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WELCOME TO FIVENSON DERMATOLOGY!!

Your appointment is scheduled for: _____ @ _____ a.m. p.m.

Enclosed you will find a patient demographic and a health history questionnaire. Please complete this form and bring to your visit along with:

- Your insurance card(s) and photo identification
- Cash, check, Visa, MasterCard, Discover, AMEX for co-payments, deductible portions or payment in full for services not covered by your insurance company
- Medical records from any outside facility such as lab results, skin biopsies, doctor's notes, etc. that pertain to your current medical problem. A complete medication list including all over the counter items, creams and supplements is also very important. We encourage you to put everything you take or use in a bag and bring it with you on your first appointment.
- Any referral, if required by your insurance. If not provided, you might be responsible for the cost of your visit.

We will not be able to bill your insurance without verification of insurance. Also enclosed is a map and directions to our office. ***Please arrive 15-20 minutes early*** so that we may open a patient chart for you. This will allow you time to sign all consent forms including those for treatment, HIPAA review, portal, email/phone contacts for communication of test results, billing, electronic lab and medication interfaces (from the central pharmacy website known as Surescripts). A detailed description of these forms will be available to review in the office waiting room.

If you sign up for a portal account, you can review and electronically authorize many of these documents online, prior to your appointment. To do so, go to our website: www.fivensondermatology.com and use the link on the home page for our **PATIENT PORTAL**. All that is required to sign up and register for the portal is your name, date of birth and email address. Click on your appointment to enter your medical history information. This will help us keep your appointment on time, save repeated questions and avoid errors. The portal is also a great way to manage other routine tasks such as paying your bill, request appointments, request medication refills and get lab results. On the portal you can also fill out your medical history, surgery history, medications, allergies, as well as review copies of the office policies.

We participate with most major insurance companies including Aetna, BC/BS of Michigan, Blue Care Network, Health Plus, Humana, BC/BS PPO, PPOM, BC/BS Preferred, Medicare, Priority Health and MCare POS, HAP. We ***do not*** participate with Blue Cross Blue Shield *Preferred Plus or Traditional plans*. It is important to check with your insurance company to verify coverage before your appointment.

We look forward to meeting you and making your visit as pleasant as possible. Please telephone our office if you have any questions prior to your visit with us.

NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

As of April 14, 2003 HIPAA requires that healthcare practices take certain steps, and provides steep penalties for those who do not comply. Under HIPAA, Patients are now given new fundamental rights, including:

- The right to inspect and/or obtain copies of your medical records.
- The right to request amendments to your records (if you feel your records are incorrect you may submit to the Office a written request for changes to your records).
- The right to request restrictions on the disclosure of your protected health information.
- The right to ask our practice to communicate with you in a certain manner. For example, certain contact number only, email, mail, etc.
- The right to ask our practice for a log of who has accessed your protected health information.

Acknowledgment of Receipt of Notice of Privacy & Patient Rights

I would like a copy of the Notice of Privacy Practice form.

Declined copy of Notice of Privacy Practice form.

Patient Signature

Date

AUTHORIZATION FOR THE USE, RELEASE OF DISCLOSURE OF YOUR HEALTH INFORMATION

By signing this document, I hereby authorize the use, release, or disclosure of my Protected Health Information (PHI) to the following person(s) (i.e. family members and/or health care providers). I understand that this authorization is voluntary at my request.

<u>Name</u>	<u>Relationship</u>	<u>Telephone Number</u>	<u>This authorization shall expire on:</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature

Date

OFFICE POLICIES AND PROCEDURES

Office hours

- Monday - Thursday from 8:00am to 5:00pm, with appointments scheduled from 8:15 - 11:30 and 1:30 - 4:15.
- When our office is closed, the answering service will give instructions on leaving a message or who to call with questions.
- We will try to be available to help you with any questions that might arise related to your skin conditions, and will try to have a 'live' person answer every phone call. Our **Patient Portal** is a very efficient and secure way to communicate with us. We encourage this method for the most efficient way to have your questions answered (if a personal call is not needed).

Appointments

NO-SHOW/CANCELLATION POLICY

- It is our policy to encourage patients to arrive and receive care at their scheduled arrival time, or to give appropriate notice of cancellation to allow other patients to receive timely care.
- If you are unable to make your scheduled arrival time, we request that you notify us as soon as possible, but no later than 24 hours prior to your scheduled arrival time.
- By not providing 24 hour notice of a cancellation of your appointment, you may be assessed a \$50.00 fee for a missed office visit.

Our office will call you if there was a "no show" appointment to try and help with rescheduling. If three (3) or more appointments are missed, our office reserves the right to terminate our relationship with you.

It is not our intent to assess an additional financial burden, but it is costly if you miss your appointment and do not give us time to schedule another patient in your time slot.

-Minor children (age 17 and younger) must be accompanied by their parent or legal guardian.

Prescription Refills

We require 48 hours' notice for all prescription renewals. Using the **Patient Portal or having your pharmacy send an electronic refill request are the most efficient methods to request prescription renewals.**

For prescriptions requiring a prior authorization, be sure to allow time for insurance verification/authorizations of up to two weeks.

-We will fill prescriptions for topical medications (at our discretion) up to one (1) year after the last office visit and internal medications (at our discretion) up to six (6) months after the last office visit. Beyond these time, an office visit may be required.

-To refill a prescription, we will need the following information for each prescription you are requesting:

- Your full (legal) name and date of birth
- The medication name, dose previously prescribed the medication vehicle (i.e. cream, lotion, solution, gel or ointment and the size or number of tablets previously prescribed.
- Pharmacy name, location and phone number – be specific
- Daytime phone number and an alternative number where you can be reached, the pharmacy name and phone number, your type of insurance.

-Please feel free to leave this information on our answering machine or email it to us.

Continued on back ►

Lab Work

-Our preferred site to send biopsy specimens and blood work is St. Joseph Mercy Hospital in Ann Arbor, however, we have electronic connections to many other labs for your convenience.

-Please let us know if your insurance requires use of a specific laboratory for lab/ pathology services.

-Our **PATIENT PORTAL** AND "RESULTS CALL" SYSTEM WILL PROVIDE YOU TIMELY, SECURE ACCESS TO TEST RESULTS VIA YOUR CHOICE OF EMAIL, TEXT OR PHONE CALL.

Billing

-Payment is due at the time of service, unless Fivenson Dermatology participates with your insurance. All co-pays are due at the time of service. We accept cash, check, MasterCard or Visa.

-Patient statements will be mailed monthly by our billing service and prompt payment of remaining balances is appreciated. Our **Patient Portal** credit card payment is an easy way to manage these balances.

-We strongly encourage you to enter your credit card information on the **Patient Portal** as a pre-approved payment method. You can choose a maximum amount to pre-approve and payment plans are available.

-There will be a \$50 service charge for any check returned to us from the bank.

-Balances of greater than 60 days past due will be subject to a 2 % monthly fee.

Privacy Statement

We respect that your personal information is private and will only exchange such information with those parties whom we have your permission to and only as part of your health care in Dr. Fivenson's practice. Confidential health care information is only released with your permission to other health care providers. Your health care information may also be shared with your insurance company to allow us to collect for Dr. Fivenson's services. Details of our HIPAA Policy are available for your review.

PLEASE SIGN BELOW

1. I give my consent for treatment: Signed _____ Date _____

Print Name: _____

2. I understand the policies and have been advised of and offered to review the practices HIPAA Privacy policies on site. _____ (Initial)

2. I have read the above and consent to phone messages, email, text message or telephone "Results Call" notification of laboratory results. (Circle all that you agree to.) _____ (Initial)

3. I hereby give my consent to Dr. Fivenson to access and download my medication history electronically into my chart. _____ (Initial)

4. I hereby give my consent to Fivenson Dermatology to send orders and receive results of any lab work electronically through electronic interface or HL7. _____ (Initial)

* Primary Care Physician: _____ Telephone: _____

* Referring Physician: _____ Telephone: _____

* Pharmacy of Choice: _____ Telephone: _____

ATTENTION MEDICARE PARTICIPANTS: New regulations now encourage use of electronic prescribing to avoid errors, drug interactions and control costs. Please make sure we have your pharmacy of choice on file and tell the staff if you need any refills. Our electronic medical records system includes E- Prescribing software and we will try to use this for all of your prescriptions.

* **Allergies** Please list Medications/Substances that you are allergic to and the reaction you have/had.

NONE

Medication/Substance

Reaction/Date

_____	_____
_____	_____
_____	_____

* **List Your Surgeries** **NONE**

Date

Surgeon

_____	_____	_____
_____	_____	_____
_____	_____	_____

* **SOCIAL HISTORY**

Married Single Divorced Widowed

Do you smoke? Yes No If yes, how much? _____ How long? _____

Do you drink alcohol? Yes No If yes, how much? _____

Do you work? Yes No

Do you use recreational drugs? Yes No

Have you ever had an STD? Yes No

* **FAMILY HISTORY**

Family History	YES	NO	RELATIONSHIP- Please indicate maternal (M) or paternal (P) for relatives
Arthritis			
Cancer – Breast			
Cancer – Colon			
Cancer – Lung			
Cancer – Skin			
Diabetes			
Heart disease			
Hypertension			
Leukemia/lymphoma			
Lupus			
Psoriasis			

Please check current conditions for which you see a doctor regularly (in bold text).

* Current Symptoms/Complaints are in plain text.

<p>GENERAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> appetite change <input type="checkbox"/> chills <input type="checkbox"/> dizziness <input type="checkbox"/> fatigue <input type="checkbox"/> fever <input type="checkbox"/> night sweats <input type="checkbox"/> weight change <hr/> <p>EYES</p> <ul style="list-style-type: none"> <input type="checkbox"/> cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> macular degeneration <input type="checkbox"/> double vision <input type="checkbox"/> dry eyes <input type="checkbox"/> blurry vision <input type="checkbox"/> light sensitive <input type="checkbox"/> red eyes 	<p>CARDIO-VASCULAR</p> <ul style="list-style-type: none"> <input type="checkbox"/> hi cholesterol <input type="checkbox"/> hi triglycerides <input type="checkbox"/> hypertension <input type="checkbox"/> heart attack <input type="checkbox"/> arrhythmia <input type="checkbox"/> heart valve problem <input type="checkbox"/> coronary artery disease <input type="checkbox"/> lymphedema <input type="checkbox"/> phlebitis <input type="checkbox"/> raynaud's <input type="checkbox"/> stroke <input type="checkbox"/> varicose veins <input type="checkbox"/> heart murmur <input type="checkbox"/> leg pain with walking <input type="checkbox"/> leg swelling <input type="checkbox"/> palpitations <input type="checkbox"/> short of breath w/exertion <input type="checkbox"/> chest pain/tight 	<p>SKIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> acne <input type="checkbox"/> eczema <input type="checkbox"/> folliculitis <input type="checkbox"/> herpes <input type="checkbox"/> history of skin cancer where: _____ <input type="checkbox"/> keloids <input type="checkbox"/> lupus <input type="checkbox"/> melanoma <input type="checkbox"/> molluscum <input type="checkbox"/> pemphigus <input type="checkbox"/> psoriasis <input type="checkbox"/> sun allergy <input type="checkbox"/> wounds <input type="checkbox"/> vitiligo <input type="checkbox"/> warts <input type="checkbox"/> blisters <input type="checkbox"/> rash <input type="checkbox"/> itching <input type="checkbox"/> lesions/growths <input type="checkbox"/> nail changes <input type="checkbox"/> pigment loss <input type="checkbox"/> unusual moles <input type="checkbox"/> other
<p>ENT</p> <ul style="list-style-type: none"> <input type="checkbox"/> deafness <input type="checkbox"/> bleeding gums <input type="checkbox"/> cough <input type="checkbox"/> sinus drainage <input type="checkbox"/> dry mouth <input type="checkbox"/> growths in mouth <input type="checkbox"/> mouth ulcers <input type="checkbox"/> nose bleeds <input type="checkbox"/> thrush <hr/> <p>LUNGS</p> <ul style="list-style-type: none"> <input type="checkbox"/> asthma <input type="checkbox"/> emphysema/COPD <input type="checkbox"/> sarcoidosis <input type="checkbox"/> Pulmonary Embolism <input type="checkbox"/> cough <input type="checkbox"/> wheezing <input type="checkbox"/> TB <input type="checkbox"/> short of breath 	<p>GU</p> <ul style="list-style-type: none"> <input type="checkbox"/> renal failure/dialysis <input type="checkbox"/> urinary tract infection <input type="checkbox"/> blood in urine <input type="checkbox"/> discharge <input type="checkbox"/> frequency <input type="checkbox"/> hesitancy <input type="checkbox"/> incontinence <input type="checkbox"/> painful urination <input type="checkbox"/> kidney stones <input type="checkbox"/> urgency <hr/> <p>MUSCULO-SKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> arthritis <input type="checkbox"/> back pain <input type="checkbox"/> deformities <input type="checkbox"/> joint swelling <input type="checkbox"/> serious injuries <input type="checkbox"/> weakness 	<p>NEUROLOGIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> migraines <input type="checkbox"/> seizure disorder <input type="checkbox"/> multiple sclerosis <input type="checkbox"/> stroke <input type="checkbox"/> dementia <input type="checkbox"/> blackouts <input type="checkbox"/> headaches <input type="checkbox"/> numbness/tingling
<p>GI</p> <ul style="list-style-type: none"> <input type="checkbox"/> reflux/GERD <input type="checkbox"/> hemorrhoids. <input type="checkbox"/> hiatal hernia <input type="checkbox"/> hepatitis. <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Irritable bowel disease <input type="checkbox"/> black stools <input type="checkbox"/> bloody stools <input type="checkbox"/> constipation <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea <input type="checkbox"/> pus in stools <input type="checkbox"/> stomach pain <input type="checkbox"/> trouble swallowing <input type="checkbox"/> vomiting 	<p>HEMATOLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> anemia <input type="checkbox"/> bleeding disorder <input type="checkbox"/> sickle cell <input type="checkbox"/> leukemia <input type="checkbox"/> lymphoma <input type="checkbox"/> easy bruising <input type="checkbox"/> swollen lymph nodes <hr/> <p>ENDOCRINE</p> <ul style="list-style-type: none"> <input type="checkbox"/> diabetes <input type="checkbox"/> thyroid disorders hyper / hypo <input type="checkbox"/> menstrual problems <input type="checkbox"/> abnormal hair growth <input type="checkbox"/> abnormal hair loss <input type="checkbox"/> flushing <input type="checkbox"/> obesity 	<p>PSYCHIATRIC</p> <ul style="list-style-type: none"> <input type="checkbox"/> anxiety disorder <input type="checkbox"/> depression <input type="checkbox"/> memory problems <input type="checkbox"/> panic attacks <hr/> <p>ALLERGY/IMMUNOLOGY</p> <ul style="list-style-type: none"> <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> gout <input type="checkbox"/> hay fever <input type="checkbox"/> lupus <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> scleroderma <input type="checkbox"/> vasculitis <input type="checkbox"/> drug allergies- please list reactions on bottom of page 1 <input type="checkbox"/> food allergy <hr/> <p>OTHERS</p> <ul style="list-style-type: none"> <input type="checkbox"/> history of cancer-lung, breast, prostate, colon, other _____ <input type="checkbox"/> drug abuse <input type="checkbox"/> other diagnoses- <input type="checkbox"/> x-ray therapy <input type="checkbox"/> chemotherapy <input type="checkbox"/> unusual childhood illnesses- <hr/> <p>PAIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> Where? _____ <input type="checkbox"/> Sharp, dull, burning, aching, stabbing, throbbing,

CHECK HERE IF NONE OF THE ABOVE APPLY

Other medical conditions: _____

FIVENSON DERMATOLOGY

3200 WEST LIBERTY RD, SUITE C5, ANN ARBOR, MI 48103
(734) 222-9630



From Jackson Area:

I 94 EAST to EXIT 169 (Zeeb Road), turn right onto Zeeb. Take to Liberty Road (4 way stop). Turn left on Liberty. Office on left side. Approximately ¼ mile. *LIBERTY MEDICAL COMPLEX*

From Brighton Area:

US 23 SOUTH to M14 WEST. EXIT AT Exit #2 (Miller/Maple). Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile. *LIBERTY MEDICAL COMPLEX*

From Downtown and East Detroit

94 to 96 WEST to M14 WEST. EXIT AT Exit #2 (Miller/Maple). Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile. *LIBERTY MEDICAL COMPLEX*

From Detroit (West of Downtown): 94 WEST to 23 NORTH to M14 WEST . Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile. *LIBERTY MEDICAL COMPLEX*

From Toledo: 23 NORTH to M14 WEST. EXIT AT Exit #2 (Miller/Maple) Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile. *LIBERTY MEDICAL COMPLEX*

From Downtown Ann Arbor: MILLER WEST to Wagner, turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile. *LIBERTY MEDICAL COMPLEX*