MODERNIZING MEDICINE

To better serve you, our patient,
we would like to invite you to access our

Patient Portal,

Which can be found at

dasc.ema.md

Your username will be:

- *The capitalized first letter of your first name*
- *The first letter of your last name and*
- *Your eight-digit birthdate.*

For example, if your name is
John Smith and you were born on January 1, 1981,
your login would be JS0101981

Your password will be: Princeton1

This portal can be used to:
Review and verify your contact information, medical history, medications and allergies, communicate with your provider and/or their staff and request prescription refills.

Please call our office if you require assistance
accessing your portal or making changes
304-487-9100

Dermatology Associates & Surgery Center

Beckley	Princeton	Logan	Charleston
304-252-2673	304-487-9100	304-752-8202	304-345-1966

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality for the PHI of our patient's degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO), because we will.....

* Adhere to the standards set forth in the Notice of Privacy Practices.

* Collect, use the disclose PHI only in conformance with the state and federal laws and current patient covenants and or authorization, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of our practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.

* Use and disclosure PHI to remind patients of their appointments only within their consent.

* Recognize the PHI collected about patients must be accurate, timely, complete and available when needed. Our practice and its physicians and staff will implement reasonable measures to protect the integrity of all PHI maintained about patients.

* Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently our practice and its physicians and staff will treat all PHI data as confidential in accordance with professional ethics, accreditation standards and legal requirements. Not Disclosure PHI data unless the patient (or authorized representative) has properly consented to the release or the release is authorized by law.

* Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her medical record if he/she believes that his/her information is inaccurate or incomplete. Our practice and its physicians and staff will....

*Permit patients access their written record if approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patient's appeals.

* Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.

* All physicians and staff of our practice will maintain a list of all disclosures of PHI for purposes other than TPO for each patient. We will provide this list to patients upon request, so long as they are in writing.

* All physicians and staff of our practice will adhere to any restrictions concerning the use and disclosure of PHO that patients have requested and have been approved by our practice.

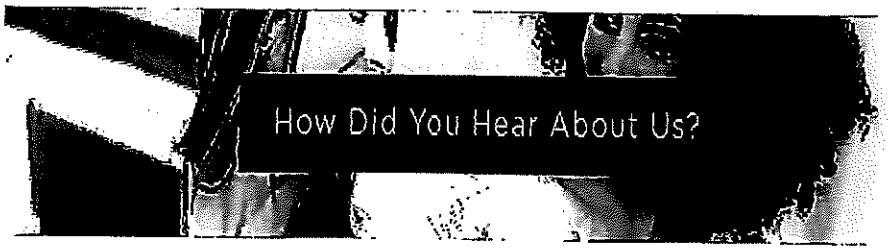
* All physicians' staff must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action up to and including termination of employment and criminal or professional sanction's in accordance with our practice's rules and regulations.

* A more detailed Notice of Privacy Practices available upon request.

* If any problems or questions please contact our privacy office listed below:

Loretta Davis, Privacy Officer 304-252-2673 Ext. 314

Dermatology Associates
and Surgery Center



	Mailer
	Social Media
	Online Ad
	Newspaper
	Doctors Referral
	Word of Mouth
	Other

Intake and History Form

Name: _____ Date: _____

Billing Address: _____ City / State: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (home): _____ Phone Number (cell): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Social Security Number _____

Preferred Pharmacy

Name: _____

Phone Number: _____

City or Zip Code: _____

If under 18 years of age, please complete:

RESPONSIBLE PARTY : _____ DOB : _____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN:

I hereby authorize payment to the undersigned physician of any surgical and/or medical benefits, if any, are payable to me for this service.

_____ _____

Signature Date

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

It is the policy of our practice that all physicians and staff preserve the integrity and confidentiality of protected information pertaining to our patients. The purpose of the policy is to ensure that our practice and physicians and staff have the necessary medical information to provide the highest quality medical care possible while protecting the confidentiality of the information of our patients to the highest degree possible. I have been given a copy of the Dermatology Associates & Surgery Center's Privacy Notice and by signing below acknowledge such.

Signature: _____ Date: _____

I give the physicians and staff at Beckley Dermatology, Inc. my permission to speak with the following person(s) listed below about my medical condition or any other information necessary for treatment or payment operations.

NAME: _____ NAME: _____

NAME: _____ NAME: _____

8-8-10

Intake and History Form

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____

_____

_____

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart: Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt

- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy: Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP

Intake and History Form

- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma

- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other

_____

_____

_____

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other

_____

_____

Do you wear Sunscreen?

○ Yes ○ No

If yes, what SPF? _____

Do you tan in a tanning salon?

○ Yes ○ No

Do you have a family history of Melanoma?

○ Yes ○ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____

_____

Intake and History Form

Do you have any advanced directives?

Do Not Resuscitate _____

Medical Power of Attorney _____

Living Will _____

Have you had the following vaccines?

Flu _____

PCV 13 (Pneumococcal Conjugate Vaccine) _____

PPSV23 (Pneumococcal Polysaccharide Vaccine) _____

Occupation and Workplace:

_____

_____

Any Additional Immediate Family History:

_____

_____

_____

2-2-18

Intake and History Form

Medications	Dose	Route	Frequency

List all current medications:

Allergies

List all allergies and reactions if known:

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

2-2-18

Dermatology Associates & Surgery Center

Date Completed: _____

Self Pay/Private Pay Financial Policy

Patient Name: _____ Chart #: _____

Date of Birth: _____ Initial Date of Service: _____

Full Address: _____

Home Phone: _____ Cell Phone: _____

By signing the below I agree that:

- At this time I do not have health insurance coverage. I understand that I am responsible for all charges for office visits, procedures and lab specimens that are obtained and performed at Dermatology Associates & Surgery Center.
- If at any time I have a change in insurance coverage and choose to have insurance submitted, it is my responsibility to notify Dermatology Associates & Surgery Center of these changes.
- If I have any questions regarding my account balance I will contact the billing office at 1-800-835-1945 or 1-540-504-0326.
- I understand that a payment of $100.00 must be paid in advance if I am a new patient, $50.00 if I am here for a return visit.
- Before any surgical procedures are scheduled, the front office will discuss the cost and payment arrangements will be made.
- A prompt pay discount of 30% will be given if payment made within 10 days of first statement being sent out.

Patient signature: _____ Date: _____

Representative from Beckley Dermatology: _____

Dermatology Associates & Surgery Center Financial Policy

Thank you for choosing Dermatology Associates & Surgery Center and entrusting our practice with your dermatological health. We are committed to building a successful physician-patient relationship with you and your clear understanding of our Patient Financial Policy and payment requirements is important to our relationship. Please read this carefully and ask any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
2. **Self Pay/Non Insured patients.** We require a minimum payment of $100.00 at each visit. Please review our self pay/non insured financial policy.
3. **Insurance.** We participate in most insurance plans, including Medicare. We will file all services to active insurance plans however knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
4. **Proof of insurance.** Patients are required to present driver's license and current valid insurance card. Insurance cards must be presented at each visit. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for the balance of your visit.
5. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by your insurance company. If a service is deemed non-covered you will be responsible for payment.
6. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

Patient nonpayment: Please contact our billing office in the event you are unable to pay on your account. We will work with you to develop a plan that will allow you to pay your bill and avoid outside collections

8. **Returned check fees.** The charge for a returned check is $35.00 payable by cash or money order.

2-2-18

Our office is committed to providing you the highest quality health care at the lowest cost. In order to be able to maintain low costs we need your participation with the above policy. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

_____

Signature of patient or responsible party/Date

Our office accepts the following payment types:

Cash, checks, debit cards, American Express, Mastercard, Visa and Discover