DR. MELISSA KAINER ERWIN
medical & cosmetic dermatology

Sign Up For Our Monthly Practice Newsletters, Featuring Our Cosmetic Specials!

Email Address: _____

Would You Like A Member of Our Staff To Speak With You About Our Cosmetic Services? ☐ Yes ☐ No

Welcome! Thank you for choosing our practice for your skin care needs. Please complete this form. If you have any questions, please do not hesitate to ask for assistance. **Please complete all fields fully and accurately.**

Today's Date: _____ Who Referred You? _____

Name: _____ SSN: _____ DOB: _____
Last First Middle Initial

Age: _____ Sex: _____ Marital Status: _____ Drivers Lic. # _____

Mailing Address: _____
City State Zip

Home Phone: _____ Cell Phone: _____

Primary Care Physician: _____ Pharmacy: _____

Patient's Employer: _____ Employer's Phone: _____

Spouse's Name: _____ Spouse's DOB: _____

IF PATIENT IS A MINOR:

Guarantor Name: _____ Relation to Patient: _____

Guarantor SSN: _____ Guarantor DOB: _____

Guarantor Address: _____
City State Zip

Guarantor Employer: _____ Employer's Phone: _____

INSURANCE INFORMATION MUST BE COMPLETED BY THE PATIENT
(PLEASE PRESENT INSURANCE CARD & DRIVERS' LICENSE AT TIME OF CHECK-IN)

Primary Insurance: _____	Secondary Insurance: _____
Name of Insured: _____	Name of Insured: _____
Insured ID: _____	Insured ID: _____
Group Number: _____	Group Number: _____
Relation to Patient: _____	Relation to Patient: _____
Insured's DOB: _____	Insured's DOB: _____
Insured's SSN: _____	Insured's SSN: _____

RELEASE OF INFORMATION/EMERGENCY CONTACT

Is there anyone that you authorize us to release medical record information to (including but not limited to lab/biopsy reports and billing information)? **If there is no one selected, we will only speak with the patient pertaining to medical care and account issues.**

_____ Yes _____ No If yes, name and relationship: _____

Who should we notify in case of emergency? Name/Relationship: _____ Phone No.: _____

All patient responsibility, unmet deductible, co-pay and co-insurance is required at the time of service. If your plan is not one with which the practice is contracted, payment in full is required at the time of service. We accept Visa, Mastercard, Discover, & AmEx, as well as cash and checks. The patient is responsible for any required referrals from the primary care physician.

With this signature, I authorize treatment and release of medical or other information necessary to process my insurance claim. I request payment of government or other benefits to the party accepting assignment.

_____ _____
Patient or Responsible Party Signature Date

979.543.9933 (phone) **979.543.9959 (fax)**

Please Complete Reverse Side!

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Patient Name: _____

Date of Appointment: _____ Reason for Appointment: _____

Date of Last Flu Shot: _____ Date of Last Pneumonia Shot: _____

If Female: Pregnant? □ Yes □ No
Tubal? □ Yes □ No
Hysterectomy? □ Yes □ No

Medication Allergies: _____

Current Medications/Vitamins: _____

_____

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)

Anxiety	□ Yes □ No	Diabetes	□ Yes □ No	Lymphoma	□ Yes □ No
Arthritis	□ Yes □ No	End Stage Renal Disease	□ Yes □ No	Prostate Cancer	□ Yes □ No
Asthma	□ Yes □ No	GERD	□ Yes □ No	Radiation Treatment	□ Yes □ No
Atrial Fibrillation	□ Yes □ No	Hearing Loss	□ Yes □ No	Seizures	□ Yes □ No
Bone Marrow Transplant	□ Yes □ No	High Blood Pressure	□ Yes □ No	Stroke	□ Yes □ No
BPH	□ Yes □ No	HIV/AIDS	□ Yes □ No	Uterine Cancer	□ Yes □ No
Breast Cancer	□ Yes □ No	High Cholesterol	□ Yes □ No	**OTHER MEDICAL ISSUES:**	
Colon Cancer	□ Yes □ No	Hyperthyroidism	□ Yes □ No		
COPD	□ Yes □ No	Hypothyroidism	□ Yes □ No		
Coronary Artery Disease	□ Yes □ No	Leukemia	□ Yes □ No		
Depression	□ Yes □ No	Lung Cancer	□ Yes □ No		

Past Surgeries: _____

_____

_____

SKIN DISEASE HISTORY (PLEASE CHECK ALL THAT APPLY)

Acne	□ Yes □ No	Eczema	□ Yes □ No	Psoriasis	□ Yes □ No
Actinic Keratoses	□ Yes □ No	Flaking or Itchy Scalp	□ Yes □ No	Squamous Cell Skin Cancer	□ Yes □ No
Basal Cell Skin Cancer	□ Yes □ No	Melanoma	□ Yes □ No	**OTHER SKIN DISEASE HISTORY:**	
Blistering Sunburn	□ Yes □ No	Poison Ivy	□ Yes □ No		
Dry Skin	□ Yes □ No	Precancerous Moles	□ Yes □ No		

Family History: Has anyone in your immediate family had skin cancer? □ Yes □ No

If yes, type of skin cancer: _____ Relation: _____

SOCIAL HISTORY

Do you smoke or chew tobacco? □ Yes □ No If no, have you used tobacco in the past? □ Yes □ No

If yes, frequency of current use: _____

How many alcoholic drinks do you have in a day? _____

What is your occupation? _____

What are your outdoor hobbies? _____

I acknowledge the above to be true and correct. I have received a copy of Dr. Melissa Kainer Erwin's Notice of Privacy Practices and Office Policies. By signing below, I acknowledge receipt of these Privacy Practices & Office Policies.

Signature: _____ Date: _____

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WELCOME TO MELISSA A. KAINER ERWIN, M.D., PA

Dear Patient:

We are very happy to welcome you to our Practice, and we are proud that you chose us to care for your medical needs. We will strive to make each and every visit a satisfying experience. For us to be successful in this endeavor, we must ask for your cooperation and understanding in not only supplying us with correct information, but with our office policies as well. We hope that the following information is helpful in guiding you through your years as a patient of our Practice. We ask that you keep in mind that this letter in no way constitutes a contract between you, the patient, and the physician or the Practice, but instead serves as an outline for some of our more important policies that must be followed in order to keep our office open and available to our patients.

APPOINTMENTS:

We accept patients by appointment only. As a courtesy, appointments are confirmed prior to the visit via our automated system. We caution you not to rely on a confirmation from our office to remember your appointment, as **you are still responsible for arriving on time or for cancelling when you are unable to make your appointment**. Our office utilizes an automated, pre-recorded appointment reminder service. We are required by the Federal Communications Commission to notify our patients of, and obtain express written consent for, use of this service, which may remind a patient of their visit on the cell phone number provided to the office. Your signature (under separate cover) implies express written consent.

Failure to arrive or to give a 24-hour notice for a cancelled appointment will cause the patient account to incur a charge of $25.00 for administrative fees. These fees are subject to change at any time and without written notice.

Walk in appointments are not recommended as they are very rarely able to be accommodated. We ask that you call to schedule your appointment during regular business hours. Anyone calling after hours may leave an appointment request on our after-hours voice mail system, and your call will be returned the next business day. Appointments for multiple patients within the same family/scheduled appointment time will require a $25.00 deposit per family member. If the appointment is not cancelled within 24 hours, the deposit becomes non-refundable. This deposit will be required at the time the appointment is made. A new patient that has previously no-called/no-showed for an appointment will be required to pay for a "99202 New Patient Office Visit ($125.00)" in full prior to re-booking an appointment. This balance will be credited to the account in advance of the patient visit.

If you are late for your appointment, you may be rescheduled, or you may be seen on a work-in basis. Dr. Erwin tries to keep appointments on time, but on occasion, an emergency will occur. We are respectful of your time spent with us, and we try to avoid delays while caring for each patient's needs. It is very helpful for you to let us know why you need the appointment when scheduling so that we can allocate enough time for your needs. You will be treated for the problems for which you are scheduled, and only the scheduled patient will be treated. We are happy to make appointments for additional patients requiring treatment. Please know that we will take care of you, too, when things get complicated!

Our office utilizes mid-level providers (Nurse Practitioners and/or Physician Assistants), and when scheduling your initial or return visits, you will be given the option to see either Dr. Erwin or the mid-level provider. Mid-level providers are not physicians, and they function within the scope of practice appropriate for their license.

We do not provide "wellness" or "preventative" examinations.

COLLECTION OF PERTINENT DATA:

We must collect certain information from patients in order to file to insurance, while other information is collected as per office policy. All information collected is protected by HIPAA regulations, and when it is destroyed, it is done so in a secure manner. Once a year we will ask patients to update their demographic and medical information.

PRESCRIPTION REFILLS:

Please contact your pharmacy and ask them to fax a refill request to 979-543-9959, allowing us 48 (business) hours for processing. In order for most topical prescriptions to be refilled, patients must be seen at least once per year. For prescriptions such as antibiotics to be refilled, patients must be seen at least every three months, or as directed by physician. Accutane patients must be seen once per month during the course of treatment for the drug to continue to be prescribed.

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FORMS & MEDICAL RECORDS

Forms are subject to change at any time and without prior notice. Forms may change as a result of updated office policy or protocol, or as a result of legislative changes. In order for us to release medical records to anyone other than the patient for any reason, the Practice requires that the patient complete the Authorization for Release of Protected Health Information. The Practice will not release any information without completion of this form by the party or legal guardian. Medical records that are printed and released to certain persons may be subject to charges that vary depending on the number of pates contained in the record. Patients are granted access to their own electronic health record via a patient portal.

INSURANCE & BILLING

While we participate in **most** insurance and managed care plans, it is the responsibility of the patient to know their policy, what his/her policy covers, and when they may be responsible for non-covered services. Should the insurance company fail to make payment for any number of reasons, the amount owed will then be billed to the patient and due payable upon receipt. All insurance-required referrals need to be received in our office prior to your visit. It is the patient's responsibility to obtain these referrals. If you do not have your original insurance card at the time of your appointment, your appointment may need to be rescheduled. You must provide the correct insurance card at the time that the services are rendered. This is for YOUR protection, so that you do not receive a bill for services that were not covered by the insurance due to the wrong insurance being filed.

Payment is due at the time of service. A copay, if applicable, will be collected at the time of the visit. In the case of patients who have no copay, 20% of the visit will be collected as partial payment at the time that the services are rendered. Insurance will then be filed, and patients will be balance-billed for any amounts due over and above what was collected at the time of service. If you have met your deductible and feel that you should not owe the 20% of the visit, please bring proof of this at the time of your visit. Patients who are self-pay will be responsible for the visit in full, at the time of service. We do offer a self-pay discount for those individuals electing to pay with cash or a credit card (no checks).

Once payment is determined to be the responsibility of the patient, a first billing statement will be sent to the address of record. Payment is due upon receipt. Should you be unable to make payment at this time, please contact our office at 979-543-9933 to make payment arrangements. If there is no contact with or payment made to our office, a second statement will be issued. If there is still no contact with or payment made to our office, a third and final notice will be sent. If the final notice goes unheeded, the account will be turned over to an outside collection agency and due process will begin.

TREATMENT OF MINOR PATIENTS:

Children under the age of 18 must be accompanied by a parent/guardian. If your child is to be treated without a parent/guardian present, a note must be presented to our office at the time that services are rendered. If you wish for your child to be treated without the presence of a parent/guardian, please sign below and return this signed form to our staff. **Children must be 16 years of age or older to be seen alone.**

I authorize my child to be treated without my presence:
Name of Guardian: _____ **Date:** _____
I give authorization for _____ (**Patient)** to be treated without my presence at the time medical services are rendered. Your signature will confirm that you have given Melissa A. Kainer Erwin, M.D. permission to treat your child when a parent/guardian is not present.

_____ _____
Signature of Parent/Guardian Date

Again, thank you for allowing us to take care of your dermatological and cosmetic needs. We look forward to a long and mutually-beneficial relationship. We greatly appreciate your understanding of and cooperation with our office policies and procedures. Please do not hesitate to reach out to our office staff if you have questions or concerns.

Sincerely,
The Practice of Melissa A. Kainer Erwin, M.D., PA

The Practice of Melissa A. Kainer Erwin, M.D., PA reserves the right to refuse service to any person that chooses not to follow our office policies and procedures or terminate the care of any patient who repeatedly demonstrates adverse behaviors that place the patient's medical status at risk and/or threatens health center operations, or the health or well-being of other patients and/or staff. We do not tolerate rudeness or abusive language. If you feel that you have not been given the friendly treatment that you deserve, please let Dr. Erwin or the Practice Manager know.

EXHIBIT I

Melissa A. Kainer Erwin, M.D., P.A.

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 protected 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 would include referring you to another specialist.

- 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 disclose your PHI for law enforcement and other legitimate reasons although 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
- Other uses and disclosures not described in this notice.

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 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 PHI by alterative 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 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 if effective as of **September 23, 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 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 office 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 for more information, in person or in writing.