____ (*Initial*) **RECEIPT OF NOTICE OF PRIVACY PRACTICES**

I, (print patient name)______________________________, have read a copy of Vitalogy Skincare's Notice of Privacy Practices. (This document is available at the front desk or at Vitalogyskincare.com.)

____ (*Initial*) **CANCELLATION POLICY**

In fairness to other patients and your doctor, we require at least 24 hours notice to cancel appointments. Unless cancelled at least 24 hours in advance, you may be charged a fee for a missed appointment. This fee is not covered by insurance; it will be your responsibility to pay. Please help us serve you better by keeping your scheduled appointment.

____ (*Initial*) **RELEASE OF MEDICAL INFORMATION**

I do / do not (circle one) authorize Vitalogy Skincare and its designated representatives to release medical information to (print name)______________________________ Relationship_________________________

____ (*Initial*) **CONTACT PERMISSION**

In the event that Vitalogy Skincare needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

- ☐ Leave a message on an answering machine
- ☐ Speak with spouse / significant other
- ☐ Speak with other family members

____ (*Initial*) **FINANCIAL RESPONSIBILITY**

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining any referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Vitalogy Skincare for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however I will be billed if any procedure is denied, considered cosmetic, or not paid in a timely manner. **If you do not have insurance coverage**, payment in full is due at the time of your visit unless payment arrangements are made prior to your appointment.

My signature below indicates that I have read and agree with all statements initialed above.

____ ______ _________________

Signature of Patient (or guardian) Date

3010 Williams Dr, Suite 177
Georgetown, TX 78626
512.868.3376
FAX 512.869.5868

1464 E. Whitestone Blvd, Suite 301
Cedar Park, TX 78613
512.260.3376
FAX 512.260.1177

Wonder World Dr, Suite 108
San Marcos, TX 78666
512.393.3376
FAX 512.754.3378

441 Hwy 71 West Suite E
Bastrop, TX 78602
512.321.9400
FAX 512.321.4343

200 CR 340 A
Bldg 4, Suite B
Burnet, TX 78611
512.756.2525
FAX 512.756.2533

101 N. Hwy 281,
Suite 200
Marble Falls, TX 78654
512.830.798.1144
FAX 830.201.4106

201 Bay West Blvd
Horseshoe Bay, TX 78657
830.798.1144
FAX 512.756.2533

100 Commons Rd,
Suite 9
Dripping Springs, TX 78620
512.829.4427
FAX 512.829.4432

Patient Information

Patient Name ______________________________ Nick Name ______________
First Middle Last

Date ______________________________ DOB ______________________________

Female ☐ Male ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐

Address ____
City ______________________________ State ____________ Zip Code ______________
SSN ______________________ Home Phone ______________ Cell ______________
Email Address____

Primary Insurance Carrier ____
Policy Holder Name ______________________ Relationship to Patient ______________
Policy Holder Employer ______________________ Occupation ______________________
DOB ______________ GROUP # ______________________ INS I.D. # ______________
Policy Holder SSN ______________________ (Required in order to file insurance)
Card Holder Address (If different from above)
Address ____
City ______________________________ State ____________ Zip Code ______________

Secondary Insurance Carrier ____
Policy Holder Name ______________________ Relationship to Patient ______________
Policy Holder Employer ______________________ Occupation ______________________
DOB ______________ GROUP # ______________________ INS I.D. # ______________
Cardholder SNN ______________________ *Required in order to file insurance

Policy Holder Address (If different from above)
Address ____
City ______________________________ State ____________ Zip Code ______________

Emergency
Contact______________________________________ Phone__________________________________
Referring
Physician______________________________________ Phone__________________________________

How did you hear about us?

☐Newspaper ☐Physician ☐Mailer/Postcard ☐Phonebook

☐Internet ☐Friend ☐Other_________________________________

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Vitalogy SKINCARE

Patient Medical History

Patient Name: ______________________________________ **Date:** ______________

DOB: _____________ **Height:** ______ **Weight:** ______ **Occupation:** _________________

Please answer all questions to the best of your knowledge. This insures the best patient care and proper documentation.

Please list your drug allergies:

____ ____

____ ____

Please list current prescription and over the counter medications that you take:

____ ____

____ ____

Have you ever had any of the following?

Asthma/Allergies (respiratory condition)	☐Yes	☐No	Measles	☐Yes	☐No
Bleeding problems (Are you on blood thinners?)	☐Yes	☐No	Pacemaker of Defibrillator	☐ Yes	☐No
Blood Transfusion	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Chicken Pox	☐Yes	☐No	Skin Rash to foods/plants	☐Yes	☐No
Stent, bypass, or mitral valve prolapse	☐Yes	☐No	Diabetes	☐Yes	☐No
Hepatitis/HIV	☐Yes	☐No	Weight Gain/Loss	☐Yes	☐No
Yeast infections when taking antibiotics	☐Yes	☐No	Keloids (difficulty healing	☐Yes	☐No
Joint Replacement (hip/knee/shoulder	☐Yes	☐No			

Skin Cancers:

Basal Cell Carcinoma	☐Yes	☐No	Malignant Melanoma	☐Yes	☐No
Squamos Cell Carcinoma	☐Yes	☐No	If Yes, what level/stage ______	Year_____	
Are you pregnant or planning to become pregnant?	☐Yes	☐No	Are you sexually active?	☐Yes	☐No
Do you take antibiotics before minor procedures such as dental work?				☐Yes	☐No
Do you smoke?	☐Yes	☐No			

Has anyone in your family had any of the following skin cancers?

Basal Cell Carcinoma	☐Yes	☐No	Malignant Melanoma	☐Yes	☐No
Squamos Cell Carcinoma	☐Yes	☐No	If Yes, what level/stage ______	Year_____	

Please list any other health-related conditions not previously identified:

____ ____

____ ____

Reason for today's visit (chief complaint):

____

Have you had a comprehensive skin screening within one year (examination of moles, etc.)? ☐Yes ☐No

Medical Asst. Initials: _________ **Date:** _______ **Physician Initials:** _________ **Date:** __________

F-361-WS-OFF-9/30/10-AM

Notice of Privacy Practices

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

Vitalogy SKINCARE is required by law to maintain the privacy of your health information, notify you of our legal duties and privacy practices with respect to your health information, and follow the terms of this notice. We will not share or disclose medical information about you without your written authorization, except as described in this notice.

How Vitalogy SKINCARE May Use or Disclose Your Health Information

Vitalogy SKINCARE and its staff protect the privacy of your health information. The law permits us to use or disclose your health information for the following purposes:

· **Treatment, Payment and Regular Health Care Operations:** We may use or disclose, as needed, your protected health information to support the business activities of Vitalogy SKINCARE. Information obtained by Vitalogy SKINCARE will be used to provide medical care, dermatological goods and services to you, bill your insurance carrier if you have third party coverage, and record and monitor medical care that you receive. Information will be provided to you upon your written request. Other uses may include, but are not limited to quality assessment activities, employee review activities, training, licensing, and conducting or arranging other medical business activities.

· **When Required by Law:** Without your authorization we may use and disclose your health information to public health officials, law enforcement, health oversight activities, judicial and administrative, and the Food & Drug Administration if: there is a serious threat to patient health or safety, you are in the military, you are a veteran of the armed forces, there is a national security incident, or you are incarcerated.

· **Personal Communications:** We may contact you or authorized individuals involved in your care or the payment of your care to provide appointment reminders and other information about treatment alternatives or health related benefits and services that may be of interest to you. Communication methods include phone, mail, fax and other methods.

· **Lab Disclosure:** Results from surgical procedures may be evaluated by your physician or sent to a pathology lab to complete medical diagnoses. When surgical procedures are performed, we may disclose health information about you to a laboratory to enable evaluation and bill you or your insurance carrier for services. Vitalogy SKINCARE only contracts pathology labs that comply with the privacy practices identified in this notice.

· **Victims of Abuse, Neglect or Domestic Violence:** We may disclose your health information to a government authority, such as a social service or protective services agency, if we reasonably believe you are a victim of abuse, neglect or domestic violence.

Vitalogy SKINCARE May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, Vitalogy SKINCARE and its staff will not use or disclose your health information without your written authorization. If you do authorize Vitalogy SKINCARE to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. In instances where state law provides additional restrictions on our use or disclosure of your health information, Vitalogy SKINCARE complies with the law.

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Notice of Privacy Practices

You Have the Following Rights With Respect to Your Health Information

· You have the right to request restrictions on certain uses and disclosures of your health information. You must submit this request in writing. Vitalogy SKINCARE is not required to agree with all requests. If Vitalogy SKINCARE believes it is not in your best interest to permit the use or disclosure of your protected health information, your protected health information will be restricted. You then have the right to use another healthcare professional.

· You have the right to receive a notification of disclosures of your protected health information.

· You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy psychotherapy notes, information compiled in reasonable anticipation of or use in a civil, criminal, or administrative action or proceeding, or information that is prohibited from disclosure under federal law.

· You have the right to request that Vitalogy SKINCARE communicate with you at a specific location or through a specific phone number. This request must be in writing.

· You have the right to ask us to amend your health information if you believe it is incorrect or incomplete at any time that the information is kept by Vitalogy SKINCARE. This request must be in writing.

Changes to this Notice of Privacy Practices

Vitalogy SKINCARE reserves the right to amend this Notice of Privacy Practices at any time and make the new notice effective for all health information we maintain. If this Notice is amended, it will be posted in the lobby of each Vitalogy SKINCARE facility, and hardcopies will be available upon request. Until such amendment is made, Vitalogy SKINCARE is required by law to comply with this Notice.

Complaints

If you believe your privacy rights have been violated, you may file a written complaint with Vitalogy SKINCARE or the United States Department of Health and Human Services. We will not retaliate against you for filing a complaint.

If you have any questions or concerns, we ask that you submit them in writing. Vitalogy SKINCARE will respond within thirty days.

Authorization for Release of Medical Information

I, the undersigned, do hereby authorize Dr. __________________ to release the information described below from the medical record of:

Patient name: ____________________ DOB: _______________ SSN#: _________________

From Dr. ______________________ To Dr. _________________________
______________________ _________________________
______________________ _________________________

Information to be released: (Reports may include information on drug / alcohol / psychological / communicable disease treatment)

- Progress notes Consultation Lab/Path reports
- All medical records requested/received on my behalf from other medical providers regarding my history and treatment.
- All medical records

HIV/AIDS: I consent to the release of any positive or negative test result for AIDS or HIV infection, antibodies to AIDS or infection with any other causative agent of AIDS, if any, with the rest of my medical records. Initial _____ Date: _____
Dates of treatment: ____

Reason for release of information:

- Application for insurance coverage Other (Please specify):
- Change of physician/Relocation ________________________________

I understand that I may revoke this consent at any time except to the extent that action has already been taken in reliance on it and that in any event, this authorization expires automatically ninety (90) days from the date of signature, unless the physician prior to that date receives revocation.

Patient signature: __________________________ Date: ________________________________

____ ________________________________
Representative or person legally authorized to sign Relationship to patient

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(Office use only)
This information has been disclosed to you from records protected by Federal confidentiality (42 CFR part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by 42 CFR part 2. A general authorization for release of medical or other information in NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

Signature of physician _________________________ Date ________________________