200 Silver Street, Suite 106 – Agawam, MA 01001 – Phone: 413-341-5350 – Fax: 413-341-5335 – www.hillsidederm.com

Thank you for choosing Hillside Dermatology as your healthcare provider. We're committed to keeping you healthy and giving you the confidence to look and feel your best. At Hillside Dermatology, we believe an exceptional provider-patient relationship is essential for your continuing healthcare needs. You can help develop your relationship with us by making sure all the demographic information and medical history you provide to us is filled out completely and accurately. If you have any questions about the information we're requesting, please ask our staff to assist you.

Reason for visit ____ **Today's date** _____/_____/________

Is your current skin condition (please circle): ☐ Bleeding ☐ Itching ☐ Painful ☐ Growing ☐ Changing

Duration of skin condition: ____

Have you tried any medications in the past for your current condition? ☐ *Yes* ☐ *No*

If Yes, please list:

____

For females: Having periods? ☐Yes ☐No **Are periods regular? ☐Yes ☐ No** **Are you pregnant? ☐Yes ☐No**

Patient's Name _______________________________________ **Date of Birth** ______/______/__________

Address ____

(Street) (Apartment Number)

____

(City) (State) (Zip Code)

Mobile Tel # ____________________ **Home Tel #** ____________________ **Work Tel #** ____________________

Email Address ____ *Providing us with your email address will give you access to a patient portal where you can update your medical records, access test results, and send us private messages.*

Preferred Method of Contact ☐ Mobile phone ☐ Home phone ☐ Work phone ☐ Email

Gender ☐Male ☐ Female ☐ Other: __________________________

Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Other __________

Language ☐ English ☐ Spanish ☐ Farsi ☐ Portuguese ☐ Other ________________________

Work status ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

(Please complete the information on the back)

Occupation ____________________________________ **Employer** _______________________________________

Do you have a Primary Care Physician? ☐ Yes ☐ No

Primary Care Physician's Name ______________________________ **Telephone #** ______________________________

Referring Physician Name __________________________________ **Telephone #** ______________________________

Would you like us to send a summary of your visit to your Primary Care Physician? ☐ **Yes** ☐ **No**

Would you like us to send a summary of your visit to your Referring Physician? ☐ Yes ☐ No

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Primary Insurance

Insurance Company _____________________________

Member ID ____________________________________

Policy Holder

Name ______________________________________

Policy Holder Date of Birth ___/___/______

Secondary Insurance

Insurance Company _______________________________

Member ID _______________________________________

Policy Holder

Name ____

Policy Holder Date of Birth ___/___/______

PHARMACY INFORMATION

Preferred Pharmacy Name __________________________________ **Telephone** _______________________________

Street Address ____

City _________________________ **State** ____ **Zip Code** _____________

HEALTH HISTORY

Cancer (other than skin cancer)	☐ *Yes*	☐ *No*
Asthma	☐ *Yes*	☐ *No*
Anesthetic Complications	☐ *Yes*	☐ *No*
Autoimmune Disease	☐ *Yes*	☐ *No*
HIV/ AIDS	☐ *Yes*	☐ *No*
Hepatitis C / Liver Disease / Thyroid Disorders	☐ *Yes*	☐ *No*
Diabetes	☐ *Yes*	☐ *No*
Kidney Disease	☐ *Yes*	☐ *No*
High Blood Pressure	☐ *Yes*	☐ *No*
Heart Attack or Stroke	☐ *Yes*	☐ *No*
Artificial Heart Valve Pacemaker/ Defibrillator	☐ *Yes*	☐ *No*
Organ/Bone Marrow Transplant	☐ *Yes*	☐ *No*
Artificial Joint within the last 6 months	☐ *Yes*	☐ *No*

If you answered YES to any of the above, please explain: -

____

____

SURGICAL HISTORY

Please list any surgeries that you have had: ____

____

SKIN HISTORY

Have you ever been seen by a dermatologist? ☐ Yes ☐ No

If yes, have you been treated by a dermatologist in the past year? ☐ Yes ☐ No

What was the purpose of your most recent visit? ____

Have you ever had a full body skin exam? ☐ Yes ☐ No

If yes, when was your last full body exam? ________________________

(Please complete the information on the back)

Please select any of the following skin conditions you have ever had.

- ☐ **Acne**
- ☐ **Actinic Keratosis**
- ☐ **Blistering sunburns**
- ☐ **Dry skin**
- ☐ **Childhood Eczema/Eczema**
- ☐ **Flaking/Itchy scalp**
- ☐ **Hay Fever/Allergies**
- ☐ **Melanoma**
- ☐ **Poison Ivy**
- ☐ **Precancerous/Dysplastic moles**
- ☐ **Psoriasis**
- ☐ **Keloids**
- ☐ **Other:** _____________________________
- ☐ **None (I have none of these skin conditions)**

Have you ever had a Basal Cell Skin Cancer? ☐ Yes ☐ No If yes, indicate location/date ______________________

Have you ever had a Squamous Cell Skin Cancer? ☐ Yes ☐ No If yes, indicate location/date __________________

Have you ever had a Melanoma? ☐ Yes ☐ No If yes, indicate location/date ______________________

Did you have a sentinel lymph node biopsy? ☐ Yes ☐ No

If yes, do you have routine scans (x-ray, CT scan, PET scan) ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative? ______________________

Do you wear sunscreen? ☐ Yes ☐ No If yes, what SPF? _________

MEDICATIONS

Please list all current medications you are taking (include vitamins and herbal supplements).

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

_______________________________________ _______________________________________

MEDICATION ALLERGIES & OTHER ALLERGIES

Please select all known allergies and detail your allergic reaction.

☐ Penicillin __________________ ☐ Sulfa ____________________ ☐ Epinephrine ____________________

☐ Latex _______________ ☐ Pet (indicate type) ________________ ☐ Food (indicate type) ________________

☐ Other ____

☐ **NO KNOWN ALLERGIES**

SOCIAL HISTORY

Cigarette/cigar smoking
- ☐ Never smoked
- ☐ Quit (former smoker)
- ☐ Smokes less than once/day
- ☐ Smokes daily

Alcohol consumption
- ☐ None
- ☐ Less than 1 drink/day
- ☐ 1 – 2 drinks/day
- ☐ More than 3 drinks/day

Recreational drugs
- ☐ Never
- ☐ Quit (former recreational drug user)
- ☐ Consume once/day
- ☐ Consume multiple times/day

FAMILY HISTORY

Do you have a 1st degree relative with any of the following conditions? Please list family member(s) with the condition.

☐ Yes ☐ No Eczema __________________________

☐ Yes ☐ No Psoriasis __________________________

☐ Yes ☐ No Skin Cancer __________________________

☐ Yes ☐ No Melanoma __________________________

Other Major Illnesses: ___________________________

____

____

____

REVIEW OF SYSTEMS

Please check any of the following symptoms that apply to your current state of health. If you do not have any of the following symptoms, select "None."

If YES, please circle: fevers, chills, nausea, vomiting, diarrhea, constipation, chest pain, shortness of breath, cough, headaches, numbness, joint pain, changes in vision, unintended weight loss, anxiety, depression, easy bruising/bleeding, painful urination

☐ **None**

Have you ever fainted when undergoing a medical procedure? ☐ Yes ☐ No

(Please complete the information on the back)

Referral Requirement

Due to contractual obligations with insurance companies, it is the policy at Hillside Dermatology that a valid, non-expired referral must be on file at the time of visit for patients whose insurance requires a referral by their primary care doctor to be seen by a dermatologist. Failure to provide a valid referral can result in denial of the insurance claim and leave the patient responsible for the allowed amount of your visit.

Cancellation Policy

We understand there may be times when you might miss an appointment due to emergencies or obligations to work or family. However, we urge you to contact us 48 hours in advance to avoid being subject to a $50 cancellation fee. Three consecutive no-show appointments will result in no further appointments being scheduled.

Co-Pay Policy

Some health insurance companies require patients to remit a co-pay for services provided. We require patients to remit this co-pay before each visit.

Statement of Patient's Financial Responsibility

We appreciate the confidence you have shown in choosing Hillside Dermatology to provide your healthcare needs. The medical service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify and bill your insurance company on your behalf. However, you are ultimately responsible for payment of our fees.

You are responsible for payment of any deductible and copayment/co-insurance as determined by your contract with your insurance company. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance company. If your insurance company does not hold you responsible for a co-pay or out of pocket expense which you paid to Hillside Dermatology, that amount will be used as a credit toward a future visit or you may request a refund. In signing below, you hereby give permission to Hillside Dermatology to release any information concerning your treatment to insurance companies as deemed necessary for the processing of claims.

In signing below, you acknowledge that you have read the above policy regarding your financial responsibility to Hillside Dermatology for providing services to you. You certify that the information is to the best of your knowledge, true and accurate. You authorize any payment of any insurance benefits to Hillside Dermatology, or the physician/provider indicated on the claim, the full and entire amount of the bill incurred by you or the above-named patient; or, if applicable any amount due after payment has been made by your insurance company.

Consent to Treatment

I, ____, hereby request and consent to diagnostic and medical treatment by Hillside Dermatology, as deemed necessary in the professional medical judgement of my treating physician/provider. I am aware the practice of medicine and related procedures is not an exact science and I acknowledge that no guarantees as to the outcome of any procedures, treatments or examinations have been made to me during my course of care. Furthermore, I give consent to Hillside Dermatology to take photographs or other images of me as they relate to my care, which made be used for purposes of documenting my medical status, for my medical benefit and for the purpose of medical education and training.

For female patients: Many oral and topical medications prescribed by dermatologists are unsafe for use during pregnancy. Please inform our office if you are pregnant, breastfeeding, or planning to become pregnant at any time while under the care of Hillside Dermatology.

General Release and Acknowledgement of Receipt of Notice of Privacy Practices

I, ____, acknowledge and agree that I have had the right to review a copy of the Hillside Dermatology Notice of Privacy Practices prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my protected health information (PHI). I hereby consent to Hillside Dermatology physicians/providers, outside providers who are involved in my care, organized health care arrangements ("OHCA") with which Hillside Dermatology participates as well as other providers within the OHCA, networks such as IPAs and accountable care organizations that coordinate care for providers who may treat me, and insurers to obtain payment. I am aware that Hillside Dermatology disclaims any liability or harm resulting from my incorrect or incomplete provision of my primary care physician's contact information, and that Hillside Dermatology reserves the right to revise its Notice of Privacy Practices at any time. I am also aware that an updated copy of Hillside Dermatology's Notice of Privacy Practices is available on Hillside Dermatology's website.

✎____

Signature of Patient | Print name | Date

✎____

Signature of Patient's legal representative (if applicable) | Print name | Date

Consent to Contact

I hereby consent to Hillside Dermatology with regard to calling my home, cell phone, business phone or other designated means of communication and leaving a message on my voicemail or in-person in reference to anything that assists in carrying out treatment, payment, and healthcare operations, including but not limited to appointment reminders, insurance items and any call pertaining to clinical care, including laboratory results, medications, and other information relating to treatment.

I hereby consent to Hillside Dermatology with regard to mailing me materials to my home or other designated address, text messaging or e-mailing me regarding marketing/promotional offers, anything pertaining to my clinical care, including PHI and other matters related to treatment, such as appointment reminders and patient statements, or payment for services. I acknowledge that Hillside Dermatology cannot and does not guarantee the privacy, security, or confidentiality of an e-mail message or text message sent or received.

I hereby consent to Hillside Dermatology to have communications with the following people regarding PHI:

1. ________________________________(relationship) _______________________

2. _______________________________(relationship) ________________________

3. ________________________________(relationship) _______________________

Name of emergency contact: ________________________________(relationship)________________ Telephone of emergency contact: __________________

This consent shall specifically include information relating to appointments, after care, and the release of test results.

✎ ____

Signature of Patient Print name Date

✎ ____

Signature of Patient's legal representative (if applicable) Print name Date

Consent to Telehealth Visit

The purpose of this form is to obtain your consent for a telehealth visit (or "video visit") with a dermatologist/provider at Hillside Dermatology. The purpose of the visit is to assist in the diagnosis and treatment of your skin condition. In a telehealth visit, you will interact in real-time with your dermatologist via a secure, online videoconferencing technology. Alternatively, the dermatologist may give you the option of submitting a photo and chief complaint via secured electronic messaging. Your dermatologist will look at your skin during the videoconference or review the photos that you submitted. You will then be given advice about your condition and how to treat and take care of your condition.

All federal and state laws covering access to your medical records also apply to telehealth. No one other than your health care provider can view your photos or other information unless you agree to give them access. You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits.

Telehealth visit charges are billed and collected in the same manner as regular office visits. Your co-payment will be due prior to your telehealth encounter. Final financial responsibility including deductible and co-insurance amounts will be determined after the claim is filed and processed by your insurance carrier(s).

On March 11, 2020, the World Health Organization declared the COVID-19 viral disease to be a pandemic. As a result of this emergency, a rapidly evolving situation, practice patterns for physicians, physician assistants, and nurse practitioners are shifting to accommodate the need to treat in conjunction with unprecedented guidance from federal, state, and local authorities – which include, but are not limited to, self-quarantines and/or limiting physical proximity to others under any number of circumstances. It is within this context (and with the understanding that this method of patient encounter is in the patient's best interest as well as the health and safety of other patients and the public) that telehealth is being provided for this patient encounter rather than a face-to- face visit. This patient encounter is appropriate and reasonable under the circumstances given the patient's particular presentation at this time. The patient has been advised of the potential risks and limitations of this mode of treatment (including, but not limited to, the absence of in-person examination) and has agreed to be treated in a remote fashion in spite of them. Any and all of the patient's/patient's family's questions on this issue have been answered, and Hillside Dermatology has made no promises or guarantees to the patient. The patient has also been advised to contact our office for worsening conditions or problems and to seek emergency medical treatment and/or call 911 if the patient deems necessary.

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 telehealth visit or in the electronic submission of any 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 your dermatologist/provider and his/her institution or practice from any claims you may have about this advice or the telehealth visit. 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 telehealth visits that occur during the one-year period after your signature date.

____ ________________

Signature of Patient or Legal Representative Date