Welcome to Dermuss Dermatology! Enclosed are forms needed for your appointment, a copy of our office policies, and directions on how to get to our office from various starting points. We have also enclosed our office's Notice of Privacy Practices for your information. There are 13 pages total. Please bring the completed forms **with you** for your appointment. Please **do not** fax or email these forms as we need the signed originals on file. At your appointment time, please check in with the receptionist and provide the following:

- All insurance/HIPAA/health history/credit card authorization forms filled out and signed (6 pages)
- Drivers License/ State ID
- Current Insurance Card
- Applicable specialists copay

Thank You and we look forward to seeing you.

e-reg

DERMUSS DERMATOLOGY, LTD.
REGISTRATION

PATIENT INFORMATION

_____ _____ _____
(First, Middle, Last Name) (Date of Birth) (Social Security Number)

_____ _____
(Address) (City, State, Zip Code)

_____ _____
(Occupation) (Employer)

_____ _____ _____ _____
(Home Telephone Number) (Work Telephone Number) (Cell Phone Number) (E-Mail Address)

Marital Status: __ Single __ Married __ Divorced __ Widowed
Ethnicity: __ Asian/Pacific Islander __ Black Non-Hispanic __ Hispanic __ White
Sex: __ Male __ Female
Cellular Carrier: __ Verizon __ AT&T __ Sprint __ Other (List) _____

EMERGENCY CONTACT

_____ _____ _____ _____
(Name) (Phone Number) (Relationship to Patient) (Cell Phone Number)

INSURANCE INFORMATION (PRIMARY)

_____ _____ _____
(Name of Insured) (Date of Birth) (Relationship to Patient)

_____ _____
(Employer) (Work Number)

_____ _____ _____
(Insurance Company) (Group Number) (subscriber ID Number)

_____ _____
(Claims Mailing Address) (City, State, Zip Code)

Please enter your **SPECIALISTS COPAY** amount_____ _____
(insurance claims phone number)

ADDITIONAL INFORMATION (SECONDARY)

_____ _____ _____
(Name of Insured) (Date of Birth) (Relationship to Patient)

_____ _____ _____
(Insurance Company) (Group Number) (subscriber/member ID Number)

_____ _____
(Claims Mailing Address) (City, State, Zip Code)

RESPONSIBLE PERSON FOR PAYMENT

_____ _____ _____
(Name) (Date of Birth) (Relationship to Patient)

_____ _____
(Address) (City, State, Zip Code)

_____ _____ _____
(Phone Number) (Social Security Number) (Occupation)

We normally contact our patients between 8:00 am and 5:00 pm. What is the phone number we should use to contact you? Home Work Cell (Please Circle)

If you are unavailable at the time we contact, may we
Leave medical information with another person?
If Yes, who_____ YES NO
(example: discuss test results with spouse, disclose diagnosis to lab or pharmacy)
Leave medical information on voice mail or answering machine? YES NO

How were you referred to our office?

__ Insurance
__ Phone Book
__ Ad in paper
__ Hospital referral
___By a Doctor, specify _____
___By another patient, specify_____
___Former patient (seen in Arlington Heights office prior to May 2003)
___Other, please specify_____

CONSENT TO TREATMENT

I voluntarily consent to receive medical and health care services that may include diagnostic procedures, examinations and treatment.

Financial Responsibility and Assignment of Benefits
I agree to pay all charges for medical and health care services not covered by my insurance company. I understand that product purchases I choose to make are not covered by insurance and cannot be returned or exchanged. I have reviewed the office policies and agree to abide by them.

I certify that I have read this form and understand its contents.

_____ _____
(Patient or Other Legally Authorized Person) (Date)

CREDIT CARD AUTHORIZATION

I hereby authorize Dermuss Dermatology, LTD to charge the patient responsibility balance due after insurance pays on my account. I understand this card will also be charged for no show and last minute cancellation fees. The card to be used is the following:

Patient Name

Name on Credit Card

Credit Card Number: circle which one VISA MC DISC

Expiration Date

3 Digit Security Code

Authorized Signature

The amount charged will be the patient responsibility balance due per insurance explanation of benefits(EOB). After the charge is processed and posted, patient will be sent a letter of acknowledgement and receipt.

In the event the above reference card is no longer valid and/or charge denied by the bank, patient will be sent notice and balance will be due in full within 15 business days.

Patient/Guarantor Signature

Date

Witness Signature

Date

DERMUSS DERMATOLOGY, LTD
Health History (CONFIDENTIAL)

Name: _____ Date: _____

Completed by: ( ) Self ( ) Parent/Guardian ( ) Other_____

Dear Patient,

This information is confidential and helps us to understand any pertinent medical information that could affect your care. If you have any questions or concerns with completing this form (i.e. lengthy medical history, confidential issues) please let the doctor or nurse know. Thank you.

Please list ALL MEDICATIONS that you take and use (please include topical medicines and over the counter medications):

_____
_____
_____

Who is your Primary Care Physician? _____

Do you have any allergies to medications or substances? ( ) No ( ) Yes,
Please list: _____

Do you smoke ( ) No ( ) Yes, packs per day: _____

Do you drink alcohol? ( ) No ( ) Yes, per day: _____

Have you ever had a skin cancer? ( ) No ( ) Yes, Basal Cell Squamous Cell Melanoma Unknown

Is there a family history of skin cancer? ( ) No ( ) Yes, in whom_____

Circle which type: Basal Cell Squamous Cell Melanoma Unknown

For Women: Are you pregnant or think you might be pregnant? ( ) No ( ) Yes
Nursing? ( ) No ( ) Yes

Do you have a pacemaker? ( ) No ( ) Yes

Do you need antibiotics before any procedures for a pre-existing heart condition? ( ) No ( ) Yes

Do you have a personal history of skin disease? ( ) No ( ) Yes, type_____

Do you have any family history of skin diseases? (Such as eczema, psoriasis, etc.)
( ) No ( ) Yes, please list: _____

Preferred Pharmacy: _____
Exact Pharmacy Address and Phone Number: _____

PATIENT'S PERSONAL (**NOT** FAMILY) HEALTH HISTORY

CHECK **"X"** TO ONLY WHAT APPLIES

(CONFIDENTIAL)

_____AIDS
_____Alcoholism
_____Allergy history in family
_____Anemia
_____Anorexia
_____Arthritis
_____Asthma
_____Bladder Problems
_____Bleeding Disorders
_____Bowel Problems
_____Bulimia
_____Cancer, what type_____
_____Chemical Dependency
_____Chicken Pox
_____Depression
_____Diabetes
_____Emphysema
_____Epilepsy
_____Glaucoma
_____Gonorrhea
_____Gout
_____Heart Disease
_____Heart Valve problems
_____Heart murmur
_____Hepatitis
_____Herpes
_____High Cholesterol
_____High Blood Pressure
_____HIV Positive
_____Kidney Disease
_____Liver Disease
_____Miscarriage
_____Mononucleosis
_____Multiple Sclerosis
_____Pacemaker
_____Pneumonia
_____Polio
_____Prostate Problem
_____Psychiatric Care
_____Rheumatic Fever
_____Scarlet Fever
_____Seasonal Allergies
_____Seizures
_____Stomach Problems
_____Stroke
_____Suicide attempt
_____Thyroid Problem
_____Tuberculosis
_____Typhoid fever
_____Ulcers
_____Vaginal Infections
_____Venereal Disease
_____Other, please specify_____

_____NONE of the above

Dermuss Dermatology, LTD.
Patient Health Information Consent Form

We want you to know how your Patient Health Information (PHI) is going to be used in this office and your rights concerning these records. Before we will begin any health care operations we must require you to read and sign this consent form stating that you understand and agree with how your records will be used. If you would like to have a more detailed account of our policies and procedures concerning the privacy of your Patient Health Information we encourage you to read the HIPAA NOTICE that is available to you at the front desk before signing this consent.

1. The patient understands and agrees to allow this office to use their Patient Health Information (PHI) for the purpose of treatment, payment, healthcare operations, and coordination of care. As an example the patient agrees to allow this office to submit requested PHI to the Health Insurance Company (or companies) provided to us by the patient for the purpose of payment. Be assured that this office will limit the release of all PHI to the minimum needed for what the insurance companies require for payment.
2. The patient has the right to examine and obtain a copy of his or her own health records at any time and request corrections. The patient may request to know what disclosures have been made and submit in writing any further restrictions on the use of their PHI. Our office is not obligated to agree to these restrictions.
3. A patient's written consent need only by obtained one time for all subsequent care given to the patient in this office.
4. The patient may provide a written request to revoke consent at any time during care. This would not affect the use of these records for the care given prior to the written request to revoke consent but would apply to any care given after the request has been presented.
5. For your security and right to privacy, all staff has been trained in the area of patient record privacy and a privacy official has been designated to enforce those procedures in our office. We have taken all precautions that are known by this office to assure that your records are not readily available to those who do not need them.
6. Patients have the right to file a formal complaint with our privacy official about any possible violations of these policies and procedures.
7. If the patient refuses to sign this consent for the purpose of treatment, payment and health care operations, the physician has the right to refuse to give care.

I have read and understand how my Patient Health Information will be used and I accept the policies as stated above.

_____

Name of Patient Date

Office Use Only

I attempted to obtain the patient's signature in acknowledgement on this <u>Notice of Privacy Practices Acknowledgement</u>, but was unable to do so as documented below:

Date:_____ Initials:_____ Reason:_____

_____

OFFICE POLICIES

Office Hours: Monday 9:00-5:30 Tuesday/Thursday 8:30-5:30 and Friday 8:30-12:30
The office is closed from 12:30 to 1:30 for lunch.

Please be advised of our office hours. In the case of an emergency after hours, please call or proceed to your nearest ER or Urgent care center. For all non-emergency questions, please call back during our normal business hours.

Check if we are in your Network :

Please keep in mind that we are taking all the necessary steps to get the most coverage for you. In order for things to run in an orderly manner, it is your responsibility to find out if we are in your network or not. Please call your insurance company before your scheduled your appointment with us. This will help manage your uninsured /out of pocket visits. Any balance left over after the insurance payment is the patients' responsibility. If your insurance card is unavailable, payment is required in full at the time of service. Payments can be made with cash, check, Visa or MasterCard, and some debit cards.

HMO Referrals :

Blue Cross Blue Shield- Blue Choice is the only HMO insurance that we accept. It is your responsibility to have your referral form at the office before or at the time of appointment. If you do not take care of this matter, payment is due in full at the time of your visit.

Refills:

Refills on the products bought at our office do not require you to see the doctor. Please come in as needed during regular business hours to purchase your products. Because of the medical grade strength of the products, they are only sold at our office and **cannot be returned or exchanged.**

Prescription refills are filled through the pharmacy only. Please contact your pharmacy with your refill request, even if your prescription says no more refills. That will give us time to access your chart and see if a refill can be given or if an office visit is required.

Late for an appointment :
We realize that days do not always run as smoothly as planned and we apologize. When a patient is late for an appointment, you have two options: reschedule or fit in as a walk-in. If we can, we will fit you in as a walk-in and you will be seen as and when time is available. We run a tight schedule and cannot delay those who are on time.

Missing an appointment :

We cannot stress enough how important it is that you come to your appointment. The doctor cannot treat you over the phone. Please realize that if you do not see the doctor as directed, she will be unable to help you or prescribe any medication.

Again, it is very important that you show up for your appointments. It is the only way the doctor will know if the treatment given is working. We try to call to remind you of the appointment 2 business days prior to your appointment, as a courtesy. This will of course require you to keep us updated with your contact information. Even if your contact information changes, you are still responsible for keeping your appointment time even if we cannot reach you. If you do not show up for a scheduled appointment and do not call, you will be charged a

no show fee of $50. There is also a fee of $15 for appointments that are cancelled with less than 24 hour notice. Thank you for giving us the same courtesy given to you.

Cosmetic Procedures :

All cosmetic procedures must be paid for at the time of service. We will be happy to give you a receipt for insurance reasons but we do not submit them here at the office. We only submit office visits and NON-cosmetic procedures to insurance companies. Examples of cosmetic procedures are skin tag removal, microdermabrasions/ chemical peel, Botox, sclerotherapy, Restylane, etc.

A common inquiry by patients is whether a procedure can be done the same day as the visit. This can never be determined until the patient is seen by the doctor, who will then allot an appropriate amount of time for such a procedure. Sometimes it is possible to it the same day, but many factors go into determining this, and it may be that another visit must be scheduled. It is always in your best interest to have the correct amount of time allotted for your procedure.

Biopsy Results :

Please be aware that we only call you if there is any concern with the biopsy performed during your visit. If you do not hear from us within 10 days, you may assume that the biopsy was benign. If you like, you may always call us to verify this.

Medical Records :

In accordance with Illinois State Law and HIPAA, a fee of 25 dollars plus a per page charge will be assessed to all requests for medical records.

Prior Authorization from Insurance :

We realize that insurance companies may request prior authorizations for medicine prescribed to you by the doctor. Please be aware that our office does not call in for prior authorization for any medication. If your insurance company faxes us a prior authorization form to be filled out, our office will charge a service fee of $25 to your account for the completion of this paperwork on your behalf. Bear in mind this additional paperwork is requested by your insurance company, NOT our office. All of our staff's time is dedicated to direct patient care, and we do not have the resources to deal with the insurers when we know that the doctor has given the best medication for your condition. Our job is to treat you, your insurers' job is to give you the proper coverage. We ask that you address the denials with your insurer, not our office.

Payment is your responsibility:

We will submit your visit to the insurance company, as a courtesy, but it is their determination whether they will cover the visit/procedure. If the insurer asks us for medical documentation, we can provide this, but if the claim is denied, the balance will be your responsibility. Forms of payment that we accept are cash, check, Visa, Mastercard, and some debit cards. There is a service fee of $35 for all returned checks.

Claims that are not paid within 90 days by the insurer will also be your responsibility. We will bill you after the insurer has paid their portion. A $10 rebilling fee will be added to your balance due for every bill sent to you after 30 days. After 90 days of inactivity, accounts will be turned over to a collection agency at which time your outstanding balance will be assessed a minimum of $25 and up to a 25% collection charge. All legal fees incurred in obtaining payment from you will be added to your account balance, and you will be liable for the full amount.

DIRECTIONS TO DERMUSS DERMATOLOGY
(Dr. Shah's office)

905 Fox Glen
Barrington, IL 60010
Phone: 847-277-1200

We are located in Barrington in the Fox Glen professional subdivision, off of Rt 22 between IL-30 (Kelsey RD) and Rt 14 (Northwest Highway). We are 1/2 of a mile west of Kelsey Rd on the South side of the road in a subdivision of all one story gray/white buildings. Our office is at the furthest South point of the subdivision (ie upon entering, go straight to the back left corner). On the building itself there is a sign that says Dermuss Dermatology-905 Fox Glen Ct

Landmarks east of us: ½ mile east is Kelsey Rd, and one mile east is Good Shepard Hospital(GSH)

Landmarks west of us: Rt 14, Walgreens

From Schaumburg
Algonquin Rd to Barrington Rd (IL-59) to Hough St, past Rt 14
Left on Rt 22

OR I-90 West, exit Barrington Rd go north, past Rt 14
Left on Rt 22

From Arlington Heights
US-14 West (Northwest Highway)
Right on Hough St (rt 59)
Left on Rt 22

From Algonquin
West County Line Rd to Ridge Rd
US-14 East(Northwest Highway)
Left on Rt 22

From Highland Park
Half Day Rd to IL 22
One mile west of Good Shepard hospital

From Elgin
Golf Rd to IL-59, go north
Left onRt 22, go 1 mile west of GSH

From Lake Forest
Townline Rd to IL-22
Go one mile west of GSH

From Cary/ Crystal Lake
US-14 east (Northwest Highway)
Left at Rt 22

From Wauconda
South on Barrington Rd (US-59)
Right on Rt 22

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Dermuss Dermatology, LTD

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

Our Legal Duty

We are required by applicable federal and state law to maintain the privacy of your medical information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your medical information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our notice effective for all medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

You may request a copy of our notice at any time. For more information about our privacy practices or for additional copies of this notice, please contact us using the information listed at the end of this notice.

Uses and Disclosures of Medical Information

We use and disclose medical information about you for treatment, payment, and health care operations. For example:

Treatment: We may use your medical information to treat you or disclose your medical information to a physician or other health care provider providing treatment to you.

Payment: We may use and disclose your medical information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your medical information in connection with our health care operations. Health care operations include quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

To You and on Your Authorization: You may give us written authorization to use your medical information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your medical information for any reason except those described in this notice.

To Your Family and Friends: We must disclose your medical information to you, as described in the Individual Rights section of this notice. We may disclose medical information to a family member, friend or other person to the extent necessary to help with your health care or with payment for your health care, but only if you agree that we may do so.

Appointment Reminders: We may use your medical information to contact you to provide appointment reminders.

Facility Directory: We may use the following medical information in our facilities directories: your name, your location in our facility, your general medical condition. We will disclose this information to members of the clergy or, except for religious affiliation, to other persons. We will provide you with an opportunity to restrict or prohibit some or all disclosures for facility directories unless emergency circumstances prevent your opportunity to object.
Persons Involved In Care: We may use or disclose medical information to notify, or assist in notification of (including identifying or location) a family member, your personal representative or another person responsible for your care, your location, your general condition, or death. If you are present, then prior to use or disclosure of your medical information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose protected health information based on a determination using our professional judgment disclosing only protected health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with our common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of medical information.
Disaster Relief: We may use or disclose your medical information to a public or private entity authorized by law or by its charter to assist in disaster relief efforts.
Marketing Health Related Services: We may use your medical information to contact you with information about health-related benefits and services or about treatment alternatives that may be of interest to you. We may disclose your medical information to a business associate to assist us in these activities.
Research: We may use or disclose your medical information for research purposed in limited circumstances.
Death; Organ Donation: We may disclose the medical information of a deceased person to a coroner, medical examiner, funeral director, or organ procurement organization for certain purposes.
Required by Law: We may use or disclose your medical information when we are required to do so by law. For example, we must disclose your medical information to the U.S. Department of Health and Human Services upon request for purposes of determining whether we are in compliance with federal privacy laws. We may disclose your medical information when authorized by workers' compensation or similar laws. We may disclose your medical information to a government agency authorized to oversee the health care system or government programs or its contractors, and to public health authorities for public health purposes.
Law Enforcement: We may disclose your medical information in response to a court or administrative order, subpoena, discovery request, or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may disclose your medical information to law enforcement officials. We may disclose limited information to a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may disclose the medical information of an inmate or other person in lawful custody to a law enforcement official or correctional institution under certain circumstances.
Abuse or Neglect: We may disclose your medical information to appropriate authorities if we reasonably believe that you are a possibly victim of abuse neglect, or domestic violence or the possible victim of other crimes. We may disclose your medical information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others. We may disclose medical information when necessary to assist law enforcement officials to capture an individual who has admitted to participation in a crime or has escaped from lawful custody.
National Security: We may disclose to military authorities the medical information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials medical information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or individual under certain circumstances.

Individual Rights

Access: You have the right to look at or get copies of your medical information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. {You must make a request in writing to obtain access to your medical information. You may obtain a form to request access by using the contact information listed at the end of this notice. You may also request access by sending us a letter to the address at the end of this notice. If you request copies, we will charge you for each page, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your medical information in that format. If you prefer, we will prepare a summary or an explanation of your medical information for a fee. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.}

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your medical information for purposes, other than treatment, payment, health care operations or pursuant to an authorization and certain other activities, since April 14, 2003. We will provide you with the date on which we made the disclosure, the name of the person or entity to whom we disclosed your medical information, a description of the medical information we disclosed, the reason for disclosure, and certain other information. If you request this accounting more than once in a 12 month period, we may charge you a reasonable cost-based fee for responding to these additional requests. Contact us using the information listed at the end of this notice for a full explanation of our fee structure.
Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your medical information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency). {Any agreement we may make to a request for additional restrictions must be in writing signed by a person authorized to make such an agreement on our behalf. We will not be bound unless our agreement is so memorialized in writing.}
Confidential Communication: You have the right to request that we communicate with you about your medical information by alternative means or to alternative locations. {You must make your request in writing, and you must state that the information could endanger you if it is not communicated by the alternative means or to the alternative location you want.} We must accommodate your request if it is reasonable, specifies the alternative means or location, and provides satisfactory explanation how payments will be handled under the alternative means or location you request.
Amendment: You have the right to request that we amend your medical information. {Your request must be in writing, and it must explain why the information should be amended.} We may deny your request if we did not create the information you want amended and the originator remains available for certain other reasons. If we deny your request, we will provide you a written explanation. You may respond with a statement or disagreement to be appended to the information you wanted amended. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
Electronic Notice: If you receive this notice on our web site or by electronic mail (e-mail), you are entitled to receive this notice in written form. Please contact us using the information listed at the end of this notice to obtain this notice in written form.

Questions and Complaints
If you want more information about our privacy practices or have questions or concerns, please contact us using the information listed at the end of this notice.
If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your medical information or in response to a request you made to amend or restrict the use or disclosure of your medical information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this notice. You may also submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services.
We support your right to privacy of your medical information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Dept. of Health and Human Services.

Contact office: Dermuss Dermatology LTD.
Attention: Alison Dal Campo
905 Fox Glen
Barrington, IL. 60010
847-277-1200