



**Registration must be completed and returned to the office
PRIOR to scheduling an appointment!**

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, the right to understand and control how your protected health information (“PHI”) is used. HIPAA provides penalties for covered entities that misuse personal 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 record only for each of the following purposes: treatment, payment and health care operations.

- 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.
- 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 an insurance company a bill for a 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 the use of a quality of care survey card.
- 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.

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 operation;
- 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 may have the following rights with respect to your PHI:

- The right to inspect and copy your PHI, with 30 days' NOTICE.
- The right to amend your PHI.
- The right to receive an accounting of non-routine disclosures of your PHI.
- The right to request restrictions on certain uses and disclosures of PHI, with certain people, groups, or companies; however, we are not required to agree to any restriction.
- The right to obtain a paper copy of this notice from us upon request.
- The right to have an alternative method of communication, other than telephone call, for appointment reminders and other information.
- 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 is effective as of December 1, 2013, and it is our intention to abide by the terms of the Notice of Privacy Practice 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.

Contact the Privacy Officer, Dr. Miriam Kravitz, at 508-255-4050 for more information. This is a brief summary of your rights and protections under the HIPAA law; you can learn more at: www.hhs.gov/ocs/hipaa.



PATIENT REGISTRATION

Please complete **ALL** sections on **ALL** pages

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Patient Name: _____

Date Of Birth: _____ Social Security Number (SSN): _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ OK to leave detailed message? Y N

Cell Phone: _____ OK to leave detailed message? Y N

Would you like text message confirmations for your appointments? Y N

Email Address: _____ Receive email notifications? Y N

EMERGENCY CONTACT: _____

Phone: _____ Relationship to Patient: _____

If patient is under the age of 18, please indicate (*circle one*): **Parent** **Guardian** **Responsible Party**

Responsible Party Name: _____ DOB: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Email: _____

Name of Primary Care Physician (PCP) or Referring Provider: _____

City/State: _____ Phone: _____



Orleans Dermatology
& Laser Therapies

Insurance Information

Subscriber Name: _____ DOB: _____

Primary Plan Name: _____ ID#: _____

Secondary Plan Name: _____ ID#: _____

HIPAA Authorization/Notice of Privacy Practices

The Notice of Privacy Practices explains the ways in which Orleans Dermatology & Laser Therapies, LLC uses and discloses protected health information. A copy of the Notice of Privacy Practices has been made available to me for review and to take with me. I hereby authorize use of and disclosure of my medical information for treatment, billing and health care operations purposes in accordance with the Notice of Privacy Practices. I also authorize Orleans Dermatology & Laser Therapies, LLC to obtain my medication history from pharmacies or pharmacy benefit managers.

Name of Patient	Signature of Patient/Parent/Guardian	Date
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Payment Authorization

I understand that my health insurance plan may not be contracted with Orleans Dermatology & Laser Therapies, LLC. If the practice is not contracted with my particular health insurance plan; if my services are of a cosmetic or aesthetic nature, or determined by insurance company to be so, I understand that payment for services are expected at the time of my visit. If for any reason my payment is not made by a financial institution, I understand I am responsible for payment of my account within 30 days, and past due balance will be reported to a collection agency if not paid. I agree to pay all reasonable costs of collection, including attorneys' fees.

I understand that Orleans Dermatology & Laser Therapies, LLC does not contract with Mass Health or other Mass Connector carriers other than Neighborhood Health Plan. The 20% balance after Medicare will not be billed to Mass Health.

I understand that Orleans Dermatology & Laser Therapies, LLC does not guarantee reimbursement by insurance carriers. It is the responsibility of the patient to follow up with their insurer should claims reject.

Name of Patient	Signature of Patient/Parent/Guardian	Date
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This form should **NOT** be altered in any way
ALL paragraphs must be acknowledged and initialed in order to receive care at
Orleans Dermatology & Laser Therapies, LLC

Today's Date

Name

Date of Birth

Authorization to Leave Voice and Email Messages

I authorize Orleans Dermatology & Laser Therapies, LLC to leave voice or email messages on my home, cell or work telephone reminding me of appointments and other medical services for myself and/or my family members. I understand no message will be left regarding detailed information.

Initials _____

Patient Consent for Use of Photographs

I hereby give permission to and hold harmless Orleans Dermatology & Laser Therapies, LLC to take and use close-range photographs of any skin lesion(s), in the course of providing a medical examination and treatment, for medical management, educational and training purposes. Note that any and all personal identifiers will be removed. Our ability to track your skin conditions photographically allows us to eliminate unnecessary surgical procedures.

Initials _____

Permission to Speak

I authorize disclosure of my health information as described below and understand that this is voluntary. I understand that once disclosed by Orleans Dermatology & Laser Therapies, LLC to such person(s), we can no longer ensure confidentiality of the information. I understand that this authorization will expire in one (1) year.

Person or Providers

Relationship to Patient

Any Restrictions? Please Specify

I give Orleans Dermatology & Laser Therapies, LLC permission to release my medical/financial information to the following parties or entities if so needed:

Primary Care Provider (PCP): _____

Specialist: _____

Signature of Responsible Party

Date



No Show/Late Cancellation Policy

This policy has been established to help serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No shows and late cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No shows and late cancellations delay the delivery of health care to other patients.

A “no show” is missing a scheduled appointment. A “late cancellation” is failure to cancel an appointment at least 48 hours in advance of that office visit.

We understand that situations such as medical emergencies occasionally arise, when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

Effective July 1, 2015, A charge of \$50.00 will be assessed for each no show or late cancellation office visit appointment, if less than 48 hours notice is given. After the second no show, a letter will be sent advising that in 30 days you will be terminated from the practice and should seek alternative care.

Please understand that insurance companies consider this charge to be entirely the patient’s responsibility.

Signature

Date



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Name: _____ DOB: _____

Pharmacy: _____ Location?: _____

Past Medical History

(Do you have or have you had any of these conditions or received any of these treatments?):

- Anxiety
- Arthritis, Rheumatoid or Osteoarthritis
- Asthma
- Atrial Fibrillation
- Bipolar Disorder
- Bone Marrow Transplant
- Breast Cancer
- Cervical Cancer
- Chemotherapy Treatment
- Chronic Obstructive Lung Disease
- Colon Cancer
- Coronary Artery Disease
- COVID-19: If yes, when? _____
- Depression
- Diabetes Mellitus, Type: _____
- Diverticulitis
- Enlarged Prostate
- Gastric Reflux (GERD)
- Hearing Loss
- Hepatitis, Type: _____
- High Blood Pressure (Hypertension)
- HIV / AIDS
- High Cholesterol
- Hyperthyroidism
- Hypothyroidism
- Inflammatory Bowel Disease
- Kidney Disease, Stage: _____
- Kidney Stones
- Leukemia
- Lung Cancer
- Lymphoma, Type: _____
- Multiple Sclerosis
- Myocardial Infarction (Heart Attack)
- Ovarian Cancer
- Parkinson's Disease
- Pancreatic Cancer
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke / Cerebrovascular Accident
- Testicular Cancer
- Uterine Cancer

Other: _____

Past Surgeries

(Please note the year):

- Appendix: Appendectomy
- Bladder: Cystectomy, Cystopexy
- Breast: Biopsy (R, L, Both)
- Breast: Lumpectomy (R, L, Both)
- Breast: Mastectomy (R, L, Both)
- Breast: Reduction, Augmentation (R, L, Both)
- Colon: Colostomy
- Eye: Cataract Extraction (R, L, Both)
- Gallbladder: Cholecystectomy
- Heart: Valve Replacement
- Heart: Coronary Artery Bypass
- Heart: Transplant
- Heart: Cardiac Ablation (Balloon Procedure)
- Joint Replacement: Hip (R, L, Both)
- Joint Replacement: Knee (R, L, Both)
- Joint Replacement: Shoulder (R, L, Both)
- Intestines: Colectomy for Diverticuli
- Intestines: Hernia Repair
- Kidney: Biopsy
- Kidney: Transplant
- Kidney: Nephrectomy
- Ligaments/Tendons: Rotator Cuff (R, L, Both)
- Ligaments/Tendons: ACL of Knees (R, L, Both)
- Liver: Hepatectomy
- Liver: Transplant
- Ovaries: Oophorectomy (R, L, Both)
- Ovaries: Excision of Ovarian Cyst(s)
- Ovaries/Fallopian: Tubal Ligation
- Ovaries/Fallopian: Salpingo-Oophorectomy
- Pancreas: Pancreatectomy
- Prostate: Biopsy
- Prostate: Prostatectomy, TURP
- Rectum: Abdominoperineal Resection, ARP
- Rectum: Low Anterior Resection
- Skeletal: Bone Fracture - where? _____
- Skin: Biopsy
- Skin Excision: Precancerous Moles
- Skin Excision: Basal Cell Carcinoma
- Skin Excision: Malignant Melanoma
- Skin Excision: Squamous Cell Carcinoma
- Spleen: Splenectomy
- Testicles: Orchiectomy (R, L, Both)
- Tonsillectomy / Adenoidectomy
- Uterus: Myomectomy for Fibroids
- Uterus: Caesarean Section (C-Section)
- Uterus: Hysterectomy, Total or Partial

Do you use a cane, walker, or wheelchair? Y N Other: _____

Do you require assistance from a caregiver? Y N _____



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Name: _____ DOB: _____

Social History Details:

Smoking Status:

- Current every day smoker
- Current some day smoker
- Never smoker
- Former smoker
 - Date/Year Quit: _____

Alcohol Usage:

- None
- Less than 1 drink per day
- 1 - 2 drinks per day
- 3 or more drinks per day

How many times in the past year have you had five (5) or more drinks in a day for men, or four (4) or more drinks in a day for women OR for any adult older than 65?

Marital Status:

- Single
- Living Together
- Married
- Divorced
- Widowed

Do you feel safe at home?

Yes No

What is your Occupation / Workplace?

Approximate Height (feet/inches): _____

Approximate Weight (pounds): _____

Natural Eye Color: _____

Advance Care Questions:

- Do you have a healthcare proxy? Y N
 - Designee Name: _____
 - Designee Phone Number: _____
- Do you have a living will? Y N

Which statement(s) best reflects your wishes:

- Do Not Intubate:** I do not wish to have a breathing tube, even if it is necessary to save my life.
- Do Not Resuscitate:** If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.
- Full Cardiopulmonary Resuscitation:** I want full cardiopulmonary resuscitation efforts to be made.