Couture Dermatology and Plastic Surgery

Patient Demographic Information

Patient Information:

Patient Name: _____ _____ _____ Gender: _____
(Last) (First) (Middle)

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _(_____) _____ Cell Phone: _(____)_____ Work Phone: _(____)_____

Email: _____ How Did You Hear About Us? _____

Employer (or school, if student): _____ Occupation: _____

Employer's Address: _____

Date of Birth: _____ Age: _____ Marital Status: _____

Emergency Contact: _____ _____ _(____) _____
(Name) (Relationship) Phone

If the patient is covered by insurance that is held under the name of a spouse, parent or other person, please complete the following information:

Information for Covered Individual:

Name of covered individual: _____ Date of Birth: _____

Relationship to patient: _____ Phone: _(____) _____

Employer: _____ Social Security No: _____

Email: _____

Race: ☐ White or Caucasian ☐ Black or African American ☐ Asian
☐ Hispanic/Latino ☐ Native Hawaiian ☐ American Indian/Alaska Native
☐ Mixed ☐ Other ☐ Declines to provide information

Ethnicity: ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Patient declines to provide information

Preferred Language: ☐ English ☐ Spanish ☐ Other _____

Medical Questionnaire

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

Do you have or have you ever had any of the following? *Check box if* – Yes -

- Acne
- Artificial Joint/Prosthesis/Heart Valve
- Asthma/Hay Fever/Hives/Sinus Problems
- Autoimmune Disease (Lupus, Arthritis, etc.)
- Back Pain
- Bleeding Disorder
- Blood Clots or DVI's
- Blood Transfusions
- Breast Cancer
- Cancer
- Chest Pain/Tightness
- Cold Sores
- COPD
- Diabetes
- Eczema/Skin Rashes/Skin Infections
- Epilepsy, Fainting, Blackouts
- Fibromyalgia
- Chest Pain/Tightness
- Glaucoma
- Heart Disease
- Heart Murmur/Mitral Valve Prolapse
- Hepatitis B or C
- High Blood Pressure
- HIV/AIDS/Blood Borne Infections
- Keloids
- Kidney Disease
- Kidney Stones
- Melanoma
- Psoriasis
- Sexually Transmitted Disease
- Skin Cancer
- Skin Disease
- Stroke
- Thyroid Disorder
- Tuberculosis
- Ulcers (Heart Burn, Gastritis
- X-ray (Radiation) Therapy

Are you allergic to any medication? (Please list)

_____
_____
_____

List current medications:

_____
_____
_____

Surgeries/Hospitalizations:

Operation Date Hospital

_____
_____
_____
_____

Name of your Primary Care Physician:

_____
–

Please Complete Carefully:	Yes	No
Are you currently taking Accutane or have you used Accutane in the past?	☐	☐
Are you in good health?	☐	☐
Are you under a physician's care?	☐	☐
If so, for what condition? _____		
Name of physician caring for you: _____		
Do you drink alcohol?	☐	☐
If yes, how many drinks per day/week? _____		
Do you smoke?	☐	☐
If yes, how much? _____		
Do you sunbathe or use tanning booths?	☐	☐
Do you need antibiotics before having dental work done?	☐	☐
Do you use sunscreen?	☐	☐
Do you bleed easily for a long time after a cut or extraction?	☐	☐
Do you have an Advance Directive and/or a Living Will?	☐	☐

Signature: _____

Date: _____

(rev 12/01/2016)

Cosmetic Questionnaire

_____ Are you interested in having a cosmetic consultation?**

Are you concerned with:

_____ Wrinkles/Volume Loss (smokers lines, frown lines, smile lines, etc)

_____ Brown Spots/Discoloration

_____ Redness

_____ Spider Veins

_____ Skin Elasticity

_____ Scarring

_____ Hair Loss

_____ Unwanted Hair

_____ Unwanted Moles

_____Body Contouring

_____ Breast Augmentation

Please provide your email to receive information regarding products and services we offer:

_____

**Cosmetic consultations are specifically scheduled so our provider has sufficient time to spend with you discussing your goals and preferences, and providing guidance to assist you in making the decisions that are perfect for you. Your cosmetic consultation may be booked with our front desk staff. The $100 consultation fee is required in advance to reserve that consult time.

Couture Dermatology and Plastic Surgery

Patient's Name: _____ Date: _____

☐ Check here if patient is a minor or otherwise unable to give consent.

I consent for medical photographs to be made of me or my child (or person for whom I am legal guardian). I understand that the information may be used in my medical record, for the purpose of medical teaching, or for publication in medical textbooks or journals, as I have designated below. I understand that my consent or refusal to consent to these medical photographs will in no way affect the medical care I will receive; however, the tracking of patient progress may be inhibited. If I have questions or if I wish to withdraw my consent in the future, I may contact:

Couture Dermatology and Plastic Surgery Attention: Administration
Attn: Administration Las Vegas, NV 89128
Phone: 702-998-9001 E-Mail: Admin@couturemedical.com

By signing below I confirm that this consent form has been explained to me in terms which I understand.

☐ I consent for these photographs to be used in medical publications, including medical journals, textbooks and electronic publications. I understand that the image may be seen by members of the general public in addition to scientists and medical researchers who regularly use these publications in their professional education. Although these photographs will be used without identifying information such as my name, I understand that it is possible that someone may recognize me. I also agree for my image to be shown for teaching purposes and to be used for my medical record.

_____ _____

Patient signature *Witness*

☐ I agree for my image to be shown for teaching purposes AND to be used for my medical record BUT NOT for medical publication.

_____ _____

Patient signature *Witness*

☐ I do not consent to any of the above (I consent to medical records ONLY).

_____ _____

Patient signature *Witness*

For patients between the ages of 7 and 18 years, a signature below indicates that the information in the consent form has been explained to me, and I consent to the use of these images as outlined above.

_____ _____

Patient Name *Patient Age*

_____ _____

Legal Guardian's Name (Printed) *Legal Guardian's Signature*

Patient's Name: _____ Date of Birth: _____
(please print legibly)

Primary Insurance

Insurance Name: _____ Pol or ID # _____ Grp # _____

Policy Holder's Name: _____ Date of Birth: _____

Relation to patient: _____ Co-Pay Amount: _____

Secondary Insurance

Insurance Name: _____ Pol or ID # _____ Grp # _____

Policy Holder's Name: _____ Date of Birth: _____

Relation to patient: _____

NOTE: IF MEDICARE IS SECONDARY, YOU MUST COMPLETE THE MEDICARE SECONDAY PAYER QUESTIONNAIRE – PLEASE ASK FRONT DESK STAFF FOR FORMS.

Release of Information and Assignment of Benefits

I hereby assign all medical and/or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to Marvin D Spann, MD, PLLC, dba Couture Dermatology and Plastic Surgery. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges not paid by said insurance. I hereby authorize said assignee to release all medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. _____ (***Initials***)

Payment Policy

Payment is required for all services at the time they are rendered. Any applicable co-payments, co-insurance and/or deductible amounts will be collected at the time of service. We accept payment in the form of cash, check and credit card. Your insurance plan will be billed for the charges incurred. Prior authorization does not guarantee payment of claims. If a diagnostic procedure is performed, it is the patient's responsibility to pay any balance due to any outside facility (such as a lab, etc.) utilized to complete and determine the diagnosis for such a procedure. If you are being treated for a condition that is not medically necessary and so is considered cosmetic, payment in full will be collected at the time of service. Should your doctor examine you and document any other conditions that are medical in nature, this examination and any resulting treatment will be billed separately to your insurance company. Depending on your plan, you may be responsible for additional copay and/or deductible amounts. Your signature below signifies your understanding and willingness to comply with these policies. _____ (***Initials***)

No Show Fee and Insufficient Funds Fee

A $35.00 “No Show” fee will be charged to your account if you fail to cancel or re-schedule your appointment at least 24 hours in advance.

A $35.00 fee will also be charged for any returned check. _____ (***Initials***)

Insurance Coverage

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain and bring this in with you on the day of your appointment. If you do not have a referral number and your insurance requires it, it may be necessary to re-schedule your appointment.

Pharmacy Information

Pharmacy Name:_____

Address: _____

Phone Number: _____ Fax Number: _____

Acknowledgement

I have read the Payment Policies and the Insurance Coverage policies and procedures described above. I understand them and agree to all these provisions. _____ (***Initials***)

Written Acknowledgement of Receipt of Privacy Practices Notice, Policies and Procedures

I, _____(Responsible Party/Patient), have received a copy of Couture
(*print name here)*

Dermatology and Plastic Surgery’s Notice of Privacy Practices. _____ (***Initials***)

Signed: _____
(Patient or Responsible Party’s Signature)

Couture Dermatology and Plastic Surgery

HIPAA Patient Questionnaire

1. Please list family members or other person(s), if any, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations):
   Name: _____ Phone Number: _____
   Name: _____ Phone Number: _____
   Name: _____ Phone Number: _____

2. Please list family members or others, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY**:
   Name: _____ Phone Number: _____
   Name: _____ Phone Number: _____
   Name: _____ Phone Number: _____

3. Please list the address of where you would like your billing statements and/or correspondence from our office to be sent ***if other than your home*** (Confidential Communications):
   _____
   _____

4. Please indicate if you want all correspondence from our office sent in a sealed envelope marked "CONFIDENTIAL": ☐ Yes ☐ No

5. Please print the telephone number or email address where you want to receive calls/correspondence about appointments, lab and x-ray results or other health care information ***if other than your home***:
   Phone Number: _____ E-Mail: _____

6. Can confidential messages (i.e., appointment reminders) be left on your telephone answering machine or voicemail? ☐ Yes ☐ No

7. I understand the Privacy Protection Act and have been offered a copy of this organization's Notice of Privacy Practices updated for the HITECH Omnibus Rule of 2013.

   Patient's Name: _____
   Please print patient's name or Guardian's name, if patient is under 18 yrs old

   _____ _____
   Patient/Guardian Signature Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

To our patient – Note - You may refuse to sign this Acknowledgement

I, _____, have received a copy of this
(Patient – Print Name Here)

office's Notice of Privacy Practices.

_____ _____
(Signature) *Date*

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained because:

- ☐ The patient refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please specify):

_____

_____

_____

HIPAA NOTICE OF PRIVACY PRACTICES

Couture Dermatology and Plastic Surgery

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 is provided to you pursuant to the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and its implementation and regulations. It is designed to tell you how we may, under federal law, use or disclose your Health Information. It has been updated to the HITECH Omnibus Rule requirements.

Your Rights

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, as per Nevada State regulations.

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 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. We would ask that you sign our "Do Not File Insurance" form.

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
- Use or disclosure of psychotherapy notes – *Written* authorization is required if our practice intends to use or disclose psychotherapy notes.
- Fundraising. We may contact you for fundraising efforts, but you can tell us not to contact you again.

You should be aware that we may also use or disclose your health information for the following purposes:

Appointment reminders. We may use your Health Information to contact you to provide appointment reminders or to give you information about other treatments or health-related services and benefits that might be of interest to you.

Change of Ownership. In the event that our business is sold or merged with another organization, your Health Information/record will become the property of the new owner.

Electronic Exchange. Your information may be shared with other providers, labs, and radiology groups through our Electronic Medical Records (EMR) system. Some of these entities are might include Quest Labs, Miraca Labs, and LabCorp.

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.

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
- To notify and/or communicate with your family. We will only communicate with family members that we are authorized to communicate with based on your completion of the *Authorization to Disclose Health Information* to Family and Friends form.
- 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.

You have been provided with a paper copy of this Notice of Privacy Practices. If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, please contact our HIPAA Compliance Officer at 702-998-9001.

You may make complaints to our HIPAA Privacy Officer or the Secretary of the Department of Health and Human Services if you believe your rights have been violated.