Mullick Dermatology

Patient Registration

Last Name_____ First Name_____ M.I._____

Preferred Name _____ Date of Birth _____ Age _____

Social Security Number _____Marital Status _____Sex Female Male

Street Address_____

City, State, Zip_____

Cell Phone _____ Home Phone _____

Employer_____ Email Address_____

Guarantor/Financially Responsible Party

Last Name _____ First Name _____Phone Number _____

Street Address _____

City, State, Zip _____

Insurance Information

Primary	**Secondary**
_____ Name of Insurance Company	_____ Name of Insurance Company
_____ Address	_____ Address
_____ City, State, Zip	_____ City, State, Zip
_____ Policy Holder's Name	_____ Policy Holder's Name
_____ Policy Holder's Date of Birth	_____ Policy Holder's Date of Birth
_____ Policy Holder's Address	_____ Policy Holder's Address
_____ ID Number	_____ ID Number
_____ Group Name	_____ Group Name
_____ Group Number	_____ Group Number

I authorize Mullick Dermatology PLLC to release medical information necessary to process insurance claims. I further authorize payment of medical benefits directly to the physician or supplier of services rendered. I certify the information I provided on this form is correct to the best of my knowledge.

_____ _____

Patient or Parent/Guardian Signature Date

Mullick Dermatology
Patient Medical History

Name _____ Date of Birth_____

Referring Physician. Full Name and Fax Number _____

Primary Care Physician. Full Name and Fax Number (if different than above)_____

If you are a new patient, how did you hear about us (google, referral from doctor, friend, etc)? _____

I give permission for the clinic to leave voicemails about my protected health information including lab results on my given phone number(s) and I understand that these are not private line. YES or NO

I give permission to clinic to discuss with individuals listed my protected health information and billing. List full name of individuals, relationship, and telephone number. _____

_____

Preferred Pharmacy. Name, Cross Street/Street Name, and Phone Number _____

_____

Current Medications. List name, dosage, and frequency._____

_____

_____

_____

Allergies. List name and reaction._____

Past Medical History. List all medical conditions and surgeries. (Please continue to back of page if not enough space.)

_____

_____

_____

Family Medical History. List conditions and family member affected. _____

_____

_____

_____

Social History

Do you use tobacco? Mark one: ___ Never used tobacco ___ Current tobacco user ___ Previous tobacco user
If male, have you had 5 of more drinks in a single day more than once in the past year? YES or NO
If female, have you had 4 or more drinks in a single day more than once in the past year? YES or NO

Review of Symptoms. Circle all that apply to symptoms you are currently having.

(*Constitutional*) fever, fatigue
(*Eyes*) vision problems
(*ENT*) nosebleeds, nasal discharge
(*Cardiovascular*) chest pain, palpitations, syncope (fainting)
(*Respiratory*) shortness of breath, orthopnea (difficulty breathing while lying flat)
(*Gastrointestinal*) abdominal pain, vomiting, nausea
(*Genitourinary*) dysuria (pain with urination), urinary incontinence
(*Musculoskeletal*) muscle aches, joint pain
(*Integumentary*) skin lesions, rash, unexplained itching
(*Neurological*) dizziness, recent seizure
(*Psychiatric*) emotional problems
(*Endocrine*) hot flashes, polyuria (too frequent urination), polydipsia (need to drink water too frequently),
(*Heme/Lymph*) easy bleeding, easy bruising

I agree that the information provided is true and complete.

Patient or Parent/Guardian Signature_____ Date_____

Mullick Dermatology

Name_____ Date of Birth _____

I agree that I currently have no symptoms of cough, fever, shortness of breath, have not been exposed to anyone with Covid-19, nor have I tested positive for Covid-19 in the past 2 weeks.

_____ _____

Patient or Parent/Guardian Signature Date

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Patient Name _____ Date of Birth _____

Mullick 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 REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act (HIPAA; "Act") of 1996, revised in 2013, requires us as your health care provider to maintain the privacy of your protected health information, to provide you with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. We are required to maintain these records of your health care and to maintain confidentiality of these records.

The Act also allows us to use your information for treatment, payment, and certain health operations unless otherwise prohibited by law and without your authorization.

- Treatment: We may disclose your protected health information to you and to our staff or to other health care providers in order to get you the care you need. This includes information that may go to the pharmacy to get your prescription filled, to a diagnostic center to assist with your diagnosis, or to the hospital should you need to be admitted. If necessary to ensure that you get this care, we may also discuss the minimum necessary with friends or family members involved in your care unless you request otherwise.
- Payment: We may send information to you or to your health plan in order to receive payment for the service or item we delivered. We may discuss the minimum necessary with friends or family members involved in your payment unless you request otherwise.
- Health operations: We are allowed to use or disclose your protected health information to train new health care workers, to evaluate the health care delivered, to improve our business development, or for other internal needs.
- We are required to disclose information as required by law, such as public health regulations, health care oversight activities, certain law suits and law enforcement.

Certain ways that your protected health information could be used disclosed require an authorization from you: disclosure of psychotherapy notes, use or disclosure of your information for marketing, disclosures or uses that constitute a sale of protected health information, and any uses or disclosures not described in this NPP. We cannot disclose your protected health information to your employer or to your school without your authorization unless required by law. You will receive a copy of your authorization and may revoke the authorization in writing. We will honor that revocation beginning the date we receive the written signed revocation.

You have several rights concerning your protected health information. When you wish to use one of these rights, please inform our office so that we may give you the correct form for documenting your request.

- You have the right to access your records and/or to receive a copy of your records, with the exception of psychotherapy notes. Your request must be in writing, and we must verify your identity before allowing the requested access. We are required to allow the access or provide the copy within 30 days of your request. We may provide the copy to you or to your designee in an electronic format acceptable to you or as a hard copy. We may charge you our cost for making and providing the copy. If your request is denied, you may request a review of this denial by a licensed health care provider.
- You have the right to request restrictions on how your protected health information is used for treatment, payment, and health operations. For example, you may request that a certain friend or family member not have access to this information. We are not required to agree to this request, but if we agree to your request, we are obligated to fulfill the request, except in an emergency where this restriction might interfere with your care. We may terminate these restrictions if necessary to fulfill treatment and payment.

- We are required to grant your request for restriction if the requested restriction applies only to information that would be submitted to a health plan for payment for a health care service or item for which you have paid in full out-of-pocket, and if the restriction is not otherwise forbidden by law. For example, we are required to submit information to federal health plans and managed care organizations even if you request a restriction. We must have your restriction documented prior to initiating the service. Some exceptions may apply, so ask for a form to request the restriction and to get additional information. We are not required to inform other covered entities of this request, but we are not allowed to use or disclose information that has been restricted to business associates that may disclose the information to the health plan.
- You have the right to request confidential communications. For example, you may prefer that we call your cell phone number rather than your home phone. These requests must be in writing, may be revoked in writing, and must give us an effective means of communication for us to comply. If the alternate means of communications incurs additional cost, that cost will be passed on to you.
- Your medical records are legal documents that provide crucial information regarding your care. You have the right to request an amendment to your medical records, but you must make this request in writing and understand that we are not required to grant this request.
- You have the right to an accounting of disclosures. This will tell you how we have used or disclosed your protected health information. We are required to inform you of a breach that may have affected your protected health information.
- You have the right to receive a copy of this notice, either electronic or paper or both.
- You have the right to opt out of fund raising communications.

If you have any questions about our privacy practices, please contact our Privacy Officer at the number below.

You have the right to file a complaint with us or with the Office for Civil Rights. We will not discriminate or retaliate in any way for this action. To file a complaint, please contact the applicable party:

Katie Daugherty
Phone number: 901-572-0005
Fax number: 901-572-1102

Office for Civil Rights
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

We are required to abide by the policies stated in this Notice of Privacy Practices, which became effective on 01/01/2020.

I acknowledge receipt of Mullick Dermatology's Notice of Privacy Practices.

_____ _____

Patient or Parent/Guardian Signature Date

Patient Name _____ Date of Birth_____

Mullick Dermatology

"No Show" and "Cancellation" Policy & Procedure for Office Visits, Procedures & Surgery

At Mullick Dermatology, our goal is to provide quality dermatological care in a timely manner. We have implemented a no show and cancellation policy which enables us to better utilize available appointments for our patients in need of dermatological care. The following policy is with regard to patients who fail to keep their scheduled office visit appointment, procedure appointment, or scheduled surgery appointment.

Please be courteous and call Mullick Dermatology promptly if you are unable to attend an appointment. The time will be reallocated to someone who is in urgent need of treatment. Available appointments are in high demand and your early cancellation will give another person the possibility to have access to timely dermatological care.

- Patients who fail to show for their scheduled appointment or did not notify the office at least 24 hours prior to their scheduled appointment time shall be subject to a "No Show/Cancellations" fee of $25.00. In the event of an actual emergency and prior notice could not be given, consideration will be given and a one-time exception may be granted.
- Patients who fail to show for their scheduled office surgery or procedure (excision or filler) appointment or did not notify the office at least 48 hours prior to their scheduled appointment time shall be subject to a "No Show/Cancellation" fee of $50.00.
- These fees are not covered by insurance and are therefore the sole responsibility of the patient.

How to Cancel Your Appointment

To cancel or reschedule your appointments call Mullick Dermatology at 901-572-0005. If you have any trouble getting through, you can leave a message with your name, appointment date, and cancellations reason or request for rescheduling.

_____ _____

Patient or Parent/Guardian Signature Date