Dr. Loretta Gremillion
New Patient Registration

(PLEASE PRINT) Date _____

Name _____
Last First MI

Address _____
Street City State Zip

Phone: Home (___)_____ Work (___)_____ Cell (___)_____

EMAIL _____ SSN _____

PHARMACY_____ DOB_____

☐ Male / ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

ETHNICITY (PLEASE CIRCLE): DECLINED - HISPANIC/LATINO - NOT HISPANIC/LATINO PREFERRED LANGUAGE (PLEASE CIRCLE); ENGLISH - SPANISH - ASIAN - OTHER

RACE (CIRCLE ONE): AMERICAN INDIAN/ALASKA - ASIAN - BLACK/AFRICAN AMERICAN - NATIVE HAWAIIAN/OTHER PACIFIC ISLANDER - WHITE - OTHER

Employer_____

Employment Status: ☐ Full Time ☐ Part Time ☐ Not Employed ☐ Self Employed ☐ Retired

Primary Care Physician:_____Referring Doctor:_____

Guarantor (Responsible Party) ☐ Self ☐ Spouse ☐ Parent ☐ Other

Name_____ DOB_____ SSN_____
Last First MI

Address_____
Street City State Zip

INSURANCE INFORMATION

☐ **Primary Insurance**_____

ID#_____Group#_____

If Other Than Patient: Name_____Relationship to Patient _____

Phone: Home (___)_____ Cell(___)_____DOB_____SSN_____

☐ **Secondary Insurance**_____Eff Date:_____

ID#_____Group#_____

If Other Than Patient: Name_____Relationship to Patient_____

Phone: Home (___)_____Cell (___)_____DOB_____SSN_____

WHO TO NOTIFY IN CASE OF EMERGENCY (nearest relative or friend)?

Name_____DOB_____Relationship_____

Address_____
Street City State Zip

Home Phone (___)_____ Cell Phone(___)_____

FINANCIAL ASSIGNMENT AND AGREEMENT:

1. We participate in a variety of insurance plans and will directly bill your insurance under these plans. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.
2. In Order To Control Billing Costs, We Request That Charges Not Covered by Insurance For Office Visits And Procedures Be Paid At The Conclusion Of Each Visit.
3. I request that payment of authorized Medicare, Medicaid or private insurance benefits be made either to me or on my behalf to Advanced Dermatology Care, APMC for any services furnished by the provider. I authorize any holder of medical information about me to release to the center's for Medicare and Medicaid services or my private insurance carrier and its agents any information needed to determine these benefits payable.
4. 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 whether or not paid by said insurance. I hearby authorize said assignee to release all information necessary to secure the payment.

Signature of Patient or Parent (if minor)_____ **Date**_____

PATIENT AUTHORIZATION

I consent to treatment, **including biopsies**, necessary for the care of the below named patient. ***I understand that I will receive a separate bill from Dr. T. Nicotri (a skin pathologist from Delta Pathology) for each skin specimen processed. (By law, Dr. Gremillion is required to send skin specimens to a pathologist for Biopsies and surgeries.)***

I authorize the release of all medical records to the referring and family physicians. I allow fax transmittal of my medical records, if necessary.

I acknowledge full financial responsibility for services rendered by Advanced Dermatology Care, Dr. Loretta Gremillion. I understand I have 30 days after insurance pays to pay in full. I also understand that if surgery is needed, I am required to pay the patient portion upon completion of the surgery. (This DOES NOT APPLY to Medicare or any Medicare related insurance plan).

I have read and fully understand the above consent for treatment, biopsies, financial responsibility, release of medical information, and insurance authorization.

Date_____Signature_____

PATIENT CONSENT AND ACKNOWLEDGMENT OF RECEIPT OF PRIVACY

I understand that as part of the provision of healthcare services, Advanced Dermatology Care, creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment.

I have been offered a Notice of Privacy Practices that provides a more complete description of the uses and disclosures of certain health information. I understand that I have the right to review the notice prior to signing the consent. I understand that the organization reserves the right to change their Notice and practices. I understand that I have the right to object to the use of my health information for directory purposes, I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing except where disclosures have already made in reliance of my prior consent.

This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purpose of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which may have been previously agreed upon.

_____ _____

PATIENTS NAME PRINTED DATE

_____ _____

PATIENTS SIGNATURE (OR GUARDIAN, IF A MINOR) SOCIAL SECURITY # (FOR ID PURPOSES ONLY)

Patient:_____ Date____/____/____

Reason for today's visit:_____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:

1._____ 2._____ 3._____ 4._____

Have you ever had a reaction to lidocaine or betadine? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1._____ 3._____ 5._____ 7._____

2._____ 4._____ 6._____ 8._____

Do you have now, or have you ever had diseases or conditions of: (please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma/ Hay Fever/ Hives	☐	☐
Shortness of Breath	☐	☐
Tuberculosis	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pains	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
High Cholesterol	☐	☐
Anemia	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Gastrointestinal	☐	☐
Crohn's Disease/Ulcerative Colitis	☐	☐
Arthritis / Joint Deformity	☐	☐
Organ Transplant	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Have you had or have you been exposed to HIV (AIDS) or Hepatitis?	☐	☐
Have you had or have you been diagnosed with any type of cancer?	☐	☐

If YES, what type? _____

Skin:	**YES**	**NO**
Do you have a history of fever blisters?	☐	☐
Have you ever taken Accutane?	☐	☐
Do you bleed easily?	☐	☐
Do you develop skin rashes from bandages or topical Neosporin (antibiotic ointment)?	☐	☐
Do you have a family history of Melanoma, Skin Cancer, Psoriasis, Lupus, other Connective Tissue Disease, or Severe Acne?	☐	☐

Do you have or have you had:	**YES**	**NO**
Melanoma	☐	☐
Skin Cancer	☐	☐
Psoriasis / Eczema / other skin rashes	☐	☐
Specific Skin Disease	☐	☐
Unusual / Dysplastic Moles	☐	☐
Keloid Scars	☐	☐

IF YES, list family member / relationship and disease:

Family Member:_____ Disease:_____

Social History:	**YES**	**NO**
Do you drink alcohol?	☐	☐
Are you a former smoker?	☐	☐
Do you currently smoke?	☐	☐
How soon after you awake do you smoke your first cigarette? _____		
Are you interested in quitting?	☐	☐

If YES,_____drinks per day

If YES, how long since you last smoked?_____

If YES, how many per day?_____

(Women) Are you pregnant or trying to conceive? ☐ **YES** ☐ **NO** Due date ____/____/____

What is your occupation? _____

Are you exposed to dust, solvents, or other chemicals at your place of employment? ☐ YES ☐ NO If YES, what?_____

Do you have a history or tendency of fainting during medical procedures? ☐ YES ☐ NO

Dr. Loretta Gremillion
2409 Broadmoor Blvd
Monroe, LA 71201

Surgical • Medical • Laser

Medical Information Release Form
(HIPAA Release Form)

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

Release of Information

I authorize the release of information including the diagnosis, records, examination rendered to me, and claims information.

This information may be released to:

[ ] Spouse _____
[ ] Child(ren) _____
[ ] Other _____
[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell number:_____

If unable to reach me:

[ ] you may leave a detailed message
[ ] please leave a message asking me to return your call
[ ] Other_____

The best time to reach me is (*day*)_____between (*time*)_____
CAN LAB RESULTS BE LEFT ON YOUR ANSWERING MACHINE? ☐ YES ☐ NO

Signature:_____Date:_____

Cosmetic Inquiry:
I would be interested in more information on the following: (Please check all that apply)
☐ BOTOX ☐ Chemical Peel ☐ Restylane ☐ Microdermabrasion ☐ Skin care products
☐ Leg Vein Therapy ☐ Laser Hair Removal ☐ Vascular Laser Treatment

How did you hear about our office?_____

Advanced Dermatology Care
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, and 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

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• 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.

Updated September 4, 2013

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 copy your PHI.
• 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 September 4, 2013 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 for more information.

Compliance Officer:

Clesi Neitz
Advanced Dermatology Care

318-323-8799
info@advanceddermcareapmc.com