SKIN SOLUTIONS, LLC

Dr. Eduardo Rivera M.D.

122 Demaree Drive
Madison, IN 47250
(812)265-9191

2510 Sandcrest Drive
Columbus, IN 47203
(812) 348-1000

Patient's Information (Please fill in all blanks)

Name: Last _____ First _____Middle _____ **Social Security #**_____

Address_____ **Date of Birth**: _____

City_____ State_____ Zip Code_____ **Marital Status**: (circle) S M Other: _____

Sex: (circle) M F **Employer Name**:_____ Job Title:_____ Other:_____ Student Status: Full __ Part __

Race: (circle) American Indian or Alaska Native Asian Black or African American

Hispanic or Latino Native Hawaiian or Other Pacific Islander White or Caucasian

Place of Birth: City:_____ State:_____ Country:_____ (New Government Regulation)

Cell phone _____ **Land line**_____ **E-mail** _____

Primary Care Doctor (First and Last Name) _____ **Referring Doctor** (First and Last Name)
_____

_____ _____

Primary Pharmacy Name and Location **Secondary Pharmacy Name and Location**

HIPPA

Do you give our office permission to release medical information? ☐ Yes ☐ No
If yes, whom do you wish this to be released? (List name, relationship, phone #)

_____

MESSAGING

Do you give our office permission to leave a Detailed message? ☐ Yes ☐ No
Do you give our office permission to leave information with family member? ☐ Yes ☐ No
If yes, who can we leave information with? (List name, phone #)_____

ADVANCED CARE PLAN or DESIGNATED DECISION MAKER (HEALTH CARE PROXY)

_____

EMERGENCY CONTACT INFORMATION (Someone outside the house, if possible)

Name_____ Relationship_____

Address_____ City _____State_____ Zip Code _____

Primary phone_____ Alternate phone_____

IF PATIENT IS A MINOR (Fill in the blanks that apply)

Guardian's Name_____ before 5 p.m. phone _____ After 5 p.m. phone_____

How did you hear about our office? _____

HISTORY AND INTAKE FORM

Past Medical History: (please check all that apply)

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
  Last A1C _____
  Last Foot Exam _____
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE

Other:_____

The CDC recommends everyone over the age of 2 get a flu vaccine during flu season (October-January)

Have you receive a flu vaccine? Yes / No Have you received a pneumonia vaccine? Yes / No
Have you received the Zoster (Shingles) Vaccination? Yes / No

Past Surgical History: (please check all that apply)

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Breast: Breast Biopsy
- ☐ Breast Lumpectomy (Both Breasts)
- ☐ Breast Lumpectomy (Right Breast)
- ☐ Breast Lumpectomy (Left Breast)
- ☐ Breast Mastectomy (Both Breasts)
- ☐ Breast Mastectomy (Right Breast)
- ☐ Breast Mastectomy (Left Breast)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replacement
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Both)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Right)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE

Other: _____

_____

Skin Disease History: (please check all that apply)

☐ Acne	☐ Dry Skin	☐ Poison Ivy
☐ Actinic Keratoses	☐ Eczema	☐ Precancerous Moles
☐ Asthma	☐ Flaking or Itchy Scalp	☐ Psoriasis
☐ Basal Cell Skin Cancer	☐ Hay Fever/Allergies	☐ Squamous Cell Skin Cancer
☐ Blistering Sunburns	☐ Melanoma	☐ NONE

Other:_____

_____

Do you wear Sunscreen? ☐ Yes ☐ No

If yes, what SPF? _____

Do you tan in a tanning salon? ☐ Yes ☐ No

Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, which relative(s)? _____

Medications: *REQUIRED FIELD* Please enter all current medications

_____

_____

_____

Permission to upload your medication history into your chart if available electronically?

☐ Yes ☐ No

Allergies: (Please enter all allergies)

_____

_____

_____

PLEASE ANSWER THE FOLLOWING QUESTIONS:

Do you take oral antibiotics before you go to the dentist? Yes No
Do you have a pacemaker OR defibrillator? _____
Are you pregnant? _____ Are you planning to get pregnant? _____ If so when? _____
Are you on birth control pills? _____ Are you breast feeding? _____

Do you currently take a blood thinner such as?
Aspirin, Coumadin, Plavix, Advil, Motrin, Vitamin E, Gingko, or Garlic Supplements? _____

SOCIAL HISTORY
Do you live alone? Y N
Do you drink alcohol? Y N if yes How Much (Oz/week)? _____
Do you smoke or chew tobacco? Y N if yes # times/day? _____# of years? _____ Never Smoked _____
If you currently smoke, we recommend that you take steps to quit. If you would like more information about quitting smoking, please inquire during your visit.
Caffeine? Y N if yes Cups/Day? _____
Regular Exercise? Y N if yes how often _____
Street Drugs? _____
Occupation? _____ Hobbies and leisure activities _____

Do you feel safe at home? Y N

Do you drive during the day? Y N

Do you drive during the night? Y N

(Family History)

PLEASE CHECK THE FOLLOWING

	Melanoma	**Psoriasis**	**Eczema**	**Allergies**	**Asthma**	**Alopecia** (Hair loss)	**Diabetes** (Type 1 or 2)
Mother							
Father							
Sister							
Brother							
Daughter							
Son							

Skin Solutions LLC
Eduardo Rivera, M.D.

Please fill in all blanks so that we may properly bill your insurance.

Primary Insurance Information

Insurance Company Name_____ Policy/ID#_____

Group #_____ Patient relationship to Policy Holder_____

Policy Holder Name

Last _____ First _____ Middle_____ Employer_____

Home Address_____ Address _____

City _____State_____ Zip_____ City_____

Primary phone _____Alternate phone_____ State _____ Zip_____

Date of Birth_____ Sex: M F (circle)

Secondary Insurance Information

Insurance Company Name_____ Policy/ID#_____

Group #_____ Patient relationship to Policy Holder) _____

Secondary Insurance Policy Holder

Last _____ First _____ Middle_____ Employer_____

Home Address_____ Address _____

City_____ State_____ Zip_____ City_____

Primary phone _____Alternate phone_____ State _____ Zip_____

Date of Birth_____ Sex: M F (circle)

Skin Solutions LLC
Eduardo Rivera, M.D.

PAYMENT IS REQUIRED AT TIME OF SERVICE
UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
We accept payment in the form of cash, check or charge.

You will be required to furnish us with your insurance card(s) so a photocopy can be added to your record. Your co-pay and deductibles will be verified with your insurance company prior to your appointment. As a courtesy to you, our office will file a claim to your insurance provider(s). By doing so you are authorizing us to release medical information necessary to process any claim submitted to your insurance company on your behalf and also authorize the direct payment of surgical/medical benefits to the physician for the services rendered by him in person or any person under his supervision. A photocopy of these assignments shall be valid as the original.

Should the account be referred for collection, the undersigned shall pay any past due sums including reasonable attorney, court costs, and a collection fee in the amount of $100.00. All unpaid accounts bear interest at the statutory amount of 8%. The undersigned recognizes that all treating health care providers furnishing services to the patient may send a separate statement or account from/for each such health care provider.

Your signature below signifies that you will comply with the terms of your insurance coverage including having an appropriate referral from your primary care provider and paying the co-pay and plan percentage at time of service, as well as being responsible to pay for all services that your insurance company deems a "non-covered" service. Should the account be referred for collection, the undersigned shall pay any past due sums including reasonable attorney's fees, court costs, and a collection fee in the amount of $100.00. All unpaid accounts bear interest at the statutory amount of 8%. The undersigned recognizes that all treating health care providers furnishing services to the patient may send a separate statement or account from/for each such health care provider.

I authorize the physicians of Skin Solutions, LLC/Madison Dermatology LLC and/or any person under his/her supervision to examine and treat me and I understand that it is medically important to follow up with another appointment if I am instructed to do so by the physicians and/or physician assistant.

I authorize the physicians of Skin Solutions, LLC/Madison Dermatology LLC and/or any person under his/her supervision to photograph the operation or procedures to be performed, including appropriate portions of my body for medical, scientific or educational purpose.

Skin Solutions LLC
Eduardo Rivera, M.D.
Medicare

I certify that the information given by me in applying for payment is correct.
I request that payment of authorized benefits be made on my behalf.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Skin Solutions, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations.

I acknowledge that I have reviewed and either received a copy of the Notice of Privacy document or I was offered a copy of said document and I willingly refused the copy. I acknowledge that a copy of the Notice of Privacy document will always be available for my inspection at my request. Skin Solutions, LLC reserves the right to revise its Notice of Privacy Practices document at any time.

With my consent, Skin Solutions, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminders, insurance items, any calls pertaining to my clinical care including laboratory results among others.

With my consent, Skin Solutions, LLC may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment and health care operations. Such as appointment reminder cards, patient statements among others.

I have the right to request that Skin Solutions, LLC restrict how it uses or discloses my protected health information to carry out treatment, payment, and health care operations. This practice is not required to agree to my restrictions. If it does agree, it is bound by this agreement. By signing this form, I am consenting to Skin Solutions, LLC the use and disclosure of my protected health information to carry out treatment, payment, and health care operations.

I may revoke consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Skin Solutions, LLC and Madison Dermatology, LLC may decline to provide treatment to me.

I acknowledge that I have reviewed and either received a copy of the Consent of Use and Disclosure of Protected Health Information document or I was offered a copy of said document and I willingly refused the copy. I acknowledge that a copy of the Consent of Use and Disclosure of Protected Health Information document will always be available for my inspection at my request.

Skin Solutions LLC
Eduardo Rivera, M.D.

Notice of Privacy

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU ACCESS THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY

1. **How we may use and disclose your health information.** We use health information about you for treatment, to get paid for treatment, for administrative purposes, and to evaluate the quality of care that you receive. Your health information may be shared with other providers to whom you are referred or who referred you to our practice. We may use and disclose your health information to contact you via phone or mail about your up- coming appointment or in reference to items that assist the practice in carrying out treatment, payment or healthcare operations. We will disclose your health information when we are required to do so by federal, state or local law enforcement agencies as well as, when ordered by the court. If you are an inmate of a correctional facility or under the custody of a law enforcement official, we may disclose your health information to the institution or official in order to provide you with medical services, protect you or others or to ensure the safety of the facility to which you return. We may disclose your health information as it relates to a workers compensation claim or FMLA. We may also disclose your health information to your employer if the health care services we provided to you were at the request of your employer in order to carry out a workers compensation claim. Information may be shared by paper, mail, fax or other methods. We may disclose your health information for several reasons, but beyond those situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses and disclosures.
2. **Your rights.** In most cases, you have the right to look at or get a copy of your health information that we use to make decisions about your care. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect or information is missing, you have the right to request that we correct the existing information or add the missing information.
3. **Our legal duty.** We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policy, we will change our notice and post the new notice conspicuously in the waiting room. You can also request a copy of our Notice of Privacy at any time by contacting the privacy officer listed below. For information about our privacy policies, contact: Kelli Crain, practice manager/privacy officer, 2510 Sandcrest Drive, Columbus, IN. 47203, 812-348-1000.
4. **Privacy complaints.** If you are concerned that we have violated your privacy rights, our privacy policies, or if you disagree with a decision we made about access to your health information, you may contact Kelli Crain, practice manager/privacy officer, 2510 Sandcrest Drive, Columbus, IN. 47203, 812-348-1000. You also may send a written complaint to the U.S. Department of Health and Human Services.

SKIN SOLUTIONS, LLC

Dr. Eduardo Rivera M.D.

122 Demaree Drive
Madison, IN 47250
(812)265-9191

2510 Sandcrest Drive
Columbus, IN 47203
(812) 348-1000

MISSED APPOINTMENT POLICY

We are experiencing a significant problem with patients failing to keep their scheduled appointments. This prevents patients who need to be seen from having an appointment. Their care must be delayed while many "missed" appointment slots sit empty. To improve this situation, we are going to begin charging a fee to any patient that misses a scheduled appointment.

It is our sincere hope that all patients keep their appointments, but if they cannot, we ask that they be courteous and allow us at **least 24 hours** notice so that another person in need of dermatologic care may be seen.

Effective January 27, 2020, it will be the policy of Skin Solutions, LLC that patients missing scheduled appointments for office visits or procedures will be charged a "missed appointment" fee.

The guarantor will be billed directly.
(A claim will not be filed with the patient's insurance carrier/supplier/company)

- **All future appointments will be cancelled and no further appointments will be made for the patient until the assessed fee has been paid.**
- **Occurrences accrue within one year**

Physician / Physician Assistant
Charges for cancellations within 24 hours of your appointment time or "no shows" are as follows:

- **First Occurrence: $25 per 15 minutes blocked**
- **Second Occurrence & thereafter: $50 per 15 minutes blocked**

Cosmetic Appointments with Physician, Physician Assistant or Esthetician

- **Your cosmetic deposit will be retained**

Certain exceptions may apply. Practice dismissals are at the provider's discretion.

☐ **I would like to have a credit card saved on file for future services (See Back)**

I have read this new policy as stated above and have had an opportunity to have my questions answered.

Patient Name _____ Relationship to patient_____

Signature_____ Date_____

SKIN SOLUTIONS, LLC
Dr. Eduardo Rivera M.D.

122 Demaree Drive
Madison, IN 47250
(812)265-9191

2510 Sandcrest Drive
Columbus, IN 47203
(812) 348-1000

Credit Card Authorization

I, _____, give Skin Solutions, LLC the authorization to charge my credit card as noted in the missed appointment policy for each missed appointment where 24 hour notice is not given. I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, deposits, and fees).

I understand that I may revoke this agreement at any time by providing a request in writing.

Name on Card: _____

Card Number: _____

Expiration Date: _____ CVC: _____

Street Address: _____

_____

Zip Code: _____

Email for receipt: _____

Patient Name (Printed) _____

Patient/Guardian Signature: _____