DERMATOLOGY ASSOCIATES OF MACOMB-OAKLAND, PC

THE PATIENT-SPECIALIST PROVIDER PARTNERSHIP AGREEMENT

As specialty providers our mission is to improve our patients' dermatologic health by providing high quality patient-centered care with excellence. This can be achieved when we work with both you, the patient, and your Primary Care Provider, your Patient Centered Medical Home, to maintain your health and wellness. Thank you for choosing to partner with Dermatology Associates of Macomb-Oakland for your dermatologic needs, below you will find your responsibilities as our patient as well as our responsibilities as your specialty provider.

Patient's Responsibilities:

- Make and keep all appointments recommended by our office. If you must cancel an appointment, make every attempt to reschedule it as soon as possible.
- Ask questions, share your feelings, and be part of your care.
- Be honest about your history, symptoms, and other important information about your health.
- Make healthy decisions about your daily habits and lifestyle.
- Follow through with recommended testing and contact the office if you cannot get these tests completed.
- Participate and commit to the treatment plan developed by you and your provider or other health professionals.
- Be sure you understand the treatment plan. If you do not understand, ask questions until you feel comfortable with the agreed upon treatment plan.
- Tell us immediately if you are not able to follow the treatment plan for any reason so we can assist you in adjusting the plan, so you get the best results.
- Follow up with your Primary Care Physician for your overall healthcare needs.

Specialty Provider's Responsibilities:

- Our office will strive to schedule your appointment as soon as possible, keeping in mind the goals and recommendations of your Primary Care Physician
- Explain diseases, treatments, and results in an easy-to-understand way.
- Provide instruction on how to self-manage your condition and assist you with establishing goals for this condition.
- Keep treatments, discussions and records private.
- Provide 24-hour access to medical care and same day appointments, whenever possible.
- Provide instruction on how to meet your health care needs when the office is not open.
- Communicate regularly with your Primary Care Physician, making sure that we receive and provide information to coordinate your care.
- To care for you to the best of my abilities based on my understanding of current medical methods available.
- When necessary, direct and coordinate your care through referrals to appropriate community resources.
- End every visit with clear instructions about your diagnosis, expectations, treatment goals, and future plans.

Thank you,
Dermatology Associates of Macomb-Oakland, PC

Dermatology Associates of Macomb-Oakland, PC

AUTHORIZATION AND ACKNOWLEDGEMENT OF PRIVACY PRACTICES

Patient's Name: _____ Date of Birth: _____/_____/_____

Authorization for release of information to family members or friends without power of attorney

I, _____, hereby give the following person(s) authorization to
(Printed name of: Patient, Parent, or Legal Gaudian)
obtain information regarding my:

- ☐ Appointments
- ☐ Lab Work / Test Results
- ☐ Medical Records Information
- ☐ All of the Above

Person 1: _____ Relationship to Patient: _____

Person 2: _____ Relationship to Patient: _____

Person 3: _____ Relationship to Patient: _____

Authorization to leave a message on given telephone number

I, _____, hereby give Dermatology Associates of
(Printed name of: Patient, Parent, or Legal Gaudian)
Macomb-Oakland, PC permission to leave a message on my given contact method regarding my:

- ☐ Appointments
- ☐ Lab Work / Test Results
- ☐ Medical Records Information
- ☐ All of the Above

Receipt of Notice of Privacy Practices written acknowledgement

I, _____, hereby acknowledge the receipt of Dermatology
(Printed name of: Patient, Parent, or Legal Gaudian)
Associates of Macomb-Oakland, PC's Notice of Privacy Practices.

Printed Name of Patient, Parent, or Legal Guardian: _____

Relationship to Patient:

- ☐ Self
- ☐ Parent
- ☐ Legal Guardian

Signature: _____ Date: _____

Signature of Witness: _____ Date: _____

DERMATOLOGY ASSOCIATES OF MACOMB-OAKLAND, PC

CANCELLATION AND NO-SHOW POLICY

Cancellation and No-Show Policy for Appointments

We understand that there are times when you must miss an appointment due to an emergency or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule.

If you do not cancel scheduled appointments at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

Cancellation and No-Show Policy for Procedures

Due to the large block of time needed for procedures, last minute cancellations can cause problems and added expenses for the office.

If you do not cancel scheduled procedures at least 48 hours in advance, you will be charged a seventy-five-dollar ($75) fee; this will not be covered by your insurance company.

Late Arrivals for Scheduled Appointments and Procedures

We understand that delays can happen, however we must try to keep other patients and our providers on time.

If a patient is 10 minutes past his or her scheduled appointment time we may have to reschedule the appointment.

Account Balances

We require that patients with previous balances bring their account balance to zero ($0.00) prior to receiving further services from our practice.

Patients who have questions about their bill or who would like to discuss a payment plan option may ask to speak to a billing representative with whom they can review their account and any concerns.

Patients with balances over one hundred dollars ($100) must make payment arrangements prior to future appointments being scheduled.

Printed Patient Name: _____

Signature: _____ **Date:** _____/_____/_____

Relationship to Patient:

- ☐ Self
- ☐ Parent, Printed Name: _____
- ☐ Legal Guardian, Printed Name: _____

Dermatology Associates of Macomb-Oakland, PC

PATIENT INFORMATION

PLEASE PRINT ACCOUNT #: _____

Patient Name: _____ Date of Birth: _____/_____/_____
First Middle Last

Circle which apply: Dr. Mr. Mrs. Miss Ms. Male Female

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Social Security Number: _____-_____-_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Preferred Contact Number: (_____)-_____-_____ ☐ Home ☐ Work ☐ Cell

Alternate Contact Number: (_____)-_____-_____ ☐ Home ☐ Work ☐ Cell

Email Address: _____

INSURANCE INFORMATION

Primary Insurance

Name of Policy Holder: _____ Date of Birth: ____/____/____

Employer of Policy Holder: _____

Secondary Insurance

Name of Policy Holder: _____ Date of Birth: ____/____/____

Employer of Policy Holder: _____

EMERGENCY CONTACT

Name of Contact: _____

Relationship to Patient: _____ Phone Number: (_____) -_____-_____

Dermatology Associates of Macomb-Oakland, PC

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and receive a copy your PHI. A fee may be applied for resources associated with copy requests.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of November 2017 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer Suzanne Somers, (Phone: 248-380-8900) for more information, in person or in writing. If you would like a printed copy of the Notice of Privacy Practices for your records, please ask.

DERMATOLOGY ASSOCIATES OF MACOMB-OAKLAND, PC

PATIENT FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing Dermatology Associates of Macomb-Oakland, PC (DAMO) for your dermatology needs. The medical services you seek imply a financial responsibility on your part. This responsibility obligates you to ensure payment in full for the services you receive. To assist in understanding that financial responsibility, we ask that you read and sign this form. Feel free to ask if you have any questions regarding your financial responsibility. If someone else (parent, spouse, domestic partner, etc.) is financially responsible for your expenses or carries your insurance, please share this policy with them, as it explains our practices regarding insurance billing, copayments, and patient billing. By signing below and/or by receiving medical services from DAMO, you agree to the following:

1. You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. You are responsible for deductibles, co-payments, coinsurance amounts, or any other patient responsibility indicated by your insurance carrier or our financial policies, which are not otherwise covered by supplemental insurance.
2. You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at DAMO, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at DAMO are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at DAMO; or (v) you have chosen not to use your health plan coverage. If you are not familiar with your plan coverage, we recommend you contact your carrier or plan provider directly.
3. You will be required to follow all registration procedures, which may include updating or verifying personal information, presenting verification of current insurance and paying any co-pays or other patient responsibility amount at each visit. Your card or other insurance verification must be on file for your insurance to be billed. If we do not have your card on file, or are unable to verify your eligibility for benefits, you will be treated as a self-pay patient. As a self-pay patient, our fee is expected to be paid in full at the time of service. If the insurance card or other necessary information is furnished after the visit, we may file a claim with your insurance; and, if paid in full by your insurance, you will be reimbursed. If you are not prepared to make your co-payment or other patient responsibility amount, your visit may be re-scheduled by DAMO.
4. You agree to facilitate payment of claims by contacting your insurance carrier when necessary. Without waiving any obligation to pay, you assign to DAMO, insurance benefits for services rendered for application onto your bill for services, all of your rights and claims for the medical benefits to which you, or your dependents are entitled, under any federal or state healthcare plan (including, but not limited to, Medicare), insurance policy, any managed care arrangement or other similar third-party payor arrangement that covers health care costs and for which payment may be available to cover the cost of the services provided to you. You authorize DAMO to release patient information acquired in the course of your examination and/or treatment including but not limited to any and all medical records, notes, test results, or other documents related to your treatment (including itemization of any charges and payments on my account) that is deemed necessary to process this claim to the necessary insurance companies, third party payors, and/or other physicians or health care entities as they require to participate in your care. It is important to notify us as soon as possible of any changes related to your insurance coverage. Failing to do so may result in unpaid claims, and you will be responsible for the balance of the claim. DAMO does not accept responsibility for incorrect information given by you or your insurance carrier regarding your insurance benefits or benefit plans.

If your insurance carrier does not remit timely payment on your claim, you will be responsible for payment of the charges. Once your insurance carrier processes your claim, we will bill you for any remaining patient

1. responsibility deemed by your insurance carrier. If any payment is made directly to you for services billed by us, you agree to promptly submit payment to DAMO until your patient account is paid in full. If you make a payment that results in a surplus on your account, you authorize DAMO to apply the overpayment to any other account for which you are financially responsible, including your account, a member of your family's or dependent's account, or on any account for which you are a financially responsible party, and any remaining balance will be returned to the payor.
2. You will be mailed a billing statement that contains the total cost of your service(s) or procedure(s) received during your visit(s). If there is a problem with your account, it is your responsibility to contact DAMO to address the problem or to discuss a workable solution. Whether or not you have insurance or are self-pay, payment of any account balance is due within thirty (30) days of receipt of your billing statement. If any balance on your account is over ninety (90) days past due, your account will be in default and referred to a collection agency. For small balances, below $25.00, DAMO may stop sending billing statements, but you understand that the amount shall remain due and owed until paid in full.
3. We accept payment by check, cash, or credit cards with proper identification. If payment by check is returned or declined for any reason your account will be charged a $25.00 surcharge.
4. DAMO participates with Blue Cross Blue Shield of Michigan (BCBC MI) and Medicare. We accept assignment from BCBS MI and Medicare. This rule excludes pre-existing conditions, cosmetic procedures, copays, deductibles, or any policy provisions, you may have. Many BCBS MI policies do not cover office visits. You may be responsible for an office visit on the date of service. We do not bill master medical. We also participate with some Preferred Provider Organization(PPO) Insurances and many private insurances. Policies are subject to copays, deductibles and any policy provisions you may have with your insurance. Copays and deductibles will not be waived. This is a fraudulent act and our office will be held liable by the insurance company.

Acknowledgement

By signing below, I acknowledge that: (i) I have been provided a copy of the DAMO PATIENT FINANCIAL RESPONSIBILITY STATEMENT; (ii) I have read, understand, and agree to their provisions and agree to the specified terms; (iii) I agree to pay all charges due (or to become due) to DAMO for the below Patient's care and treatment, including copayments and deductibles, as required or provided pursuant to my insurance plan and/or the insurance plan of another, as applicable; (iv) benefits, if any, paid by a third-party will be credited on the Patient account; (v) regardless of my insurance status or absence of insurance coverage, I am ultimately responsible for the balance on the account for any services rendered.

ONCE I HAVE SIGNED THIS AGREEMENT, I AGREE TO ALL OF THE TERMS AND CONDITIONS CONTAINED HEREIN AND THE AGREEMENT SHALL BE IN FULL FORCE AND EFFECT.

Patient Name: _____ **Date of Birt**h: ____/____/____

Signature of Financially Responsible Party: _____ Date: ____/____/___

Printed Name of Financially Responsible Party: _____

Date of Birth of Financially Responsible Party: ____/____/____

Financially Responsible Party's Relationship to Patient:

- ☐ Self
- ☐ Parent
- ☐ Legal Guardian
- ☐ Other: _____

DERMATOLOGY ASSOCIATES OF MACOMB-OAKLAND, PC

MEDICAL HISTORY FORM

Today's Date: _____/_____/_____

Patient Name: _____ **DOB:** _____ /_____ /_____ **HEIGHT:** _____ **WEIGHT:** _____

RACE: ____White ____American Indian or Alaskan Native ____Asian ____Black or African American ____Native Hawaiian or Pacific Islander ____Decline to Answer **Ethnicity:** ____ Hispanic or Latino ____ Not Hispanic or Latino ____Decline to Answer

Preferred Spoken and Written Language: _____

SKIN HISTORY

Present Problem: _____ **Duration of Problem:** _____

Previous Treatment? _____

Have you had any of the following skin conditions? ***(Check all that apply)***

- ☐ Acne
- ☐ Dry Skin
- ☐ Eczema
- ☐ Psoriasis
- ☐ Flaking or Itchy Scalp
- ☐ Poison Ivy
- ☐ Blistering Sunburns
- ☐ Hay Fever/Allergies
- ☐ Rosacea
- ☐ Shingles
- ☐ Warts
- ☐ Actinic Keratosis (AK)
- ☐ Precancerous Moles
- ☐ Basal Cell Skin Cancer
- ☐ Squamous Cell Skin Cancer
- ☐ Melanoma Skin Cancer

Do you wear sunscreen? ____YES ____NO If Yes, what SPF? _____ **Do you tan in a Salon?** ____YES ____NO

Has anyone in your family had Melanoma skin cancer? ____YES ____NO If yes, what is the relationship to you? _____

MEDICAL HISTORY

Smoking status: _____ Never _____ Former _____ Current If current or former, how much per day? _____

Alcohol intake: _____ None _____ Less than 1 drink per day _____ 1-2 drinks per day _____ 3 or more drinks per day

Has the patient had his/her flu shot this year? ____YES ____NO

Check any of the following medical conditions the patient has/had, or is currently being treated for:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Cancer: _____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ GERD (Heartburn/Acid Reflux)
- ☐ Glaucoma
- ☐ Hearing Loss
- ☐ Heart Attack / Stroke YEAR: _____
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ HIV/AIDS
- ☐ Hypertension (High Blood Pressure)
- ☐ Hyperthyroidism (Overactive Thyroid)
- ☐ Hypothyroidism (Underactive Thyroid)
- ☐ Pacemaker or Implanted Heart Device
- ☐ Radiation Treatment, Body Location: _____
- ☐ Renal Disease
- ☐ Seizures/Epilepsy
- ☐ Ulcers

Other Medical Conditions: _____

MEDICATIONS AND ALLERGIES

List All Current Medications: (If you have a list please give that to reception and we will make a copy)

_____

_____

Is the patient currently using oral contraceptives, a contraceptive patch, or a contraceptive implant? (Birth control)
_____ YES _____NO If yes please specify: _____

Is there any chance that the patient is pregnant at this time? _____ YES _____ NO

Allergies: ____Latex ____Penicillin ____Sulfa ____Keflex ____Codeine ____Erythromycin ____Tetracycline
Other allergies: _____

PRIMARY CARE AND PHARMACY

Primary Care Physician: _____ Phone: (_____) _____-_____

Preferred Pharmacy Name: _____ Phone: (_____) _____-_____

Pharmacy City and Cross Roads: _____

Signature of Patient, Parent or Legal Guardian: _____ **Date:** _____/_____/_____