Patient's Last Name: _____ First Name: _____ MI : _____

Address:_____ City: _____

State:_____ Zip: _____ Assigned Gender at Birth (M/F):_____

Referring Dr.:_____ Pronouns: he/him, she/her, they/them

Birth Date: ____/____/_____ Marital Status: S M D W S Work Phone:(___)_____

Emerg Contact Name: _____ Home Phone:(___)_____

Emerg Contact Phone: _____ Cell Phone: (___)_____

Relationship to Patient:_____ Patient Email: _____

PRIMARY INSURANCE COVERAGE

Company: _____

Insured Name :_____

Relationship:_____ DOB: ____/___/___

Co-Pay Amount:_____

Policy Number:_____

Group Number:_____

Employer:_____

SECONDARY INSURANCE COVERAGE

Company:_____

Insured Name:_____

Relationship:_____ DOB:___/___/___

Co-Pay Amount:_____

Policy Number:_____

Group Number: _____

Employer: _____

GUARANTOR INFORMATION

Guarantor Name :_____

Address :_____

City:_____ State Code :_____ Zip Code : _____

Telephone # : (____) _____ Relationship :_____

PATIENTS' AUTHORIZATION

I authorize SIMMONS-O'BRIEN & ORLINSKY, LLC to apply for benefits on my behalf for services rendered by SIMMONS-O'BRIEN & ORLINSKY, LLC. I request payment, only from the insurances that SIMMONS-O'BRIEN & ORLINSKY, LLC participates with, be made directly to the practice. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time, in writing. I understand that nothing herein relieves me of the primary responsibility and obligation to pay for medical services provided, when statement is rendered.

Signature of Subscriber or Beneficiary _____ Date:_____

Print Name:_____

OFFICE AND FINANCIAL POLICIES

Thank you for choosing our office for your dermatologic needs. This letter has been prepared to help clarify frequently asked questions regarding fees, billing, and insurance coverage.

Please consult the office staff before treatment is rendered if you have any questions.

FEES:

The office fee visit covers the examination, discussion, and issuing of prescriptions or samples for your skin condition. Some skin diseases or conditions may require more extensive evaluation or discussion. In these circumstances, the fee may be higher than the "standard" office visit. Surgical fees cover the surgical procedure. Additional fees may be assessed for photography.

All co-pay/co-insurance/deductibles are due at the time of service. If you have insurance we do not participate with, all fees are due at time of service. Please be advised that we cannot bill your insurance unless you provide us with a copy of your **current** insurance card. Our office staff will request a copy of your insurance card and driver's license at your first visit.

PAYMENT:

Medicare: We do not accept Medicare. We have completely opted out. You will be Responsible for the entire payment. If you have a secondary insurance that is not a Medicare supplement, they may reimburse you twenty percent if your deductible has been met. Under the **Medicare affadavit**/opt out contract, you may not submit for reimbursement to Medicare or a Medicare supplemental insurance.

MINOR PATIENTS: A parent or guardian must accompany patients under the age of 18 at the time of service. All fees, co pays/co-insurances and deductibles are due *at the time of service* in concurrence with office policy.

CANCELLATION AND MISSED APPOINTMENT POLICY:

If, for any reason, you cannot keep your scheduled appointment, please call 410-821-SKIN (7546) with at least 24 hours notice. You are welcomed to send us a fax (410-821-7576) canceling your appointment if we cannot be reached by phone. We reserve the right to charge for missed appointments or appointments cancelled with less than **24 hours notice**. If a patient misses two consecutive appointments (no shows), you may be notified and advised to find another practice to serve your dermatologic needs.

PAST DUE ACCOUNTS:

Accounts are considered past due after 30 days. After 90 days past due, you can be asked to leave the Practice. If your check is returned from the bank, you will be billed a $25.00 service charge.

MEDICAL RECORD COPYING FEE POLICY:

If you, an insurance company, lawyer, or any of your other physicians request Medical Records, you or the appropriate requesting authority (should it apply) will be billed in accordance with **Maryland State Law and HIPPA** requirements.

OFFICE HOURS:

Our office hours are Monday through Friday 8:30 am to 4:30 pm.

There may be occasional changes due to holidays or other unforeseen events.

For all prescriptions refills, routine appointments, and non-urgent questions, please call during office hours. Please arrive on time for your appointment, and 10-15 minutes early for a procedure.

If you have an urgent problem during non-office hours,
please call the office and follow the instructions on the recorded message.

PATIENT SIGNATURE:_____Date_____

NOTICE OF PRIVACY PRACTICES

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.

THIS NOTICE GIVES YOU INFORMATION REQUIRED BY LAW about the duties and privacy practices of *Simmons-O'Brien & Orlinsky, LLC* (the "Practice") to protect the privacy of your individually identifiable health information or Protected Heath Information, as that term is defined under the Health Insurance Portability and Accountability Act of 1996 ("Information"), in providing for your medical treatment and needs.

THE EFFECTIVE DATE OF THIS NOTICE IS APRIL14, 2003. The Practice is required to follow the terms of this Notice until it is replaced. The Practice may make changes to the terms of this Notice at any time. Upon your request, the Practice will provide you a copy of its current Notice. The Practice reserves the right to make the new changes apply to Information maintained be the Practice before and after the effective date of the new Notice.

Purposes for which the Practice May Use or Disclose Your Medical Information With Your Consent The Practice may request your consent for the use and disclosure of your Information for treatment, payment or health care operations as described below:

Treatment Purposes . For example, your Information may be disclosed to your primary care physician or another specialist who referred you to the Practice for treatment.

Payment . For example, your Information may be used and disclosed to submit claims to your insurer and/or to obtain payment for services provided.

Health Care Operations . For example, your Information may be used and disclosed by the Practice to engage in case management, coordination of your care, schedule your appointments and inform you of your lab results or to convert your medical record to an electronic record.

Health Care Services. Your Information may be used and disclosed to contact you and to give you information about treatment alternatives or other heath benefits and services that may be of interest to you.

Uses and Disclosures with Your Verbal Consent

Your Information may be disclosed to a family member, friend or other person designated by you or as designated by the law, if you verbally agree. With your verbal consent, directory information also may be used and disclosed.

Uses and Disclosures with Your Authorization

Except as provided below, your Information will not be used for any non-routine purposes unless you give the Practice your written authorization to do so. The Practice may request your authorization to use and disclose your Information for research purposes. If you give the Practice written authorization to use or disclose your Information for a purpose that is not described in this Notice, then with certain exceptions, you may revoke it in writing at any time. Your revocation will be effective for the Information the Practice maintains, unless the Practice has taken action in reliance of your authorization.

Uses and Disclosures without Your Consent or Authorization

As required by law . The Practice must provide your Information to the U.S. Department of Health and Human Services and to you upon request.

To Business Associates . Your Information may be disclosed to the Practice's business associates who require the Information to perform a function for the Practice (i.e. accountant). Each business associate of the Practice must agree in writing to ensure the continuing confidentiality and security of your Information.

Additionally, your Information may be used and disclosed without your consent, opportunity to agree or disagree or authorization for other reasons including:

To comply with legal proceedings, such as a court or administrative order or subpoena;

To law enforcement officials for limited law enforcement purposes;

For research purposes in limited circumstances;

To a coroner, medical examiner, or funeral director about a deceased person;

To an organ procurement organization in limited circumstances;

To avert a serious threat to your health or safety or the health or safety of others;

To a governmental agency authorized to oversee the health care system or government programs; To

federal officials for lawful intelligence, counterintelligence and other national security purposes; To public

health authorities for public health purposes; and

To appropriate military authorities, if you are a member of the armed forces.

Your Rights

You may make a written request to the Practice to do one or more of the following concerning your Information:

To put additional restrictions on the Practice's use and disclosure of your Information.

To communicate with you in confidence about your Information by a different means or at a different location that the Practice is currently doing.

To see and get copies of your Information.

To correct your Information.

To receive a list of disclosures of your Information that the Practice and its business associates, make for certain purposes for six (6) years prior to your request (after April 14, 2003), with certain exceptions permitted by law including exceptions for disclosures made to you or made pursuant to your authorization.

To send you a paper copy of this Notice if you receive Notice by e-mail or on the Internet.

If you want to exercise any of these rights described or required further information about the Practice's privacy practices, please contact the Practice at the address below. Please know that in certain instances, the Practice does not have to agree to your request. The Practice will give you the necessary information and forms for you to complete and return. Records requested for yourself, the Practice would charge you a fee of $0.60 per page for copying and postage if mailed to your home.

Complaints

If you believe your privacy rights have been violated by the Practice you have the right to complain to the Practice or to the Secretary of the U.S. Department of Health and Human Services. You may file a written complaint with the Practice by contacting the Practice at the address below. The Practice will not retaliate against you if you choose to file a complaint with the Practice or with the U.S. Department of Health and Human Services.

Patient signature acknowledging Notice of Privacy Practices:

_____

Phone: 410-821-SKIN (7546)
Fax: 410-821-7576
8320 Bellona Ave., Suite 20, Towson MD, 21204

PATIENT CONSENT TO THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Simmons-O'Brien and Orlinsky, LLC (the "Practice") obtains and maintains health information relating to my past, present or future physical or mental condition, provision of health care or payment for health care, referred to as "Protected Health Information." This Protected Health Information may be used or disclosed by the Practice for purposes of treatment, payment or health care operations, including, but not limited to:

- planning for my care and treatment;
- calling me with appointment reminders and lab results;
- submitting a claim to my insurer or health plan;
- converting my medical record to an electronic record; and
- assessing the quality of care provided to me.

The *Practice's Notice of Privacy Practices* contains a more complete description of how my Protected Health information may be used and disclosed and how I can obtain access to this information. I understand that the Practice reserves the right to change its Notice and practices and I can request a copy of its current *Notice.*

I understand that I have the right to request restrictions as to how my Protected Health Information may be used or disclosed by the Practice. The Practice is not required to agree to my request but if the Practice does agree, the requested restrictions will be binding on the Practice.

I further understand that, at any time, I may revoke this consent in writing, except to the extent that the Practice has already taken action in reliance on it.

By signing this form below, I consent to the Practice's use and disclosure of my Protected Health Information for the purposes of treatment, payment and/or healthcare operations. I also acknowledge that I have received a copy of the *Notice of Privacy Practices* of the Practice.

_____ _____

(Signature of Patient or Legal Representative) (Print Name)

_____

(Date)

If executed by Legal Representative, please describe relationship to patient:

_____

Name (Please Print):_____ Age:_____

Referred By: Physician:_____ Patient:_____ Other:_____

HEIGHT: Feet:_____ Inches:_____ **Weight** (lbs):_____

1.What is the reason for today's visit? _____

2. Do you have a **personal** or **family history** of skin cancer? **YES** **NO** (circle)
If yes, **sun induced** or **melanoma** (circle)
Do you have a personal history of pre-skin cancers (actinic keratosis)? **YES** **NO** (circle)
Have you ever had a mole removed? **YES** **NO** (circle)

3. We recommend that all of our patients have full skin examinations to check for abnormal moles or potential skin cancers. Would you like to schedule a complete skin examination? **YES** **NO** (circle)

4. Have you ever been treated for the following conditions? (Circle all that apply)

Arthritis/Rheumatoid	Gout	Lung Disease	Stroke/Pacemaker	_____
Asthma	Heart Disease	Mental Illness	Thyroid	_____
Bleeding Disorders	Hepatitis	Osteoporosis	Tuberculosis	_____
Cancer (please list)	High Blood Pressure	Phlebitis	Ulcers	_____
Diabetes	HIV, AIDS or exposure	Sickle Cell Disease	Other: Please list here →	_____

5. Have you ever had the following?

Difficulty with healing of wounds	**YES**	**NO**	Overgrown scars or keloids	**YES**	**NO**
Excess Bleeding	**YES**	**NO**	Yeast infection from taking antibiotics	**YES**	**NO**
Diarrhea from taking medications	**YES**	**NO**	Reaction to local or dental anesthetics	**YES**	**NO**

6. List any prior surgery (include dates please): _____
_____

7. List all medications you are currently taking (including over the counter drugs, vitamins & alternative herbal preparations)
_____
_____

8. List all allergies to medications (including foods, herbs, talc, adhesive tape, etc. If none, write NKDA)

9. FOR WOMEN: Are you pregnant? **YES** **NO** Are you taking birth control pills? **YES** **NO** If yes, name?_____
Are you sexually active? **YES** **NO** If yes, what birth control method are you using? _____
*You must inform the doctor if you become (or plan to become pregnant) during your treatment period.

10. Are you interested in learning how to improve the appearance of your skin through our cosmetic services? **YES** **NO**
If so, please indicate your interest in the following services:

☐ Neurotoxin or Filler therapy for facial wrinkles ☐ Laser Hair Removal ☐ Skin Rejuvenation
☐ Facial , skin and body care products ☐ ec rc e ☐ Chemical Peels
☐ Body Contouring

Patient Signature:_____ Date:_____
(Signature) (Print name)

Provider Signature:_____ Date:_____