TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

Patient Registration Information

Welcome To Our Office

PLEASE PRINT and COMPLETE ALL PARTS

Today's Date_____

PATIENT INFORMATION: (This section refers to the PATIENT ONLY)

First Name: _____ Last Name: _____ (Nickname): _____

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

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Social Security #: _____ Date of Birth: _____ Age: _____ Sex: _____

Employer: _____ Occupation: _____

Is the Patient? Single Married Separated Divorced Widowed

Spouse's Name: _____ Occupation: _____ Work phone: _____

PRIMARY CARE PHYSICIAN:

Name: _____ Location: _____ Phone: _____

REFERRING PHYSICIAN:

Name: _____ Location: _____ Phone: _____

E-MAIL:

We have a patient portal available that will allow you to send us secure messages from your home computer. In order to activate the patient portal we need to send you an email. From that email you may set up a username and password.

Your email address is kept confidential and will not be shared with any outside solicitor.

E-mail Address: _____

Please note that we can take care of minor issues and discuss prescription refill requests through the patient portal but if you have a serious medical issue which is urgent the fastest way to contact us is by calling the office.

TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

INSURANCE: (Please complete thoroughly. We will also need a copy of your insurance card.)

Primary Insurance: _____ **Secondary Insurance**: _____

The information below is about the CardHolder – the person who has the insurance policy in their name:

For Primary Insurance:
Cardholder Name: _____
Date of Birth: _____
Social Security Number: _____

For Secondary Insurance:
Cardholder Name: _____
Date of Birth: _____
Social Security Number: _____

RESPONSIBLE PARTY: (Person who should receive the bill): please circle one - SELF, PARENT, SPOUSE, OTHER
Name: _____ Social Security #: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Work Phone: _____ Employer: _____

I consent to the release of medical information to my insurance company, and request that any insurance benefits be paid directly to Twin Peaks Dermatology, PC.
CONSENT FOR TREATMENT: I hereby apply for the voluntarily consent to examination and treatment performed by the medical staff of Twin Peaks Dermatology, PC.

Patient Signature: _____ Date: _____

TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

Patient Statement of Financial Responsibility

Please Note: Complete insurance and personal information is required at the time of your appointment in order for our office to file a claim to your insurance company.

The purpose of the Patient Statement of Financial Responsibility is for you to understand that you are obligated to ensure that our fees are paid in full.

Your insurance policy is an agreement between you and your Insurance Company. Our relationship is with you and not your Insurance Company. Therefore, all charges are ultimately your responsibility, regardless of your insurance status. Questions regarding your insurance coverage and benefits are best directed to and answered by your Insurance Company.

Patient Statement:

- I understand and agree that my co-payment, co-insurance and deductibles are due and payable at the time of service, and I may receive a bill for any amounts due that are not collected at time of service.
- I understand that services not covered through my benefits, as well as any applicable co-payments and deductibles are my responsibility.
- I understand that an inactive insurance card, no insurance, no insurance card, or insurance we are not a participating provider for, will render me responsible for payment for services.

Though Twin Peaks Dermatology, PC may be a contracted provider with my Insurance Company, I understand that some or all of the services which are requested and rendered may not be deemed a “covered” service under my particular plan. I am responsible to pay Twin Peaks Dermatology, PC for any copayments as instructed by my Insurance Company, any unsatisfied deductible, co-insurance or termination of coverage, and any amount considered non-covered by my insurance company. Should my insurance company or any benefits provided by that insurance company change, I will immediately notify Twin Peaks Dermatology, PC of said changes.

_____

Patient Name (PRINT)

_____ _____

Patient Signature (Or Parent/Guardian) Date

TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

HIPAA ACKNOWLEDGEMENT RECEIPT OF NOTICE OF PRIVACY PRACTICES

As a patient of Twin Peaks Dermatology, you are entitled to the latest copy of our Notice of Privacy Practices. This notice describes how your health information can be used and disclosed by Twin Peaks Dermatology and how you may obtain access to and control of this information. This notice is available upon request and is also posted on our website.

By signing below, I acknowledge I have received Twin Peaks Dermatology's Notice of Privacy Practices (last updated February 12, 2018):

Today's Date: _____

Patient Name: _____ **Date of Birth:** _____

Signature: _____ **Relationship to Patient:** _____
(Of Patient or Legal Representative)

Please list any members of your friends or family with whom we may discuss your medical and billing information:

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

Name: _____ **Relationship:** _____ **Phone #:** _____

FOR OFFICE USE ONLY

Complete this section if this form is not signed and dated by the patient or patient's legal representative.

I have made a good faith effort to obtain from the patient or patient's legal representative a written acknowledgement of his/her receipt of Twin Peaks Dermatology's Notice of Privacy Practices but was unable to for the following reason:

- ☐ The patient had a medical emergency
- ☐ Patient refused to sign.
- ☐ Patient was unable to sign because: _____
- ☐ Other (Please describe): _____

Employee Signature: _____ Date: _____

TWIN PEAKS DERMATOLOGY, PC
205 SOUTH MAIN STREET, SUITE E
LONGMONT, CO 80501
PHONE: (303) 485-8913 www.twinpeaksdermatology.com FAX: (303) 485-8914

TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

Patient History Form

NAME: _____ NICKNAME: _____ AGE: _____ DATE OF BIRTH: _____

What is the reason for your visit? _____

Where is the problem located? _____ How long have you had this condition? _____

How have you been treating this condition? _____

Have you ever had an abnormal mole or skin cancer proven by a biopsy? Yes No

If yes, where on the body? _____ Year(s) occurred? _____

Which type of skin cancer was it? (Circle all that apply): Basal Cell Type, Squamous Cell Type, Melanoma, or "I don't know"

Have any of your family members had abnormal moles, pre-skin cancers, or skin cancers? Yes No

If yes, please describe: _____

Do you have any history of thickened scars (keloid scars) from ear/body piercings or medical procedures? Yes No

Are you supposed to take antibiotics prior to a dental appointment or surgical procedure? Yes No

If Yes, which medication and why do you need to take it? _____

Female patients: Are you pregnant? Yes No If yes, what is your due date? _____

Please list all medications, both prescription and non-prescription, that you are **currently** using/taking. This should include all vitamins, herbs, dietary supplements, birth control pills, Coumadin, Garlic, Gingko, Ginseng, Aspirin, etc. Please also list why you are taking it.

_____

_____

_____

_____

_____

_____

Are you allergic to any medications (circle)? Yes No

If yes, which medication(s) and what was your reaction it?

_____

_____

Circle the following conditions you have had and list the approximate date beside it:

Easy or excessive bleeding	Heart Valve Replacement	High Blood Pressure
Blood clots	Pacemaker or Implanted Defibrillator	High Cholesterol
HIV	Heart murmur	Heart Attack
Hepatitis B or C Specify: _____	Joint Replacement	Stroke

Please list all other medical conditions which you have that are not listed above:

_____

_____

_____

TWIN PEAKS DERMATOLOGY, PC
205 SOUTH MAIN STREET, SUITE E
LONGMONT, CO 80501
PHONE: (303) 485-8913 www.twinpeaksdermatology.com FAX: (303) 485-8914

TWIN PEAKS DERMATOLOGY, PC

JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

Patient History Form, Continued

Please list any surgeries:

_____

Please list any hospitalizations:

_____

Review of Systems:

Please circle any of the following symptoms which you currently have:

GENERAL HEALTH: Fever, feeling "bad", unusual weight loss or weight gain, muscle or joint pain, weakness, fatigue, night sweats

HEENT: Headache, burning eyes, eye pain, drainage from the eyes, runny nose, ear pain with drainage, bloody nose, difficulty swallowing, tooth pain, sinus pain, change in hearing, blurred vision, double vision

CHEST: Cough, chest pain, coughing up blood or pus, shortness of breath, neck pain, jaw or elbow pain, irregular heartbeat, wheezing

GI: Nausea, vomiting, diarrhea, constipation, change in bowels, black or red bowel movements

GU: Pain with urination, frequent urination, pus or blood in the urine, kidney pain

Social History:

Do you smoke cigarettes, use snuff or chew tobacco? No Yes If Yes, how often? _____

Do you take/use any street drugs? (including marijuana) No Yes If Yes, which type? _____

Did you have a drink containing alcohol in the last year? No Yes

How often did you have 6 or more drinks on one occasion in the past year?

Never, less than monthly, monthly, weekly, daily, or almost daily

How many drinks did you have on a typical day when you were drinking in the past year?

1 or 2 drinks, 3 or 4 drinks, 5 or 6 drinks, 7 to 9 drinks, 10 or more drinks

How often did you have a drink containing alcohol in the past year?

Never, monthly or less, 2 to 4 times a month, 2 to 3 times a week, 4 or more times a week

Household Information:

Adults, are you: Married, Separated, Divorced, Widow/Widower, Single

Adults, do you live alone: Yes No

For patients under 18: Do you live with: both parents who are married, both parents who are divorced, mom, dad, grandparent, aunt, uncle, court appointed guardian

I confirm that the above medical history is true to the best of my knowledge.

Signature of patient or guardian: _____ Date: _____

TWIN PEAKS DERMATOLOGY, PC
JOHN FUESTON, MD

DIPLOMATE AMERICAN BOARD OF DERMATOLOGY FELLOW AMERICAN ACADEMY OF DERMATOLOGY

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

OUR COMMITMENT TO YOUR PRIVACY:
Our practice is dedicated to maintaining the privacy of your Protected Health Information ("PHI"). In conducting our business we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are also required by law to provide you with this notice of legal duties and the privacy practices that we maintain in our practice concerning your PHI. By Federal and State Law we must follow the terms of the privacy practices that we have in effect at the time.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requires 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, 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 will not use or disclose your PHI except as described in this Notice. This Notice applies to all of the medical records generated by Twin Peaks Dermatology, PC as well as records we receive from other providers.

We may use and disclose your medical records for each of the following purposes:

- ***Treatment*:** Providing, coordinating, or managing health care and related services by one or more healthcare providers. Examples of this include referring you to another doctor, sending a prescription to your pharmacy, sending an order for bloodwork to a laboratory.

- ***Payment*:** This includes such activities as obtaining reimbursement for services, confirming coverage/eligibility with your insurance company, obtaining prior authorization for a procedure or visit or medication, billing or collections activities, demonstration of necessity of care, 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. We may use and disclose your PHI to third parties responsible for payment, such as family members, and to third parties that specialize in payment collection, such as our accounts receivable management company. We may also disclose your PHI to other health care providers and entities involved in your care that require information to assist in their billing and collection efforts.

- ***Health Care Operations*:** This includes business aspects of running our practice such as: customer service; conducting quality assessments and improvement activities; auditing functions such as medical reviews, legal services, and maintaining compliance programs; cost management analysis; employee review activities and training programs; accreditation, certification, licensing, or credentialing activities; business management and general administrative activities. An example of this would be new patient survey cards. In addition, we may disclose your protected health information to other health care providers and entities to assist in their health care operations.

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.

USES & DISCLOSURE IN CERTAIN SPECIAL CIRCUMSTANCES

- ***Research:*** Under certain circumstances, our practice may use and disclose your PHI to approved clinical research studies. While most clinical research studies require specific patient consent, there are some instances where a retrospective record review with no patient contact may be conducted by such researchers. For example, the research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for that same condition.
- ***Regulatory Agencies:*** Our practice may disclose your PHI to government and certain private health oversight agencies, e.g., the Department of Public Health and Environment or the Board of Medical Examiners, for activities authorized by law, including, but not limited to: licensure, certification, audits, investigations, and inspections. These activities are necessary to monitor compliance with the requirements of government programs.
- ***Law Enforcement/Litigation:*** Our practice may disclose your PHI for law enforcement purposes as required by law or in response to a court order or other process in litigation.
- ***Public Health:*** As required by law, our practice may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability. We are required to report the existence of a communicable disease to the Department of Public Health and Environment to protect the health and well-being of the general public.
- ***Workers' Compensation:*** Our practice may release PHI about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illnesses.
- ***Military/Veterans:*** If you are a member of the armed forces, our practice may disclose your PHI as required by military command authorities.
- ***Organ Procurement Organizations:*** To the extent allowed by law, our practice may disclose your PHI to organ procurement organizations and other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
- ***As Otherwise Required or Permitted By Law:*** Our practice will disclose your PHI in any situation in which such disclosure is required by law (e.g., child abuse, domestic abuse) or any other use permitted under HIPAA, its amendments, or regulations.
- ***Organizations assisting in disaster relief programs:*** Such as during floods and other natural disasters.
- ***Assisted Living and Long-Term Care Facilities:*** Facilities where you may reside and who are involved in your medical care.

The following uses 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.

You 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 PHI by alternative means or at alternative locations. For example, you may request that we contact you at work, by mail, through the online secured patient portal, or by secured fax.

- 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, or 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 is effective for all PHI created on or after September 23, 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 Practices 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 Practices 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 (Twin Peaks Dermatology P.C., Attn: Practice Compliance Officer- John Fueston, MD, 205 S. Main St., Ste E, Longmont, CO 80501) and with the Department of Health and Human Services, Office of Civil Rights (www.hhs.gov/hipaa). We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer (John Fueston, MD; office phone number: 303-485-8913) for more information, in person, or in writing.

Last updated: 2-12-18