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or other Pacific Islander ☐Other______________
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Primary Insurance Information

(Name of Insurance Company)

(Subscriber's Name) (Date of Birth)

(Subscriber's Employment) (Relationship to Patient)

Secondary Insurance Information

(Name of Insurance Company)

(Subscriber's Name) (Date of Birth)

(Subscriber's Employment) (Relationship to Patient)

Referring Physician

(Name)

(Address)

(City) (State, Zip Code)

(Phone)

Primary Care Physician

(Name)

(Address)

(City) (State, Zip Code)

(Phone)

Patient Employment

(Name)

(Position)

Emergency Contact

(Name)

(Phone number)

How did you hear about our clinic?

☐ Referring Provider
☐ Mailer ☐ Newspaper
☐ Insurance Company ☐ Family member
☐ Other ______________________________
☐ Online ______________________________

Name ___________________________________ Date of Birth _____________________ Date _________________

History and Intake Form

Review of Systems	YES
Lightheades/Dizziness	
Nausea/Vomiting	
Headaches	
Upset stomach with antibiotics	
Excessive Fatigue	
Yeast infections with antibiotics	
Problems with bleeding	
Problems with healing	
Problems with Scarring	
Changing Mole	
Rash	
Vision Changes	
Alerts	
Pregnancy or Planning Pregnancy?	
Currently Breastfeeding?	
Have a Pacemaker?	
Have a Defibrillator?	
Artificial Joints within the past two years?	
Artificial Heart Valve?	
Allergy to Adhesive?	
Allergy to Lidocaine?	
Require Premedication Prior to a Procedure?	
Allergy to Latex?	
Currently Taking Blood Thinners?	
Ever been diagnosed with MRSA?	
Do you have a history of melanoma skin cancer?	
Do you have a family history of melanoma skin cancer?	
Do you have a history of non-melanoma skin cancer?	
Do you have a family history of non-melanoma skin cancer?	

Past Medical History	Self	Family
Anxiety		
Arthritis		
Artificial Joints		
Asthma		
Atrial Fibrillation		
BPH		
Bone Marrow Transplant		
Breast Cancer		
Colon Cancer		
COPD		
Coronary Artery Disease		
Depression		
Diabetes		
End Stage Renal Disease		
GERD		
Hearing Loss		
Hepatitis		
High Blood Pressure		
HIV/AIDS		
High Cholesterol		
Hyperthyroidism		
Hypothyroidism		
Leukemia		
Lung Cancer		
Lymphoma		
Pace maker		
Prostate Cancer		
Radiation Treatment		
Seizures		
Stroke OR Valve Replacement		

Past Surgical History	YES
Mastectomy (Right, Left, Bilateral)	
Lumpectomy (Right, Left, Bilateral)	
Colectomy: Colon Cancer Resection	
Colectomy: Diverticulitis	
Colectomy: Irritable Bowel Disease	
Coronary Artery Bypass	
Heart Valve Replacement	
Heart Transplant	
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	
Joint Replacement within the last 2 years	
Kidney Removed (Right, Left)	
Kidney Transplant	
Ovaries Removed: Ovarian Cancer	
Prostate Removed: Prostate Cancer	
Skin Biopsy	
Basal Cell Cancer Surgery	
Squamous Cell Cancer Surgery	
Melanoma Surgery	
Spleen Removed	
Hysterectomy: Fibroids	
Hysterectomy: Uterine Cancer	
MOHS Surgery	
Skin Disease History	
Acne	
Actinic Keratoses	
Basal Cell Skin Cancer	
Blistering Sunburns	
Dry Skin	
Eczema	
Flaking or Itchy Scalp	
Hay Fever/Allergies	
Melanoma	
Precancerous Moles	
Psoriasis	
Squamous Cell Skin Cancer	
Other_______________________________	
Do you tan in a tanning salon?	
Do you wear sunscreen?	
If yes, what SPF? ________________	
Social History	
Cigarette Smoking:	
Never Smoked	
Quit: Former Smoker	
Smokes less than daily	
Smokes daily	
Alcohol Use:	
None	
Less than one drink a day	
1-2 drinks a day	

Name ___________________________________

History and Intake Form cont…

MEDICATIONS

ALLERGIES

PHARMACY INFORMATION
NAME
ADDRESS
CITY/STATE
PHONE

DERMATOLOGY
SPECIALISTS
OF SHELBY

Client: Dr. Berry
Company: Dermatology Specialists of Shelby
Project: Logo

HIPAA QUESTIONNAIRE

1. In signing this notice, I, ________________________ am granting permission for this office to inquire or obtain information from my insurance company for treatment and billing purposes for myself and family members and to receive and/or forward necessary records if indicated in the case of a referral or transfer to another facility.

2. Please list the family members or other persons, if any, whom we may inform about your medical condition (including treatment and payment).

NAME	RELATIONSHIP

3. Please list the family member who is named legal representative (guardianship, foster care or medical power of attorney), whom we may inform and/or inquire about your medical condition given more **extenuating** circumstances:
   ______________________________________ Contact number: _________________________

4. Can confidential messages (i.e. appointment reminders) be left on your telephone answering machine or voicemail? YES__________ NO__________
   Please print the telephone numbers, if any, where you want to receive calls about your appointments or other health care information if other than your home number: ___________________________
   **I am fully aware that a cell phone is not a secure and private line.*

SIGNATURE
I have reviewed this consent form and give my permission to use and disclose my health information in accordance with this consent and the notice provided upon request.
Would you like a copy of our Notice of Privacy Policies and Procedures? _____Yes _____No

PATIENT NAME (please print): ____

PATIENT SIGNATURE: ____
PARENT/GUARDIAN SIGNATURE

WITNESS: ____

____
Unable to sign　　　　　Refused to sign　　　　　Did receive information
DATE: _______________________

285 North Lilley Rd
Canton, MI 48187
Ph: (734)495-1506
Fax: (734) 495-1780

43151 Dalcoma Dr, Suite 1
Clinton Twp., MI 48038
Ph: (586) 286-8720
Fax: (586) 286-8723

2950 Keewahdin Road
Fort Gratiot, MI 48059
Ph: (810) 455-1600
Fax: (810) 455-16

50505 Schoenherr, Suite 325
Shelby Township, MI 48315
Ph: (586) 580-1001
Fax: (586) 580-9289

2305 Genoa Business Park Dr, #180
Brighton, MI 48114
Ph: (810) 355-4300
Fax: (586) 286-8723

S.L. Husain Hamzavi, MD ▪ Iltefat H. Hamzavi, MD ▪ Fasahat H. Hamzavi, MD ▪ Ali A. Berry, MD ▪ Andrea Schrieber, MD ▪ Meredith Price, MD Jennifer Rivard, MD ▪ Francisca Kartono, DO ▪ Marsha Henderson, MD ▪ Matteo C. LoPiccolo, MD ▪ Judy Fontana, MD ▪ Nana Macaron, MD Jennifer Brown, PA-C ▪ Evelyn Sommariva, PA-C ▪ Jennifer Reiss, PA-C ▪ Andrea Rosik, PA- C ▪ Jessica McLeod, FNP ▪ Ashley Senopole, PA-C

Patient Financial Responsibility

Thank you for choosing Dermatology Specialists of Shelby as your provider for dermatology care. We strive to provide the most efficient and patient-friendly skin care to all our patients. In an effort to provide the best care, it is important that you read the financial responsibility form below.

-Please inform the front office staff if your insurance plan has changed (active/inactive), if you have received a new insurance card, or if you do not have insurance currently.

-Copayments and past due balances are due following your visit for that day. **If you do not have insurance or a referral, you will be responsible for the full charged amount of your visit.**

-There are certain fees associated with requesting copies of medical records. Please ask the office staff to clarify the cost of a medical record request.

-Medicare insurance patients will be given an Advanced Beneficiary Notice (ABN) form if a service is not covered by our office. It is your responsibility to sign the ABN for that particular service.

-Cash, personal check, debit, and credit cards (Visa, MasterCard, American Express, and Discover) are acceptable forms of payment.

You will be asked to sign a copy of this document, during your visit to Dermatology Specialists of Shelby.

Your Information.
Your Rights.
Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. **Please review it carefully.**

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

➤ ***See page 2*** *for more information on these rights and how to exercise them*

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

➤ ***See page 3*** *for more information on these choices and how to exercise them*

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

➤ ***See pages 3 and 4*** *for more information on these uses and disclosures*

Your Rights

When it comes to your health information, you have certain rights.
This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we *never* share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information?
We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as: • Preventing disease • Helping with product recalls • Reporting adverse reactions to medications • Reporting suspected abuse, neglect, or domestic violence • Preventing or reducing a serious threat to anyone's health or safety
Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.
Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you: • For workers' compensation claims • For law enforcement purposes or with a law enforcement official • With health oversight agencies for activities authorized by law • For special government functions such as military, national security, and presidential protective services
Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.