Vause Cosmetic Dermatology Associates

Sandra E. Vause M.D., P.C.
545 Beckett Rd. Suite 101
Logan Township, NJ 08085
856-241-3311

Demographics and Consent Form

Name:_____ Age:_____ DOB: _____ Sex:_____

Address: _____ Please complete if applicable **(Responsible Party):**

City/State: _____ Spouse / Partner: _____

Zip:_____ SSN:_____ SSN:_____ DOB:_____

Home#:_____ Cell: _____ Employer: _____

Work#: _____ Phone:_____Cell: _____

Emergency Contact: _____ Relationship: _____

Home#:_____ Work#:_____ Cell#:_____

Email Address: _____ [ ] Please check box for permission to email special announcements

Primary Care Doctor:_____ Referred Doctor: _____

Referring Provider Address: _____

City/State: _____ Zip: _____

Pharmacy Name: _____ **Address:** _____

Pharmacy Number: _____

Insurance Information

Primary Insurance Co: _____ Secondary Insurance Co: _____

Subscriber's Name: _____ Subscriber's Name: _____

Subscriber's DOB:_____ Subscriber's DOB: _____

Subscriber's SSN: _____ Subscriber's SSN: _____

Relationship to Subscriber: _____ Relationship to Subscriber: _____

Policy Number/Group #:_____ Policy Number/Group #: _____

Copay:_____ Copay:_____

Payment Agreement

Medicare Patients:

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me at Vause Cosmetic Dermatology Associates including physician services. I authorize any holder of medical information about me to release to the Centers of Medicare and Medicaid Services and/or its agents any information needed to determine these benefits or benefits payable for related service.

All Patients:

PAYMENT IS EXPECTED FROM YOU AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES.

I agree to pay my deductibles, co-payments/and payments at the time services are rendered. We accept cash, check, or credit cards. I understand that there will be a $30.00 fee for appointments missed or appointments cancelled with less than twenty four hours notice. I also understand that there will be a $35.00 dollar fee for all returned checks. Your signature below indicates that you accept these policies. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims. You herein authorize payment of medical benefits to the Doctor when an assigned claim is filed. The charge for completing medical forms is $15.00. Copies of medical records are available at $0.50 a page.

Signature of Patient or Legal Guardian:_____Date: _____

Patient relationship to policy owner: Self Child Spouse Other_____

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Consent for Treatment and Release of Medical Information

I authorize treatment and/or services to myself or minor child at **Sandra E. Vause, M.D., P.C.** I authorize **Sandra E. Vause, M.D., P.C.**, to release information requested by my insurance company or any of its agents. I also authorize **Sandra E. Vause, M.D., P.C.**, to furnish my primary care physician, referring physician or other treating medical professional any and all information that may be requested regarding my physical or mental condition and treatment rendered there fore and, if necessary, to allow them or any physician appointed by them to examine any records or results regarding my treatment.

This authorization shall remain in force until revoked in writing by the undersigned.
Signed (patient or responsible party): _____ Date: _____
(If minor or other responsible party signs)

Staff member witness: Name _____ Signed _____

Consent for Communication of Information

In addition to release of information as authorized in the Authorization to Release Medical Records on the prior page, and in the interest of confidentiality, and compliance with HIPAA (Health Insurance Portability and Accountability Act), your careful consideration and acknowledgement as to whom we may release information on your behalf is required.

I authorize the release of information as it pertains to my care only to the following individuals:

Name:_____ Relationship: _____ Tel#: _____

Name:_____ Relationship:_____ Tel#: _____

Name: _____ Relationship: _____ Tel#: _____

For the purposes of communicating test results, prescription refill requests, and other protected health information, I authorize my physician and/ or his/her designee to utilize the following mechanism/s:

On my home answering machine (# _____)

On my cell phone message system (# _____)

On my office voice mail (# _____)

Via email (email address_____)

(For security and privacy reasons, your physician will not respond to unsolicited email communications)

I have the right to revoke and change my consent options as listed above. When circumstances change regarding my response, I will submit written changes, revocation, limitations, and restrictions to **Sandra E. Vause, M.D., P.C.**, at the current address. Your physician and **Sandra E. Vause, M.D., P.C.**, will not be held liable for communication of protected health information via the consented option(s) above without an updated written consent form.

Signed: _____ Date: _____

Internal Use Only:
If the patient or patient's representative refused to sign any of the above acknowledgements, please document the date and time the patient was presented with the above material and sign below:

Information presented on (date)_____ Time: _____

Staff Name: _____ Signature: _____

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of **Sandra E. Vause, M.D., P.C.** Notice of Privacy Policies (effective date March 18, 2013) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information:

Signed: _____ Date: _____

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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 this carefully in its entirety.

Treatment Your health information may be used by staff members or may be disclosed to other health care professions for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professions who may provide treatment or who may be consulted by staff members.

Payment Your health information may be used to seek payment from your health plan, for other sources of coverage such as an automobile insurer or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided and the medical condition being treated. You are required to provide this practice with all health, automobile and workers compensation (if applicable) insurance coverage information, or discuss and provide an alternative method for providing payment for services to this practice.

Health Care Operations Your health information may be used as necessary to support the day to day activities and management of support, budgeting, financial reporting and activities to evaluate and promote quality.

Law Enforcement Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's health department.

Other uses and disclosures require your authorization Disclosure of your health information or its use for any purpose other than those listed above require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect any use or disclosure of information that occurred before you notified us of your decision.

Additional uses of information Your health information may be used by our staff to send you appointment reminders. Your health information may also be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest or be of benefit to you.

Individual Rights You have certain rights under the federal privacy standards. These include:
1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information.
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed.
6. The right to receive a printed copy of this notice.

This medical practice, known as Vause Cosmetic Dermatology Associates, is required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state law and regulations. Whatever the reason for the revision, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to inspect information As permitted by federal regulation, we require that requests to inspect or copy protected information be submitted in writing. You may obtain a form to request access from this office.

Complaints If you would like to submit a comment or complaint about our privacy practices, or suspect violation, you may do so by letter outlining your concerns.

EFFECTIVE DATE OF THIS NOTICE: March 18, 2013

PATIENT HISTORY

CHIEF COMPLAINT

HISTORY OF PRESENT ILLNESS:

Patient: _____ D.O.B. __/__/__ DATE: _____

FAMILY HISTORY

- ☐ HAY FEVER
- ☐ CANCER
- ☐ PSORIASIS
- ☐ ASTHMA
- ☐ HAIR LOSS
- ☐ SKIN CANCER
- ☐ DIABETES
- ☐
- ☐ ECZEMA
- ☐ ARTHRITIS
- ☐

MEDICATIONS

PAST MEDICAL HISTORY

☐ -POS ☐ -NEG NA-Not Applicable

- ☐ Recent Weight Gain
- ☐ Eczema
- ☐ Asthma
- ☐ Herpes
- ☐ Hives
- ☐ Psoriasis
- ☐ Hay Fever
- ☐ Kidney Disease
- ☐ Keloids
- ☐ Arthritis
- ☐ Skin Cancer
- ☐ Migraine
- ☐ Aids Risk
- ☐ Headaches
- ☐ Hair Loss: Progressive
- ☐ Hair Loss: Recent
- ☐ Diabetes
- ☐ Seizures
- ☐ Thyroid
- ☐ Neurol. Disease
- ☐ Coronary Heart Disease
- ☐ Lupus
- ☐ Hypertension
- ☐ Anemia
- ☐ Lung Disease
- ☐ Cancer *Type:*
- ☐ Hepatitis
- ☐ X-Ray Therapy
- ☐ Previous Surgery

FEMALES-Pregnant

- ☐ Menst. Irreg.
- ☐ Birth Control

ALLERGIES

HABITS

CIG _____

ALCOHOL _____ oz/wk

COFFEE/TEA _____ cups/day

REG EXERCISE _____

OCCUPATION _____

HOW DID YOU FIND US? _____

SUN EXPOSURE

Have You ever had a blistering sunburn? Y/N

Have you ever used a tanning bed or tanning salon? Y/N

Do you use sunscreen? Y/N

REVIEW OF SYSTEMS

Constitutional Systems	YES	NO
Fever	☐	☐
Weight loss or gain	☐	☐
Fatigue	☐	☐
Skin		
Rashes or color changes	☐	☐
Itching or dryness	☐	☐
Hair or nail changes	☐	☐
Eyes		
Loss of vision	☐	☐
Distorted vision or haloes	☐	☐
Fluctuating vision	☐	☐
Eye pain or soreness	☐	☐
Ears, Nose, Moth, Throat		
Hearing Difficulty	☐	☐
Ringing or dizziness	☐	☐
Sinus congestion	☐	☐
Runny nose or post-nasal drip	☐	☐
Nosebleeds	☐	☐
Dryness/hoarseness	☐	☐
Cardiovascular		
Chest pains or palpitations	☐	☐
Other _____		
Respiratory		
Cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Endocrine		
Heat of cold intolerance	☐	☐
Excessive thirst or hunger	☐	☐

Gastrointestinal	YES	NO
Swallowing difficulty	☐	☐
Vomiting/heartburn	☐	☐
Genito-urinary		
Urinary frequency	☐	☐
Urinary pain or blood	☐	☐
Males:		
Discharge, lesions or masses	☐	☐
Females:		
Currently pregnant	☐	☐
Breast masses or discharge	☐	☐
Vaginal bleeding, discharge	☐	☐
Musculoskeletal		
Joint pain, swelling, redness	☐	☐
Muscle pain or cramps	☐	☐
Neurological		
Headaches	☐	☐
Numbness or tingling	☐	☐
Weakness or paralysis	☐	☐
Fainting or blackouts	☐	☐
Slurred speech	☐	☐
Psychiatric		
Anxiety	☐	☐
Depression	☐	☐
Other: _____		
Hematological/Lymphatics/Immunology		
Easy bruising/bleeding	☐	☐
Blood transfusions	☐	☐
Swollen lymph nodes	☐	☐

Other symptoms not listed above:

_____

_____

_____

_____

Patient Name: _____

Date: _____

Reviewed by: _____

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