Patient Information

Patient's Full Name_____ Sex _____

Street Address_____

City, State, Zip _____

Phone (home) _____ (work/cell)_____

Employer_____

Email Address _____

Date of Birth _____ Social Security Number _____

Marital Status _____ Referred by _____

**Due to Health Care Reform this information is now required for reporting purposes.*

Ethnicity _____ Race _____ Preferred Language_____

Insurance Information – Please present your insurance card

Primary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birth date _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone_____

Secondary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birth date _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone_____

I understand that regardless of my insurance status I am ultimately responsible for the balance of my account. I have read all of the information on BOTH sides of this sheet and have completed the above information. I certify this information is true and correct to the best of my knowledge. Grekin Skin Institute has permission to contact me by email. I further understand that if I consent to the photographing of skin conditions these may be used for educational, training and patient awareness purposes. Additionally, I hereby authorize the release of any protected health information necessary to process claims for medical services performed on me. I also request that payment be sent to the provider of services Dr. Steven K. Grekin, Dr. Don Collier, Dr. Wendy Lambert, Dr. Michelle K. Bruner, Dr. Michael W. Whitworth, Dr. Arathi Goldsmith, Dr. Jean M. Holland, Jan Prusinowski, PA-C, Jennifer Meitzner, NP, and Gail M. Oehmke, RN.

*** 24-hours is required for cancellations to avoid $50 collection fee ***

Signature_____ Date: _____

Updated _____ Date: _____

Updated _____ Date: _____

Grekin Skin Institute

About Financial Arrangements

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered unless we are aware you have insurance coverage for this particular visit. It is the patient/subscriber's responsibility to submit claims covered under any Master/Major medical policy, unless prior arrangements have been made with the office staff. Returned checks and balances older than 30 days may be subject to additional collection fees.

We participate with various insurance plans, accepting assignment of benefits. Please check with your insurance company to verify that the doctor you are seeing is a participating provider. Copayments, coinsurances, and deductibles remain your responsibility. It is the responsibility of the patient/subscriber to obtain any necessary referral forms or authorization numbers. If you fail to obtain these necessary forms/numbers you will be held responsible for your balance. Please be advised that our office takes, CASH, CHECKS, VISA, MONEY ORDER, MASTERCARD, DISCOVER, AND AMERICAN EXPRESS.

We are happy to process other insurance plans. You must realize however, that:

1) **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.**
2) **Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies which pay a percentage (such as 50% or 80%) of "U.C.R.". U.C.R. is defined as "Usual, Customary, and Reasonable" by most companies. This is a "schedule of fees" which bears no relationship to the current standard and cost of care in the area.**
3) **Not all services are a covered benefit on all contracts. Some insurance companies arbitrarily select certain services they will not cover.**

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Should problems arise affecting your timely payment of this account, we encourage you to contact the billing office promptly for assistance in working this out.

If you have any questions regarding the above information, please do not hesitate to ask us. We are here to assist you.

Dermatology Medical History

Patient: _____ Date: ____ /____ /____

Reason for today's visit: _____

Are you allergic to any medications? ❑ YES ❑ NO If yes, list below:
1. _____ 2. _____

Are you allergic to Latex? ❑ YES ❑ NO
Are you allergic to Lidocaine? ❑ YES ❑ NO

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

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

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

Lungs:	**YES**	**NO**
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑

Cardiovascular:	**YES**	**NO**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Irregular Heartbeat/Murmer	❑	❑
Blood clots	❑	❑
Pacemaker/Defibrilator	❑	❑

Other Systemic:	**YES**	**NO**
Diabetes	❑	❑
Thyroid Disease	❑	❑
Kidney	❑	❑
Bladder Infections	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Joint Pain	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ❑ YES ❑ NO If yes, _____
Has anyone in your family had skin cancer? ❑ YES ❑ NO If yes, _____
Do you have a history of any specific skin diseases? ❑ YES ❑ NO If yes, _____
Do you have problems with healing ❑ YES ❑ NO
Do you develop keloids (scars) after surgery ❑ YES ❑ NO
Do you bleed easily? ❑ YES ❑ NO
Do you develop skin rashes in reaction to ❑ Medications ❑ Food ❑ Environment? _____

Social History:

Do you drink alcohol? ❑ YES ❑ NO If YES _____ drinks per day
Do you use IV drugs? ❑ YES ❑ NO If YES, what? _____ How often? _____
Do you smoke? ❑ YES ❑ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS)? ❑ YES ❑ NO

Please answer the following questions:

(Women) Are you pregnant? ❑ YES ❑ NO First Day of Last Menstrual Cycle: ____ /____ /____

What is your occupation? _____ Hobbies? _____

Completed by: ❑ Patient
❑ Medical Assistant _____ Initials

_____ ____ /____ /____
Signed by Patient Date

_____ ____ /____ /____
Reviewed by Date

Patient Intake Form Meaningful Use Measures

Our practice is now using an electronic health record called DrFirst RcopiaMU. We are participating in the meaningful use program sponsored by the federal government. This is due to President Obama's Healthcare Reform. We are collecting this data to be compliant with the program in an effort to increase patient safety, improve patient care and create a complete patient record. We appreciate your assistance with providing our practice this information.

Please fill out completely

Full Name	
Date of Birth	
Gender	*Please indicate your gender (circle):* **Male** **Female**
Race	*Please indicate your race (circle):* **Other** **Black or African American** **American Indian or Alaska Native** **Native Hawaiian or Other Pacific Islander** **Asian** **White**
Ethnicity	*Please indicate your ethnicity (circle):* **Other** **Arab-American** **Hispanic/Latino** **Non-Hispanic/Latino**
Preferred Language	*Please select your preferred language (circle):* **English** **Chinese** **Arabic** **Spanish** **Japanese** **Asian/Pacific Island Language** **French** **Italian** **Other Indo-European Language** **Portuguese** **Russian** **Other (Please Specify)** _____
Smoking Status	*Please select your current smoking status (circle):* **Current every day smoker** **Current some day smoker** **Former smoker - Please list date range you smoked _____to_____** **Never smoked** **Smoker, current status unknown** **Secondhand Smoke**
Height & Weight	_____ **Feet** _____ **Inches** _____ **lbs**
Do you have any *medication* allergies? **Yes or No**	***If yes, what are you allergic to?*** _____
Are you taking any medications? **Yes or No** ***INCLUDING:*** **Supplements, vitamins or over-the-counter products**	***If yes, which medications?*** _____
Pharmacy Information	**Pharmacy Name:** _____ **Phone Number:** _____ **Cross Streets:** _____ **City:** _____

Office Use Only: _____ ***MA Initials*** **Date of Office Visit:** _____

Chart Number: _____ **Dr:** G B H W AG C L Un

Diagnosis: _____ _____

Steven K. Grekin, D.O.
Don U. Collier, D.O.
Wendy W. Lambert, D.O.
Michelle K. Bruner, D.O.
Michael W. Whitworth, D.O.

Arathi R. Goldsmith, D.O.
Jean M. Holland. M.D.
Jan Prusinowski, PA-C
Jennifer Meitzner. R.N.. N.P.-C.
Gail M. Oehmke. R.N.

Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

Dermatology Warren
A GREKIN SKIN INSTITUTE COMPANY

GREKIN SKIN INSTITUTE

13450 E. 12 Mile Road • Warren, MI 48088-3671 • Phone: (586) 759-5525 • Fax: (586) 759-4765

Individual Patient Authorization

This form is provided to confirm your authorization to use or disclose your protected health information for a special purpose.

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

I give my permission for my protected health information to be given to the person or persons listed below and as indicated in the Privacy Notice, which has been given to me. The information to be given is including, but not limited to labs, test results, diagnosis and/or information about my condition and/or treatment.

My information can be given only to the person or persons listed below

Name _____ **Relationship**_____ **Phone**_____

Name _____ **Relationship**_____ **Phone**_____

Name _____ **Relationship**_____ **Phone**_____

I understand that I may revoke this authorization at any time by giving a written notice to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any actions taken prior to receipt of my written notice to revoke this authorization.

I have had a chance to read and think about the content of this authorization form and I agree with the statements made in this authorization. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature _____ **Date** _____

Don U. Collier, D.O., P.C., F.A.O.C.D.
Board Certified in Dermatology
Wendy W. Lambert, D.O., P.C.
Michelle K. Bruner, D.O.
Board Certified in Dermatology

Steven K. Grekin, D.O., P.C., F.A.O.C.D.
Board Certified in Dermatology
Michael W. Whitworth, D.O.
Jean M. Holland, M.D.
Jan Prusinowski, P.A.-C.

Arathi R. Goldsmith, D.O., P.C.
Board Certified in Dermatology
Jennifer A. Meitzner, R.N., N.P.-C.
Gail M. Oehmke, RN
Cosmetic Consultant

NOTICE OF PRIVACY PRACTICES

For

Steven K. Grekin, D.O., Don U. Collier, D.O., Wendy W. Lambert, D.O., Michelle K. Bruner, D.O., Michael W. Whitworth, D.O., Arathi R. Goldsmith, D.O., Jean M. Holland, M.D., Jan Prusinowski, P.A.-C., Jennifer A. Meitzner, R.N., N.P.-C., Gail M. Oehmke, R.N.

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this notice while it is in effect. This notice takes effect 04/13/03 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 health information that we maintain, including health 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.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operation: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training programs, accreditation, certification, licensing or credentialing activities, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students who see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health 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 health information for any reason except those described in this notice.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health 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 health information based on a determination using our professional judgment, disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written consent.

Required By Law: We may use or disclose your health information without your consent or authorization in certain situations. These situations include; Required By Law; Public Health; Communicable Disease; Health Oversight; Abuse or Neglect; Food and Drug Administration; Legal Proceeding; Law Enforcement; Coroners, Funeral Directors, and Organ Donation; Research; Criminal Activity; Military or National Security; Workers' Compensation; Inmates; Required uses and Disclosure. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voice mail messages, letters).

Patient Rights

Following is a statement of your rights with respect to your protected health information.

Access: You have the right to look at or get copies of your health information, with limited exceptions. You must make a request in writing to obtain access to your health information. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

Disclosure Accounting: you have the right to receive a list of instances in which we or our business associates disclosed your health information, for purposes other than treatment, payment, healthcare operations and certain other activities for the last 6 years, but not before April 14, 2003. 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.

Restriction: You have the right to request that we place additional restrictions on our use or disclose of your health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must be in writing and must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another healthcare professional.

Alternative Communication: You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You must make this request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation of how payments will be handled under the alternative means or location you request. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively; i.e.; electronically.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny the request under certain circumstances. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.