RESET

Patient Information

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date ____/____/____

Patient Name _____
Last First M.I.

Date of Birth: ____/____/____ Age: ____ Biological Sex: ☐ Male ☐ Female Preferred Pronouns: ☐ He/Him ☐ She/Her ☐ They/Them ☐ Other: _____

Mailing Address _____
City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ e-mail: _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY (if different from patient)

Name: _____ Date of Birth: ____/____/____
Last First M.I.

Address: _____
City State Zip

Home Phone: _____ Work Phone: _____

Cell Phone: _____ e-mail: _____

INSURANCE COVERAGE - PRIMARY:

Insurance Co. Name: _____

Address of Claim Center: _____

_____
City State Zip

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ____/____/____

Policy #: _____ Group Name or #: _____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other _____

INSURANCE COVERAGE - SECONDARY:

Insurance Co. Name: _____

Address of Claim Center: _____

_____
City State Zip

Name of Policy Holder (Insured): _____

Policy Holder (Insured) Date of Birth: ____/____/____

Policy #: _____ Group Name or #: _____

Policy Type: ☐ HMO ☐ PPO

If patient is child, check relationship to insured: ☐ Mother ☐ Father ☐ Other _____

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form.

Thank you.

Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC

REFERRAL INFORMATION:

Patient Name:_____
Today's Date ____/____/____
Other family members that are patients of our practice_____
Referred by: _____

Primary Care Physician _____
Phone ( )_____

EMERGENCY CONTACT INFORMATION:

In case of Emergency, who should be notified?_____
Phone ( )_____
Relationship to patient: _____

Do you give our office permission to discuss your medical information with family members?
☐ YES ☐ NO If yes, please provide their names and phone numbers below.

Name: _____
Relationship: _____
Phone # (day): (_____)_____ Phone # (evening): (_____)_____

May we leave personal medical information on your answering machine or cell phone? ☐YES ☐NO
May we e-mail personal medical information to you? ☐ YES ☐ NO
E-mail address: _____

PAYMENT POLICY:

HMO, PPO or other managed care patients: You will be responsible for paying your annual deductible,copayment and charges for any non-covered, cosmetic services at the time of service.
Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 50% of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Responsible Party Signature _____
Date ____/____/___

RESET

Dermatology & Dermatologic Surgery Group of Northern Virginia,
BOARD CERTIFIED IN DERMATOLOGY

243 Church Street, NW, Suite 200-C
Vienna, VA 22180
Tel. 703-938-5700 Fax 703-938-4467

Date_____ **Name**_____ **Date of Birth**_____
LAST, FIRST, MI mo / day / year

REVIEWED BY STAFF_____

Past/family/social/history Circle and give details

Personal History: Eczema Asthma Hay fever/allergic rhinitis Psoriasis Multiple Sclerosis

Family History : Eczema Asthma Hay fever/allergic rhinitis Psoriasis Multiple Sclerosis

Occcupation_____ Hobbies_____

Use of sun screen_____ SPF_____ **Smoker** - Yes_____No____

History of Skin Cancer Melanoma Basal cell Squamous cell

History of Other Cancer_____metastasis_____

Family History of Skin Cancer Melanoma Non-Melanoma skin cancer

History of Hepatitis? **History of Blood Transfusion** **HIV/exposure**

Reaction/contact Dermatitis: Tape/Bandage Topical Antibiotic Other

Surgeries:

ROS PLEASE ANSWER YES OR NO to the Following - If YES - Circle and give details

YES	NO						
☐	☐	**Trouble Healing**	Thick Scar/Keloid				
☐	☐	**Immunosuppression**	Cause			Organ Transplant	
☐	☐	**Vision Problem**	Cataracts	Glaucoma	Glasses	Other vision problems	
☐	☐	**Hearing, Smelling, Swallowing, Dental/Mouth problems**				Hearing loss	
☐	☐	**Difficulty Breathing**	Asthma	Emphysema	Other		
☐	☐	**Urinary difficulty**	(Men) Prostate		Incontinence		
☐	☐	**Abdominal pain/Ulcer**	Blood in stool	Diarrhea	Other		
☐	☐	**Joint Pain**	Artificial Joints Knee ☐ Hip ☐		Muscle Weakness	Other	
☐	☐	**Enlarged Lymph Nodes**	Excessive Bleeding		Abnormal white blood cells		
☐	☐	**Irregular heart beat**	Chest Pain	Pacemaker /Defibrillator	Enlarged heart		
			High Blood Pressure	Murmur	Mitral Valve Prolapse	Blood Clots	
☐	☐	**Numbness/Loss of Sensation**	Loss of movement control		Headache		
☐	☐	**Abnormal Moods**	**Depression**	Anxiety	Learning Disability	Other	
☐	☐	**High Blood Sugar**	Enlarged Thyroid /Goiter		Excessive hair growth	Weight gain	
☐	☐	**Women**	Abnormal Cycle/Irreg. Menses	Infertillity	Heavy Bleeding	Post Menopausal	
			Pregnant?	Trying to conceive?	Breast Feeding?	Using contraception?	Breast Lumps Breast Cancer
			Current Medication(s) Oral	Iv	mg_____, Frequency_____		
			Names of meds_____				
☐	☐	**Latex (Rubber) Allergies**					
☐	☐	**Allergy to Anesthetic**					
☐	☐	**History of reaction to local anesthesia**					
☐	☐	**Medication Allergy/Reaction**					
☐	☐	**Vaccination for pneumonia**					
☐	☐	**Vaccination for flu**					
☐	☐	**Vaccination for COVID**					

Are you taking- **Aspirin** **Coumadin** **Ibuprofen** **Naproxen**

Do you - **faint easily** **Take antibiotic before dental procedures**

Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC

Linda Park Nims, M.D. F.A.A.D.
Rebecca R. Barry, M.D. F.A.A.D.
Kelley P. Redbord, M.D. F.A.A.D.

Board Certified Dermatologists

243 Church Street, NW, Suite 200-C
Vienna, Virginia 22180
Voice: 703-938-5700 Fax: 703-938-4467

Records Release

I do hereby authorize any release of medical information needed for the processing of insurance claims or laboratory billing.

Deemed Consent

I understand that Virginia Law provides that if my physician or any person employed by my physician is exposed to my bodily fluids in a way that might possibly transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to allow testing for HIV and/or hepatitis B or C infection. The results of this testing must be made available to the person who has been exposed to those body fluids.

Patient's Name (Print) _____

Signature _____ Date _____

Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC

Linda Park Nims, M.D. F.A.A.D.
Rebecca R. Barry, M.D. F.A.A.D.
Kelley P. Redbord, M.D. F.A.A.D.

Board Certified by the American Board of Dermatology

243 Church Street, NW, Suite 200-C, Vienna, Virginia
22180 Voice: 703:938-5700 Fax: 703-938-4467

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

MEDICATION ALLERGIES:

Contact Phone Number:_____ ☐ **Cell** ☐ **Home**
May we leave a voicemail on this number? ☐ Yes ☐ NO

Have you had a:	**Yes**	**No**
-COVID vaccine?	☐	☐
-Pneumonia vaccination?	☐	☐
-Flu vaccination this year?	☐	☐

Date of Most Recent: _____

Do you have a history of:		
-High Blood Pressure?	☐	☐
-Smoking/Vaping?	☐	☐
-Cancer other than Skin Cancer?	☐	☐
-Metastasis	☐	☐
-Where in your body?		

Primary Care Physician

_____

Preferred Pharmacy and Address

_____

Current Medications (**including vitamin supplements**)	Route Oral/Topical/IV/IM	Dosage (mg)	Times per day	Date Recorded	Date Verified

RESET

Dermatology & Dermatologic Surgery Group of Northern Virginia, PLLC

CONSENT TO TELE-HEALTH VISIT

• The purpose of this form is to get your consent for a Tele-Health visit at our practice.

• The purpose of this Tele-Health visit is to help in the care of your skin problem.

How Tele-Health Works

In a Tele-Health visit, you will interact in real time with your dermatologist via a secure, online videoconferencing technology. Alternatively, your dermatologist may give you the option of submitting a photo and chief complaint via secured electronic messaging. Your dermatologist has the right to discontinue or not provide a consult via videoconference or secure electronic messaging should the videoconference connection or the forwarded image be of poor quality. You maybe required to make an in-person appointment for further evaluation should this occur. Your dermatologist will look at the patient's skin during the videoconference or review the photos you submitted, then give you advice about your dermatologic condition and how to treat and take care of your condition. The information from your dermatologist will not be the same as a face-to-face visit because the dermatologist is not in the same room.

Pros, Cons and Your Options

With Tele-Health, your dermatologist will advise you based on viewing your condition during a videoconference or based on the photos submitted electronically. Sometimes a face-to-face follow-up visit with your dermatologist may still be needed. If you do not come into the office for an in-person visit, your dermatologist's advice will be sole based on viewing your skin condition during the videoconference or on the information and images provided by you electronically. In the absence of an in-person physical evaluation, your dermatologist may not be aware of certain facts that may limit or affect her assessment or diagnosis of your condition and recommended treatment. It is possible that there will be errors or deficiencies in the transmission of the images of you skin condition during the videoconference or in the photos submitted electronically that may impede the dermatologist's ability to advise you about your condition. Also, vey rarely, security measures can fail to protect your personal information,, but the company that is providing the technology for your Tele-Health visit has extensive security measures in place to prevent such failures from happening.

Presence of Others During Tele-Health Visit

People other than your doctor may be a part of the patient's care and be present during a Tele-Health visit. These people may be nurses or medical assistants. Anyone that is part of the Tele-Health team will be supervised by your dermatologist, and the final recommendations about your care will come from your dermatologist. Also, non-medical people may help to set up the Tele-Health equipment. You may ask for persons other than your dermatologist to leave the room if you are uncomfortable having them participate in your Tele-Health visit.

Medical Information and Records

All federal and state laws covering access to your medical records (and copies of medical records) also apply to Tele-Health. No one other than the health care team described above can view your photos or information unless you agree to give them access.

Privacy

All information given at your Tele-Health visit will be maintained by the doctors, other health care providers, and health care facilities involved in your care and will be protected by federal and state privacy laws.

Your Rights

You may opt out of the Tele-Health visit at any time. This will not change your right to future care or health benefits.

RESET

Waiver/Release

By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your Tele-Health visit or in the electronic submission of your images to your dermatologist and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release you dermatologist and her institution or practice from any claims you may have about this advice or the Tele-Health visit generally. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any Tele-Health visits that occur during the lone-year period after your signature.

My doctor or medical assistant has talked with me about the Tele-Health visit. I have had the chance to ask questions and all of my questions have been answered. I have read this form, under-stand the risks and benefits of the Tele-Health visit, and agree to a Tele-Health visit under the terms explained above.

_____

Print Patient Name

_____ **OR** _____

Patient Signature

Signature of Patient's Representative

_____

Relationship of representative to patient

_____

Signature of Witness
(required if patient is a minor or unable to sign)

_____

Date Signed

Refusal: I do not want to be a part of a telehealth visit. _____

Signature

EXHIBIT P3: (2 pages)

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 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.

- 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

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 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 is effective as of 09/01/2013 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 (Dr. Linda P. Nims-703-938-5700) for more information.

RESET

Dermatology and Dermatologic Surgery Group of Northern Virginia, PLLC **(D&DSG)**

EXHIBIT P4:

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am a patient of D&DSG. I hereby acknowledge receipt of D&DSG ‘s Notice of Privacy Practices.

Name [please print]: _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____
[patient name].

I hereby acknowledge receipt of D&DSG ‘s Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: _____

Date: _____