NEW PATIENT REGISTRATION

Visit Overview	
Today's Date:	
Patient Name:	
Patient Date of Birth:	Patient Age:
Patient Gender:	
Gender Identity:	
Preferred Pronouns:	

Patient Demographics
Street Address:
City, State, and ZIP Code:
Home Phone Number:
Cell Phone Number:
Email Address:
Primary Language Spoken:
Race:
Ethnicity:
Marital Status:
Employment Status:
Employer Name:
Work Street Address:
Work Phone:
Preferred Method of Contact:
How did you hear about our practice?
Would you like to receive our newsletter & promotions for cosmetic services and products? Yes No

Emergency Contact
Emergency Contact Name:
Emergency Contact Relationship:
Emergency Contact Phone Number:

Medical Update
Before this appointment have you logged into your EMA patient portal to update your information (including past medical history, skin history, social history, etc.)? Yes No **If no, please complete the attached intake form.**

Primary Care Provider and Referring Provider
Who is your primary care provider?
Were you referred to our office? Yes No If yes, who is the referring provider?

Primary Insurance
Do you have health insurance? Yes No
Primary Insurance Provider Name:
Policy ID:
Policy Group Number:
Are you the policy holder? Yes No
If no, name of policy holder:
Policy holder date of birth:
Policy holder relationship to patient:

Secondary Insurance
Do you have a secondary insurance plan?
Secondary Insurance Provider Name:
Policy ID:
Policy Group Number:
Are you the policy holder? Yes No
If no, name of policy holder:
Policy holder date of birth:
Policy holder relationship to patient:

Medicare Authorization

Medicare patients, only:
I request that payment of authorized Medicare benefits be made either to me or on my behalf to Frontier Dermatology for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

____ ________________________

Patient Name **Patient Date of Birth**

____ ________________________

Patient Signature (or Legal Guardian) **Date**

Financial Policy

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please read and sign this Financial Policy prior to any treatment. You may be asked to sign this page again as it is updated. Please let us know if you have any questions. As long as current and updated insurance information is provided at time of service, Frontier Dermatology will submit all claims to the insurance plan(s) on file. However, there will be instances where services which are normally covered may be denied in situations related to certain conditions (for example, non-allowable diagnoses). Patients are responsible for these, and any cosmetic procedures not covered by insurance.

YOUR RESPONSIBILITY:

- I authorize Frontier Dermatology to bill my insurance carrier. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). I understand that it is my responsibility to verify with my insurance company if the provider is "in-network" to receive full insurance benefits. I certify that the information I provided related to my insurance coverage or other payment source(s) is correct.
- I understand that it is my responsibility to provide Frontier Dermatology with accurate and updated insurance information and provide copies of all insurance cards, as well as updated address information to ensure receipt of statements.
- I will remit payment for all balances in a timely manner.
- I will pay my copay/balance at the time of service. I understand that Frontier Dermatology accepts all major credit cards, cash, and check and that all returned, and NSF checks will result in a $25.00 fee.

REFERRALS/AUTHORIZATIONS:

- Referrals and/or Authorizations are not a guarantee of payment. I am responsible for any balances classified as 'Patient Responsibility' by my insurance company. Any dispute with claim processing is between me and my insurance company. I am, ultimately, responsible for ensuring my Primary Care Provider (PCP) has provided Frontier Dermatology with a referral or prior authorization prior to my appointment.

PAYMENT ARRANGEMENTS:

- I understand that Frontier Dermatology may store my credit card on file for future payments, although I can choose to opt out.
- If my card on file expires or payment cannot be processed for any reason, I will promptly call Frontier Dermatology's office to reinstate my payment plan before defaulting on a payment.
- Past Due balances must be settled prior to making an appointment or being seen for subsequent appointments.

GENERAL INFORMATION:

- Per the Office of the Inspector General, providers cannot change coding to obtain payment; this is illegal and falls under the "False Claims Act" and is considered Fraud and Abuse.
- If you are present for a Cosmetic Appointment and have medical questions or concerns that result in what the AMA defines as an office visit or another medical procedure, the visit and subsequent procedure(s) will be submitted to your insurance. You will be billed according to your individual insurance plan benefits.
- Pursuant to current AMA and CPT guidelines, all procedures (such as biopsies, pathology, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately and are not included in the office visit.
- Additional skin specimen pathology stains, tests, or consultations may be required through an in-house and/or outside laboratory. These services will be billed separately and will not be included in bill estimates. There is no way to determine these fees until a dermatopathologist processes your specimen in the lab.
- When outside labs, x-rays, or other tests are ordered by Frontier Dermatology, you are responsible for checking with your insurance regarding where you are authorized to have these studies done. An outside laboratory is used for these services; billing for these services is separate and you are responsible for any related balance. Any balance due outside of Frontier Dermatology is between you and that agency. Frontier Dermatology is not affiliated.
- No show appointments/cancellations less than 24 hours in advance may be charged $75.00 for a standard appointment and $150.00 for a missed surgery or cosmetic appointment.
- Some surgical procedures have a set number of days that are included in the package. This is called a 'Global Period". Suture removals may fall within the global period and no extra payment will be due. However, if the provider discusses or performs anything besides the suture removal, the visit is no longer considered global and will be billed to your insurance. The appropriate patient balance will be due.
- Ambulatory Surgery Center patients may be charged a facility fee. Insurers consider procedures in an ambulatory surgical center outpatient surgery, and you may have a higher out-of-pocket responsibility.

COLLECTION POLICY:

- If we have been unable to obtain payment in full or maintain scheduled payment arrangements from you after 3 months of repeated attempts, the account will be turned over to an outside collection agency and you will be required to pay the remaining balance prior to scheduling a future appointment.

This is a legal document and by signing, you agree that you understand and accept the terms on this form.

____ _____________________

Patient Name **Patient Date of Birth**

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Patient Signature (or Legal Guardian) **Date**

PATIENT ACKNOWLEDGEMENT OF CANCELLATION POLICY

I understand, per Frontier Dermatology's Financial Policy, no show appointments/cancellations less than 24 hours' in advance will be charged $75.00 for a standard appointment and $150.00 for a missed surgery or cosmetic appointment.

This is a legal document and by signing, you agree that you understand and accept the terms on this form.

____ _____________________

Patient Name **Patient Date of Birth**

____ _____________________

Patient Signature (or Legal Guardian) **Date**

Patient Request for Medical Records

Would you like to consent to the release of your medical records on file (to yourself)? Yes No

This request for medical records will expire one year from the date signed. You must request medical records for each occasion; they are not automatically sent following every appointment.

Frontier Dermatology will do its best to deliver a copy of requested medical records in a timely manner. Under the HIPAA Privacy Act, we are allowed 30 days from the date of request.

____ _____________________

Patient Name **Patient Date of Birth**

____ _____________________

Patient Signature (or Legal Guardian) **Date**

PHI Communications

I authorize medical providers and personnel of Frontier Dermatology to discuss my appointment, care plan, and any other Protected Health Information including billing matters with the following people:

☐ I do not consent to the release of medical information to anyone other than myself.

Name: ____

Relationship: _________________________

Phone: ___________________________

Name: ____

Relationship: _________________________

Phone: ____

In the event Frontier Dermatology may need to give your test results or medical information, we may:
Call you on your cellular phone? Yes No
Call you at work? Yes No

This authorization shall remain in effect for all past, present, and future periods unless revoked by a written notification.

I understand I have the right to revoke this authorization, in writing, at any time.
Except where we have already made disclosures in reliance on your prior consent.

I understand information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I hereby consent and acknowledge my agreement to the terms set forth in the HIPAA Information Form and any subsequent changes of office policy. I understand that this consent shall remain in force from this time forward.

____ ______________________

Patient Name **Patient Date of Birth**

____ ______________________

Patient Signature (or Legal Guardian) **Date**

Patient Acknowledgments

Non-Discrimination Notice to Patients
Frontier Dermatology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Frontier Dermatology does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Our full non-discrimination notice to patients is available at the front desk if you would like a copy.

Notice of Privacy Practices
I hereby acknowledge that I have received Frontier Derm Partner's Notice of Privacy Practices (HIPAA) form and/or been given the opportunity to read it and receive a printed copy with me if I choose to do so. I authorize benefit claim payment to be assigned to my physician at Frontier Dermatology and authorize the release of any medical or other information necessary to process claims. If I have not provided medical insurance, I confirm I do not have coverage to be billed and understand the payment is due at the time of service.

____ ______________________

Patient Name **Patient Date of Birth**

____ ______________________

Patient Signature (or Legal Guardian) **Date**

Confirmed Signer of Patient Forms

Please indicate if you are the patient:
☐ I am the patient
☐ Patient's Parent or Stepparent
☐ Patient's Spouse
☐ Other relative authorized to sign on behalf of the patient
☐ Patient's legal guardian or representative

NOTICE OF PRIVACY PRACTICES – <u>PATIENT COPY</u>

For Frontier Dermatology
Effective: 03/2023

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.
If you have any questions about this notice, please contact:
Karessah Hollingsworth, Privacy Officer
971-888-7904
1793 13th Street Se, Salem, OR 97302

WHO WILL FOLLOW THIS NOTICE

This notice describes the information privacy practices followed by our employees, staff and other personnel.

YOUR HEALTH INFORMATION

This notice applies to the information and records we have about you, your health, health status, and the health care and services you receive from Frontier Dermatology. Your health information may include information created and received by Frontier Dermatology may be in the form of written or electronic records or spoken words, and may include information about your health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, related billing activity and similar types of health-related information.

We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We may use and disclose health information for the following purposes:

- **For Treatment**. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, staff or other personnel who are involved in taking care of you and your health.

  For example, your doctor may be treating you for a heart condition and may need to know if you have other health problems that could complicate your treatment. The doctor may use your medical history to decide what treatment is best for you. The doctor may also tell another doctor about your condition so that doctor can help determine the most appropriate care for you.

  Different personnel in our organization may share information about you and disclose information to people who do not work for Frontier Dermatology in order to coordinate your care, such as phoning in prescriptions to your pharmacy, scheduling lab work and ordering x-rays. Family members and other health care providers may be part of your medical care outside this office and may require information about you that we have. We will request your permission before sharing health information with your family or friends unless you are unable to give permission to such disclosures due to your health condition.

- **For payment.** We may use and disclose health information about you so that the treatment and services you receive at Frontier Dermatology may be billed to and payment may be collected from you, an insurance company or a third party.

  For example, we may need to give your health plan information about a service you received here so your health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will pay for the treatment.

- **For Health Care Operations.** We may use and disclose health information about you in order to run Frontier Dermatology and make sure that you and our other patients receive quality care.

For example, we may use your health information to evaluate the performance of our staff in caring for you. We may also use health information about all or many of our patients to help us decide what additional services we should offer, how we can become more efficient, or whether certain new treatments are effective.

We may also disclose your health information to health plans that provide you with insurance coverage and other health care providers that care for you. Our disclosures of your health information to plans and other providers may be for the purpose of

helping these plans and providers provide or improve care, reduce cost, coordinate and manage health care and services, train staff and comply with the law.

SPECIAL SITUATIONS

We may use or disclose health information about you for the following purposes, subject to all applicable legal requirements and limitations:

- **To Avert a Serious Threat to Health or Safety.** We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Required By Law.** We will disclose health information about you when required to do so by federal, state or local law.
- **Research.** We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask you for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- **Organ and Tissue Donation.** If you are an organ donor, we may release health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate such donation and transplantation.
- **Military, Veterans, National Security and Intelligence.** If you are or were a member of the armed forces, or part of the national security or intelligence communities, we may be required by military command or other government authorities to release health information about you. We may also release information about foreign military personnel to the appropriate foreign military authority.
- **Workers' Compensation.** We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability, or report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- **Health Oversight Activities.** We may disclose health information to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- **Law Enforcement.** We may release health information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process, subject to all applicable legal requirements.
- **Coroners, Medical Examiners and Funeral Directors.** We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death.
- **Information Not Personally Identifiable.** We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- **Family and Friends.** We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise an objection. We may also disclose health information to your family or friends if we can infer from the circumstances, based on our professional judgment that you would not object. For example, we may assume you agree to our disclosure of your personal health information to your spouse when you bring your spouse with you into the exam room or the hospital during treatment or while treatment is discussed.

In situations where you are not capable of giving consent (because you are not present or due to your incapacity or medical emergency), we may, using our professional judgment, determine that a disclosure to your family member or friend is in your best interest. In that situation, we will disclose only health information relevant to the person's involvement in your care. For example, we may inform the person who accompanied you to the emergency room that you suffered a heart attack and provide updates on your progress and prognosis. We may also use our professional judgment and experience to make reasonable inferences that it is in your best interest to allow another person to act on your behalf to pick up, for example, filled prescriptions, medical supplies, or X-rays.

OTHER USES AND DISCLOSURES OF HEALTH INFORMATION

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific, written *Authorization*.

If you give us *Authorization* to use or disclose health information about you, you may revoke that *Authorization*, in writing, at any time. If you revoke your *Authorization*, we will no longer use or disclose information about you for the reasons covered by your written *Authorization*, but we cannot take back any uses or disclosures already made with your permission.

In some instances, we may need specific, written authorization from you in order to disclose certain types of specially protected information such as substance abuse information for purposes such as treatment, payment and healthcare operations.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you:

- **<u>Right to Inspect and Copy</u>.** You have the right to inspect and copy your health information, such as medical and billing records, that we keep and use to make decisions about your care. You must submit a written request in order to inspect and/or copy records of your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. A modified request may include requesting a summary of your medical record.

  If you request to view a copy of your health information, we will not charge you for inspecting your health information. If you wish to inspect your health information, please submit your request in writing.

  You have the right to request a copy of your health information in electronic form if we store your health information electronically.

  We may deny your request to inspect and/or copy your record or parts of your record in certain limited circumstances. If you are denied copies of or access to, health information that we keep about you, you may ask that our denial be reviewed. If the law gives you a right to have our denial reviewed, we will select a licensed health care professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.

- **<u>Right to Amend</u>.** If you believe health information, we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment as long as the information is kept by Frontier Dermatology.

  To request an amendment, complete and submit a MEDICAL RECORD AMENDMENT/CORRECTION FORM. We may deny your request for an amendment if your request is not in writing or does not include a reason to support the request. In addition, we may deny or partially deny your request if you ask us to amend information that:
  - We did not create, unless the person or entity that created the information is no longer available to make the amendment.
  - Is not part of the health information that we keep.
  - You would not be permitted to inspect and copy.
  - Is accurate and complete.

  If we deny or partially deny your request for amendment, you have the right to submit a rebuttal and request the rebuttal be made a part of your medical record. Your rebuttal needs to be (*number*) of pages in length or less and we have the right to file a rebuttal responding to yours in your medical record. You also have the right to request that all documents associated with the amendment request (including rebuttal) be transmitted to any other party any time that portion of the medical record is disclosed.

- **<u>Right to an Accounting of Disclosures</u>.** You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you for purposes other than treatment, payment, health care operations, when specifically authorized by you and a limited number of special circumstances involving national security, correctional institutions and law enforcement.

  To obtain this list, you must submit your request in writing. It must state a time period, which may not be longer than six years. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **<u>Right to Request Restrictions</u>.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about a surgery you had. *We are not required to agree to your request.* If we do agree, we will comply with your request unless the information is needed to provide you with emergency treatment, or we are required by law to use or disclose the information. *We are required to agree to your request* if you pay for treatment, services, supplies and prescriptions "out of pocket" and you request the information not be communicated to your health plan for payment or health care operations purposes. There may be instances where we are required to release this information if required by law. To request restrictions, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

  To request confidential communications, you may complete and submit the REQUEST FOR RESTRICTION ON USE/DISCLOSURE OF MEDICAL INFORMATION AND/OR CONFIDENTIAL COMMUNICATION. We will not ask you the reason for your request. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive it electronically, you are still entitled to a paper copy. [You *may also find a copy of this Notice on our web site:* www.frontierdermpartners.com*]*

CHANGES TO THIS NOTICE

We reserve the right to change this notice, and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future.

We will post the current notice at our location(s) with its effective date in the top heading. You are entitled to a copy of the notice currently in effect.

We will inform you of any significant changes to this Notice. This may be through our newsletter, a sign prominently posted at our location(s), a notice posted on our web site or other means of communication.

BREACH OF HEALTH INFORMATION

We will inform you if there is a breach of your unsecured health information.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services at:

Office for Civil Rights Region X-Seattle (Alaska, Idaho, Oregon Washington)
Linda Yuu Connor, Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
2201 Sixth Avenue - M/S: RX-11 Seattle, WA 98121-1831

To file a complaint with Frontier Dermatology, contact:

Karessah Hollingsworth
Compliance Manager & Privacy Officer
Mailing Address:
1793 13th ST SE
Salem, OR 97302

Phone: 971-888-7904 or 866-599-3376
Fax: 503-362-8435
Email: compliance@frontierdermpartners.com

You can also report privacy concerns safely and anonymously through Safe Hotline.

Call or Text:	Online:	Company Code (required):
1-855-622-SAFE (1-855-662-7233)	SAFEHOTLINE.COM	0777756263

You will not be penalized for filing a complaint.