AbbasiDerm.com
21401 Allen Road
Woodhaven, MI 48183
734.675.0835 Phone
734.675.0873 Fax

PATIENT INFORMATION
(please print)

Today's Date: _____/_____/_____

Legal Name:_____ D.O.B_____ SSN: _____

Mailing Address_____
Street City State Zip

Home Phone: (_____) _____-_____ Cell Phone: (_____)_____-_____ Preferred #: H / C

Sex: ___ Female ___Male ___ Other Preferred Pronoun:_____ How would you like to be addressed?: _____

Race: _____ Preferred Language: _____ Ethnicity: _____

E-mail address for portal access: _____

GUARANTOR INFORMATION

Legal Name: _____ D.O.B: _____ Phone:_____

Mailing Address_____
Street City State Zip

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship:_____

HIPAA QUESTIONNAIRE

1. In signing this notice, I, _____am granting permission for this office to inquire or obtain information from my insurance company for treatment and billing purposes for myself and family members and to receive and/or forward necessary records if indicated in the case of a referral or transfer to another facility.

2. Please list the family members or other persons, if any, whom we may inform about your medical condition(s) (including treatment and payment)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

3. Please list the family member who is named legal representative (guardianship, foster care or medical power of attorney), whom we may inform and/or inquire about your medical condition given more extenuating circumstances:

Name: _____ **Phone:** _____

4. Can confidential messages (i.e. appointment reminders) be left on your voicemail? Yes: ____ **No:** _____

CONSENT TO EXAMINATION AND TREATMENT
I understand and voluntarily consent to receive medical and health care services given by SAMI ABBASI, D.O., his associates or assistants. I understand the examination procedures will be explained to me and I authorize the administration of all diagnostic and therapeutic procedures, examinations, and treatments considered advisable or necessary in the judgment of the physician. I understand that the examination results will be provided to me with recommendations. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. The responsibility for any follow-up examinations to check abnormalities found and treated, lies with me and not with my Dermatologist. I hereby release my examiner from all responsibility in connection with the examination.

CANCELLED, MISSED APPOINTMENTS, AND SAME DAY RESCHEDULED
Broken appointments represent a cost to us, to you, and to other patients who should have been seen in the time set aside for you. Cancellations and reschedules require a 24-hour notice. We reserve the right to charge a $30.00 fee for missed, same day cancelled or same day rescheduled appointments. We also have a $150.00 charge for missed surgical appointments. Excessive abuse of scheduled appointments may result in discharge from the practice.

COSMETIC APPOINTMENTS
All cosmetic appointments require a $50.00 deposit payable when making the appointment. The deposit will be applied at the time of treatment. *If you should miss that appointment, cancel or reschedule without 24 hours notice you forfeit the deposit.*

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
INSURANCE BENEFITS: We encourage our patients to discuss fees with us prior to any major medical or surgical procedure. We will bill your insurance company as a courtesy to you. You are expected to pay your deductible and copayments at the time of service. You should contact your insurance company if you are not aware of what your copayment is. If we have not received payment from your insurance company within 90 days of the date of service you will be expected to pay the balance in full and collect from your insurance company. **You are responsible for all charges**. Should you fail to pay for services rendered, your account may be turned over to a collection agency or attorney for collection. Once your account is turned over to a collection agency or attorney, you shall be responsible for the full balance due plus an additional 30% of the current balance due to cover collection costs and/or attorney fees.

NO INSURANCE BENEFITS: For patients with no insurance or who receive cosmetic procedures, I acknowledge I am financially responsible for all charges for services and payment is expected at time of service unless arrangements are made in advance for a payment plan. RELEASE OF INFORMATION: I hereby authorize SAMI ABBASI, D.O., his associates or assistants to release any information in the course of my examination or treatment as may be needed to process my insurance claims and to inform my private physician as to my course of treatment. I hereby authorize my insurance benefits to be paid directly to SAMI ABBASI D.O.

PAYMENT FOR SERVICES IS EXPECTED AT THE TIME OF THE SERVICE: Payment is required at the time services are rendered unless other arrangements have been made in advance with a member of our office staff. This includes applicable coinsurance and copayments for participating insurance companies. Our practice accepts cash, personal checks, VISA, Mastercard, AMEX, and Discover. There will be a charge of **$30.00** for any returned checks. Patients with an outstanding balance of 90 days overdue must make arrangements for payment prior to scheduling appointments.

MANAGED CARE PLANS
If you are enrolled in a managed care insurance plan (i.e. **BLUE CARE NETWORK**), you are responsible for obtaining your referral from your primary care physician and presenting it to our office at the time of the service. If no referral is obtained you are responsible for the cost of treatment.

BY SIGNING BELOW I CERTIFY THAT I HAVE READ THIS FORM AND UNDERSTAND ITS CONTENTS.

_____ _____
Signature of Patient or Other Legally Authorized Person Date

_____ _____
Print Patient Name if different than above Date

PLEASE COMPLETE THIS SECTION IF YOU ARE 65 YEARS OF AGE OR OLDER

FLU VACCINE: Y / N **DATE**: _____ **PNEUMOCOCCAL VACCINE :** Y / N

DO YOU HAVE A HEALTHCARE PROXY OR POWER OF ATTORNEY? Y / N

IF YES, PLEASE COMPLETE NAME: _____ PHONE NUMBER: _____

DO YOU HAVE A LIVING WILL? Y / N

Which statement(s) best reflects your wishes on advanced care recommendations?

___ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

___ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

___ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

Introduction

At Abbasi Dermatology we are committed to treating and using Protected Health Information (PHI) about you responsibly. This Notice of Health Information Practices describes the personal information we collect and how we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective July 1, 2010 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Abbasi Dermatology, a record of your visit is made. Typically, this record contains your medical history, examination and test results, diagnoses, treatment and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment
- Means of communication among the many health professionals who contribute to your care
- Legal document describing the care you received
- Means by which you or a third-party payer can verify that services billed were actually provided
- A tool in educating health professionals
- A source of data for medical research
- A source of information for public health officials charged with improving the health of this state and nation
- A source of data for our planning and marketing
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.
- Understanding what is in your record and how your health information is used helps you to: Ensure its accuracy, better understand who, what, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Right

Although your health record is the physical property of Abbasi Dermatology, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request
- Inspect and copy your health record
- Amend your health record
- Request communications of your health information by alternative means or at alternative locations
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibility

Abbasi Dermatology is required to:

- Maintain the privacy of your health information
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you
- Abide by the terms of this notice
- Notify you if we are unable to agree to a requested restriction
- Accommodate a reasonable request you may have to communicate health information by alternative means or alternative locations

We reserve the right to change our practices and to make new provisions effective for all protected health information we maintain. Should our information practices change we will make a revised notice available to you.

We will use your health information for regular health operations

For example: Member of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the health care and service we provide.

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Business associates: There are some services provided in our organization through contacts and business associates. Examples include physician services in the emergency department, hospital and urgent care facility, radiology referrals, laboratory tests, and billing services associated with these associates.

When these services are contracted, we may disclose your health information to our business associates so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another responsible person, for the purposes of continuing care. For example: A specialist we referred you to may not have your correct telephone number and need to reschedule an appointment.

Organ procurement organization: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking of transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment or other health related services that may be of interest to you.

Workers Compensation: We may disclose health information to the extent necessary to comply with the laws relating to workers compensation or other similar programs established by law.

Public Health: As required by law, we may disclose your health information to public health for legal authorities charged with preventing or controlling disease, injury or disability.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue using or disclosing your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact Abbasi Dermatology at:

WOODHAVEN
21401 Allen Rd
Woodhaven, MI 48183
Phone: 734-675-0835
Fax: 734-675-0873

If you believe your privacy rights have been violated, you can file a complaint with the practices' Privacy Officer or with the Office for Civil Rights U.S. Department of Health

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ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of Abbasi Dermatology's notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available in the reception area, and that I will be offered a revised copy at my next appointment if the Notice of Privacy Practices has been amended.

_____ _____

Signature of Patient or Other Legally Authorized Person Date

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ANNUAL HISTORY AND PHYSICAL FORM

NAME: _____ **DOB:** _____

HISTORY OF MEDICAL CONDITIONS: _____

HISTORY OF SURGERIES:_____

Race/Ethnicity: _____ **Preferred Language**: _____

PERSONAL/FAMILY HISTORY OF SKIN CANCERS:

Basal Cell Carcinoma: Self: ___ Family: ___ Relationship: _____

Squamous Cell Carcinoma: Self: ___ Family: ___ Relationship: _____

Melanoma: Self: ___ Family: ___ Relationship: _____

Have you had a FULL BODY skin exam? Y / N **Year**? _____

PERSONAL HISTORY OF SKIN DISEASES:_____

FAMILY HISTORY OF SKIN DISEASES:_____

CURRENT MEDICATIONS/DOSE/FREQUENCY:_____

ALLERGIES:_____

SOCIAL HISTORY: ARE YOU PREGNANT? Y / N **PLANNING TO BE?** Y / N

TOBACCO USE? Y / N **If yes, type and frequency?** _____ **ALCOHOL** Y / N **# OF DRINKS PER WEEK?** _____

PATIENT PHARMACY INFORMATION

NAME OF PHARMACY: _____**PHONE**: _____

ADDRESS: _____

NAME OF PRIMARY CARE DOCTOR? _____**WHO REFERRED YOU**?_____

REVIEW OF SYSTEMS - PLEASE ***CIRCLE*** ANY PROBLEMS YOU CURRENTLY HAVE

Abdominal Pain	Blurry Vision	Headaches	Seizures
Anxiety	Changing Mole	Immunosuppression	Shortness of Breath
Allergy to Adhesive	Chest Pain	Joint Aches	Sore Throat
Allergy to Lidocaine	Cough	Muscle Weakness	Thyroid Problems
Allergy to Topical Antibiotics	Defibrillator	Pacemaker	Unintentional Weight loss
Blood Thinners	Depression	Problems with Bleeding	Yeast infec. w/Antibiotics
Bloody Stool	Fever / Chills	Problems with Healing	OTHER: _____
Bloody Urine	GI Upset w/Antibiotics	Problems with scarring	

FLU VACCINE: Y / N **DATE**: _____**PNEUMOCOCCAL VACCINE (if over 65):** Y / N