Housel Dermatology, P.C.

Joseph P. Housel, MD
Mohs and Reconstructive Surgery
235 Greenfield Parkway
Liverpool, NY 13088
Phone (315) 452-3376
Fax (315) 452-3377

Patient Name:_____ **Primary Care Physician**:_____
Date:_____ **Referring Physician**: _____
Date of Birth:_____ **Email**: _____

1. Select any of the following medical conditions that you are *currently* having:

- □ None
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation (Irregular Heartbeat)
- □ Bone Marrow Transplant
- □ BPH
- □ Breast Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Depression
- □ End Stage Renal Disease
- □ GERD
- □ Hearing Loss
- □ Hepatitis
- □ Hypertension
- □ HIV/AIDS
- □ Hypercholesterolemia
- □ Hyperthyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ Other _____

2. Please List any surgeries or hospitalizations and the dates:

Date	Procedure

3. Have you had any of the following skin conditions?

- □ None
- □ Acne
- □ Actinic Keratosis
- □ Blistering Sunburns
- □ Poison Ivy
- □ Eczema (Dy Skin)
- □ Flaking or Itchy Scalp
- □ Hay Fever
- □ Melanoma
  Year: _____
- □ Squamous Cell Carcinoma
- □ Basal Cell Carcinoma
- □ Other _____

Do you wear sunscreen? □ Y □ N
If yes, what SPF? _____
Do you tan in a tanning salon? _____
Do you have a family history of Melanoma? □ Y □ N
If yes, which relatives? _____

4. Do you drink alcohol?

- □ None
- □ Less than 1 drink per week
- □ One drink per week
- □ 2-3 drinks per week
- □ 3 or more drinks per week

Do you Smoke?

- □ Never Smoker
- □ Former Smoker
- □ Current Smoker
- □ Smokeless tobacco
- □ Cigar

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5. Please list any medications you are currently taking, including over-the-counter:

Medication	Dosage	Frequency

6. Do you have any allergies to medications, latex, adhesives, or other sensitivities?

_____

7. Are you experiencing difficulty *today* with any of the following?

- □None
- □ Problems with bleeding
- □ Immunosuppression
- □ Fever Chills
- □ Shortness of breath
- □ Chest pain
- □ Unintentional weight loss
- □ Night sweats
- □ Blurry vision
- □ Abdominal pain
- □ Muscle weakness
- □ Headaches
- □ Anxiety
- □ Depression
- □ Bloody Stool
- □ Thyroid problems
- □ Other _____

8. Family health history (1st degree relative): (Ex: Heart disease, Cancer, Asthma, Diabetes, Allergies)

_____

_____

9. Please describe the reason for your visit to the dermatologist today, include how long the problem has been present and all treatments:

_____

_____

10. What is your occupation? _____

Emergency Contact Name: _____

Relationship to Patient: _____

Emergency Phone: _____

11. Which Pharmacy do you use? **(PLEASE BE SPECIFIC)**

Name: _____ Phone: _____

Address: _____ City/State: _____

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Patient Information

Date: _____

Patient Name: _____ DOB: _____ Sex: □ M □ F
Address: _____ City: _____
Zip: _____ Email: _____
Home Phone: _____ Cell: _____ May we leave a message? □ Y □ N
Marital Status: □ Single □ Married □ Divorced □ Widowed
Employer: _____ Work Number: _____
Referred By: _____

Ethnic Group:
- □ Hispanic or Latino
- □ Not Hispanic or Latino
- □ Decline

Race:
- □ White
- □ African American
- □ American Indian or Alaska Native
- □ Hispanic
- □ Other Race

Emergency Contact: _____ Relationship: _____
Emergency Phone: _____

Insurance Information

Insurance Company: _____ Policy Holder: _____
Policy Number: _____ Relationship to Patient: _____
Group Number: _____ Policy Holder DOB: _____
Effective Date: _____ Policy Holder SS#: _____

Secondary Insurance

Insurance Company: _____ Policy Holder: _____
Policy Number: _____ Relationship to Patient: _____
Group Number: _____ Policy Holder DOB: _____
Effective Date: _____ Policy Holder SS#: _____

I certify that the information given by me in applying for payment under my insurance carrier is correct. I authorize any holder of medical/insurance information about me to release to my physician/insurance information required to process my claims. I understand that to knowingly withhold insurance reimbursement payments for medical services rendered would be committing a wrongful act. I request that reimbursement from my insurance be made payable to the physician's office that rendered services to me. I attest that the information I have given on these forms is true and correct to the best of my knowledge.

Signature: _____ Date: _____

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Acknowledgment of Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- **Treatment**: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- **Payment**: Obtain payment from third-party payers.
- **Operations**: Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that should I request a copy of Housel Dermatology, P.C.'s privacy practices containing a more complete description of the uses and disclosures of health information, one will be provided. I understand that this organization has the right to change its Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I authorize Dr. Housel/or his staff to discuss my medical condition, including laboratory findings with the following individuals:

_____

_____

_____

_____

Signature: _____ Date: _____

Patient Printed Name: _____ Relationship to Patient: _____

Medical Practice Use Only

If patient refuses to sign, a good faith effort was made to obtain the patient's or authorized representative's written acknowledgment of Privacy Practices. The reason the patient's or authorized representative acknowledgment was not obtained is as follows:

_____

_____

_____

_____

Documented by: _____ Date: _____

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Housel Dermatology, P.C Financial Policy

Thank you for allowing Dr. Housel and the medical providers at Housel Dermatology, P.C. to provide care for your dermatological healthcare needs. The providers at Housel Dermatology, P.C. are committed to the success of your medical treatment and care. Our practice will work with you to help fulfill your payment responsibility. Our billing office will file your primary and secondary medical claims for you. It is imperative that you provide us with accurate insurance information and EVERY visit. If you fail to provide the appropriate insurance information you will be considered a SELF PAY, and we will make payment arrangements at the time of visit. It is important that you realize that we as a medical provider and you as the insured both have a contract with the insurance company. You may need to assist us if necessary with the reimbursement process. **As the insured you are responsible for any unpaid balance not contractually covered by your insurance.**

HOUSEL DERMATOLOGY P.C. IS NOT A MEDICAID PROVIDER: We are unable to bill any claims to Medicaid even as a secondary insurance.

Medicare: This office participates as a Medicare provider, accepting assignment for Medicare Part B (Physician Services) claims. The patient is responsible for their Medicare coinsurance, deductibles, and any other service rendered that is not covered by Medicare.

Managed Care Plans: In order to see a specialist, some insurance companies require that you obtain a referral from your primary care provider or a precertification before being seen at a specialist's office. It is the patient's responsibility to ensure that we have the necessary paperwork on file to prior to your visit or the patient will be responsible for payment. **ALL COPAYS ARE DUE AT THE TIME OF SERVICE.**

Commercial Plans: Housel Dermatology, P.C. has established fees that are usual and customary for this healthcare service area. Every insurance carrier has their own usual and customary fee schedule; however, the patient is responsible for the fees regardless of the insurance carrier's arbitrary determination of rates.

Non-Covered Services: Some services we provide may not be deemed medically necessary by your insurance carrier or not a covered service benefit by your specific policy, therefore, not paid by your insurance policy. Many cosmetic procedures are not covered by your insurance company i.e. SKIN TAG REMOVAL. We cannot bill your insurance for any cosmetic procedures. The patient is responsible for the payment of any cosmetic charge at the time of the visit for ALL services not covered by insurance.

Laboratory Services: Some services such as biopsies and other specimens will be sent to an outside lab for further evaluation and processing. The patient WILL receive a separate bill for these types of services. The laboratory that we send most of the specimens to is Mass General Dermatopathology Services. The phone number to call with any billing questions for pathology specimens at Mass General is 1-855-644-3376. The patient is responsible for any laboratory service that is not covered by insurance.

Self Pay: Patients who do not have insurance coverage are considered self pay. Self pay patients need to make payment arrangements prior to being treated at this office.

Payment Arrangements: Housel Dermatology, P.C. may consider payment arrangements for those patients that are in need assistance in meeting their account obligation. Housel Dermatology, P.C. reserves the right to set the terms, conditions, and charge interest for any payment arrangement. The arrangement needs to be made prior to being seen as a patient.

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Returned Check Policy: Housel Dermatology, P.C. will charge $25.00 fee for each check that is returned by our bank for insufficient funds.

Collections: There will be a 40% fee added to any account balance that is sent to collections.

Authorization for Assignment of Benefits: In consideration of medical services provided, with your signature below, Housel Dermatology, P.C. (and/or Mass General Dermatopathology Associates in the case of laboratory services) is given the rights/title/interest to the medical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits including Medicare Part B. **THE PATIENT WILL BE FULLY RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY INSURANCE.**

Cancellations: Appointments must be canceled more than 24 hours in advance. If the patient does not show up for an appointment without 24 hour notice there will be a $100.00 fee for office visits and $250.00 fee for surgical procedures.

I have read this financial policy and authorization. I understand that there is no guarantee or assurance as to the results that may be obtained for any treatment. I understand the terms and conditions outlined herein as confirmed by my signature below.

Signature/Date

Printed Patient Name/ Relationship to Patient

Housel Dermatology P.C.

Authorization for Access to Patient Information Through a Health Information Exchange Organization

New York State Department of Health

Patient Name	Date of Birth
Other Names Used (e.g., Maiden Name):	

I request that health information regarding my care and treatment be accessed as set forth on this form. I can choose whether or not to allow the Organization named above to obtain access to my medical records through the health information exchange organization called HealtheConnections. If I give consent, my medical records from different places where I get health care can be accessed using a statewide computer network.

HealtheConnections is a not-for-profit organization that shares information about people's health electronically and meets the privacy and security standards of HIPAA and New York State Law. To learn more visit HealtheConnections website at http://healtheconnections.org/ .

The choice I make in this form will NOT affect my ability to get medical care. The choice I make in this form does NOT allow health insurers to have access to my information for the purpose of deciding whether to provide me with health insurance coverage or pay my medical bills.

My Consent Choice. ONE box is checked to the left of my choice.
I can fill out this form now or in the future.
I can also change my decision at any time by completing a new form.

☐ **1. I GIVE CONSENT** for the Organization named above to access ALL of my electronic health information through HealtheConnections to provide health care services (including emergency care).

☐ **2. I DENY CONSENT** for the Organization named above to access my electronic health information through HealtheConnections for any purpose, ***even*** *in a medical emergency.*

If I want to deny consent for all Provider Organizations and Health Plans participating in HealtheConnections to access my electronic health information through HealtheConnections, I may do so by visiting HealtheConnections website at http://healtheconnections.org/ or calling HealtheConnections at 315.671.2241 x5.

My questions about this form have been answered and I have been provided a copy of this form.

Signature of Patient or Patient's Legal Representative	Date
Print Name of Legal Representative (if applicable)	Relationship of Legal Representative to Patient (if applicable)

Details about the information accessed through [redacted] and the consent process:

1. **How Your Information May be Used**. Your electronic health information will be used **only** for the following healthcare services:

- **Treatment Services.** Provide you with medical treatment and related services.
- **Insurance Eligibility Verification.** Check whether you have health insurance and what it covers.
- **Care Management Activities.** These include assisting you in obtaining appropriate medical care, improving the quality of services provided to you, coordinating the provision of multiple health care services provided to you, or supporting you in following a plan of medical care.
- **Quality Improvement Activities.** Evaluate and improve the quality of medical care provided to you and all patients.

2. **What Types of Information about You Are Included**. If you give consent, the Provider Organization and/or Health Plan listed may access ALL of your electronic health information available through [redacted]. This includes information created before and after the date this form is signed. Your health records may include a history of illnesses or injuries you have had (like diabetes or a broken bone), test results (like X-rays or blood tests), and lists of medicines you have taken. This information may include sensitive health conditions, including but not limited to:

Alcohol or drug use problems HIV/AIDS
Birth control and abortion (family planning) Mental Health conditions Genetic (inherited) diseases or tests Sexually Transmitted diseases

If you have received alcohol or drug abuse care, your record may include information related to your alcohol or drug abuse diagnoses, medications and dosages, lab tests, allergies, substance use history, trauma history, hospital discharges, employment, living situation and social supports, and health insurance claims history.

3. **Where Health Information About You Comes From**. Information about you comes from places that have provided you with medical care or health insurance. These may include hospitals, physicians, pharmacies, clinical laboratories, health insurers, the Medicaid program, and other organizations that exchange health information electronically. A complete, current list is available from [redacted] You can obtain an updated list at any time by checking [redacted] website at http://healtheconnections.org/ or by calling 315.671.2241 x5.

4. **Who May Access Information About You, If You Give Consent.** Only doctors and other staff members of the Organization(s) you have given consent to access who carry out activities permitted by this form as described above in paragraph one.

5. **Public Health and Organ Procurement Organization Access**. Federal, state or local public health agencies and certain organ procurement organizations are authorized by law to access health information without a patient's consent for certain public health and organ transplant purposes. These entities may access your information through [redacted], for these purposes without regard to whether you give consent, deny consent or do not fill out a consent form.

6. **Penalties for Improper Access to or Use of Your Information.** There are penalties for inappropriate access to or use of your electronic health information. If at any time you suspect that someone who should not have seen or gotten access to information about you has done so, call the Provider Organization directly by accessing their contact information on the [redacted] website at http://healtheconnections.org/; or call the NYS Department of Health at 518-474-4987; or follow the complaint process of the federal Office for Civil Rights at the following link: *http://www.hhs.gov/ocr/privacy/hipaa/complaints/.*

7. **Re-disclosure of Information.** Any organization(s) you have given consent to access health information about you may re-disclose your health information, but only to the extent permitted by state and federal laws and regulations. Alcohol/drug treatment-related information or confidential HIV-related information may only be accessed and may only be re-disclosed if accompanied by the required statements regarding prohibition of re-disclosure.

8. **Effective Period**. This Consent Form will remain in effect until the day you change your consent choice or until such time as [redacted] ceases operation (or until 50 years after your death, whichever occurs first). If [redacted] merges with another Qualified Entity your consent choices will remain effective with the newly merged entity.

9. **Changing Your Consent Choice**. You can change your consent choice at any time and for any Provider Organization or Health Plan by submitting a new Consent Form with your new choice. Organizations that access your health information through [redacted] while your consent is in effect may copy or include your information in their own medical records. Even if you later decide to change your consent decision they are not required to return your information or remove it from their records.

10. **Copy of Form**. You are entitled to get a copy of this Consent Form.