Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

Please Print ***Please complete ALL requested information***

Patient Information

Today's Date	Last Name:		First Name:	Middle Initial:
Date of Birth: / /	Age:	Ethnicity: `	Marital Status:	Social Security Number:
Street Address (including City, State and Zip Code):				
E-mail Address:				
Telephone Number: Home: Work: Cell:				
Employer or School Name and Address:				
Primary Care Physician Name:			Specialty: (i.e., Internal Medicine, Family Practice, OB/GYN, Pediatrics)	
Primary Care Physician's Address including City, State and Zip:				

Parent or Responsible Party (*if different from patient)*

Last Name:	First Name and Middle Initial:			
Date of Birth: / /	Age	Sex	Marital Status:	Social Security Number:
Street Address (including City, State and Zip)			Email Address:	
Telephone Number: Home: Work: Cell:				
Employer's Name and Address:			Employer Telephone Number:	

Primary Insurance Information

Name of Insured: (Last, First, Middle)			Social Security Number:
Insured's Address, City, State and Zip Code:			
Telephone Number: Home: Work: Cell:			
Insured's Date of Birth / /	Age	Sex	Marital Status:
Primary Insured's Employer's Name:			Employer's Telephone Number:
Primary Insured's Employer Address (City, State and Zip)			
Name of Insurance			
Policy No.:			Group No.

Is prior authorization required by your insurance to see a specialist? Yes No
Do you have your Prior Authorization Reference/Tracking Number? If yes, please it write here:

Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

Secondary Insurance Information (If Not Applicable, Leave Blank)

Name of Insured: (Last, First, Middle) Social Security Number:

Insured's Address, City, State and Zip Code:

Telephone Number: Which phone number is your preferred method of contact: Home____ Work____ Cell____
Please write that number here:

Insured's Date of Birth / / Age: Sex: Marital Status:

Insured's Employer's Name: Employer's Telephone No.: ( )

Secondary Insured's Employer Address (City, State and Zip)

Name of Insurance:

Secondary Insurance Address for Medical Claims:
(Street or Post Office Box, City, State and Zip Code)

Policy No.: Group No

Tertiary Insurance Information (If Not Applicable, Leave Blank)

Name of Insured: (Last, First, Middle) Social Security Number:

Insured's Address, City, State and Zip Code:

Telephone Number: Which phone number is your preferred method of contact: Home____ Work____ Cell____
Please write that number here:

Insured's Date of Birth / / Age: Sex: Marital Status:

Name of Insurance:

Insurance Address for Medical Claims: (Street or
Post Office Box, City, State and Zip Code)

Policy No.: Group No:

DO ANY OF YOUR INSURANCES REQUIRE PRIOR AUTHORIZATION? YES _____ NO _____
DO YOU KNOW THE AUTHORIZATION OR REFERRAL NUMBER? IF YES, PLEASE WRITE HERE:
_____

Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

MEDICAL CONSENT TO TREAT AND AUTHORIZATION TO RELEASE MEDICAL RECORDS

I am voluntarily seeking medical care and hereby consent to medical treatment, procedures, laboratory tests, and other health care services provided or referred by Larry E, Urry, M.D or any other medically credentialed provider(s) under the direction of Draper Dermatology. This agreement of "Medical Consent to Treat and Authorization to Release Medical Records" may be revoked by me at any time by written notification and is valid until revoked.

I have the right to refuse specific treatment or procedures.

I have the right to discuss my diagnosis (if known), the nature and purpose or a proposed treatment or procedure, alternatives (regardless of their cost or the extent to which the treatment options are covered by medical insurance), the risks and benefits of the alternative treatment or procedure, and the risks and benefits of not receiving or undergoing a treatment or procedure.

I hereby authorize Larry E. Urry, M.D. or any other medically credentialed provider(s) under the direction of Draper Dermatology to bill my insurance plan(s) as appropriate to process primary, secondary, and/or supplemental insurance claims, insurance applications, laboratory and/or pathology tests, and/or prescriptions.

I authorize the release of medical information to my primary care or referring physician, to consultants if requested. I understand that my medical record may contain reports, test results, and notes that only a physician may interpret. I understand that I should contact my physician regarding entries made in my medical record to prevent any misunderstanding of the information provided.

I understand that once my health information is released, Draper Dermatology nor any other person employed by Draper Dermatology, may guarantee that the recipient will not re-disclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I am at least 18 years of age, an emancipated minor, or the parent/legal guardian of this patient under 18 years of age.

Patient or Responsible Party Signature:_____ Date: ___/___/___

AUTHORIZATION TO TREAT IN ABSENCE OF PARENT OR GUARDIAN

If my child(ren) is/are brought to the office by_____, I consent for my children to be treated and agree to be financially responsible for the cost of such care.

I UNDERSTAND THAT BY NOT SIGNING THIS SECTION MY CHILD(REN) MAY NOT BE SEEN BY ANY PROVIDER AT DRAPER DERMATOLOGY WITHOUT MYSELF OR ANOTHER LEGAL GUARDIAN PRESENT.

Legal Guardian Signature: _____

Legal Guardian Printed Name:_____Date: _____

Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

Preferred Method to Receive Messages and Reminders:

HOW WOULD YOU PREFER TO RECEIVE MESSAGES AND/OR BE REMINDED ABOUT APPOINTMENTS? PLEASE CHECK ONE: **(PATIENT RESPONSIBLE FOR ANY COSTS INCURRED BY TELEHONE, CELLULAR, OR INTERNET SERVICE FOR MESSAGES BY TEXT, TELEPHONE, OR EMAIL.)**

☐ **TEXT MESSAGE: CELL PHONE NUMBER** _____

☐ **PHONE CALL: PREFERRED NUMBER** _____

☐ **E-MAIL:** _____

Do we have your permission to:

Leave a message regarding upcoming or missed appointments on your answering machine or voice mail? ❑ Yes ❑ No

Leave a message regarding biopsy or other test results on your answering machine or voice mail? ❑ Yes ❑ No

Discuss upcoming or missed appointments and/or biopsy or other test results with a member of your household? ❑ Yes ❑ No

If yes, whom:_____ Relationship to patient: _____

Discuss your financial information, insurances, payments, charges, adjustments with a member of your household? ❑ Yes ❑ No

If yes, whom:_____ Relationship to patient: _____

Patient or Responsible Party Signature: _____ Date: ___/___/___

Acknowledgement of Receipt of Privacy Policy

I acknowledge I have received a copy of Draper Dermatology's privacy policy:

Patient or Responsible Party Signature:_____ Date: ___/___/___

Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

FINANCIAL POLICY AND CANCELLATION NOTICE

THE PATIENT/RESPONSIBLE PARTY IS RESPONSIBLE FOR ALL MEDICAL AND/OR AESTHETIC BILLS THAT RESULT FROM SERVICES RENDERED BY INDIVIDUALS EMPLOYED BY DRAPER DERMATOLOGY

- There is a **24 hours cancellation notice** required **for all appointments**. We reserve the right to charge **$50 for a missed office visit, $100 for a missed surgery appointment, and up to $150 for a missed hair removal, facial, FotoFacial©, peel, laser, or other medical or aesthetic appointment.**
- I hereby authorize payment of medical benefits to Draper Dermatology.
- **Co-payment is required before service is rendered.**
- **Patients without insurance and/or other cash-pay services are to be paid in full upon checkout on the day of service.**
- Payment is accepted in the form of cash, check or credit card (Visa, MasterCard, American Express, or Discover).
- **In the event of a returned check, your check is sent immediately to Express Recovery Services, Inc. wherein a minimum $25 return check fee will be assigned**. You agree to pay any additional charges assessed by Express Recovery Services, Inc.
- All delinquent accounts will be charged a 13% per annum (1.0833 percent per month) or a minimum of 65 cents ($.65) monthly finance charge, whichever is greater, which is due and payable upon receipt of statement.
- **In the event any balance is not paid as agreed, the undersigned agrees to pay a collection fee not to exceed thirty-three percent (33%) of the unpaid balance.** In the event of a lawsuit to collect the unpaid balance, the undersigned further agrees to pay court costs and reasonable attorney's fees in addition to the collection fee. You authorize us to call you at any number you provide or at any number that we reasonably believe we may contact you (including calls to mobile, cellular, or similar devices) for any lawful purpose. You agree to pay any fee(s) or charge(s) that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us. You will also be responsible for all additional costs, charges, and/or legal fees added by Express Recovery Services, Inc.
- You agree that a photocopy of this agreement is as valid as the original.

Patient or Responsible Party Signature: _____ Date: ___/___/__

Our paperwork is updated annually. Thank you for your cooperation in keeping your information current.

Draper DERMATOLOGY
The art and science of skin care

Please fill out ALL requested information

Medical History

Select any of the following medical conditions that you currently have:

- ❑ None
- ❑ Anxiety
- ❑ Asthma
- ❑ Atrial Fibrillation (Irregular Heartbeat)
- ❑ Bone Marrow Transplantation
- ❑ 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
- ❑ Other:

Have you had any surgeries on the following organs?

- ❑ None
- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (Both Breasts)
- ❑ Breast: Lumpectomy (Left Breast)
- ❑ Breast: Lumpectomy (Right Breast)
- ❑ Breast: Mastectomy (Both Breasts)
- ❑ Breast: Mastectomy (Left Breast)
- ❑ Breast: Mastectomy (Right Breast)
- ❑ Colon (Colectomy): Colon Cancer Resection
- ❑ Colon (Colectomy): Diverticulitis
- ❑ Colon (Colectomy): Inflammatory Bowel Disease
- ❑ Colon: Colostomy
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart: Biological Valve Replacement
- ❑ Heart: Coronary Artery Bypass Surgery
- ❑ Heart: Heart Transplant
- ❑ Heart: Mechanical Valve Replacement
- ❑ Heart: PTCA
- ❑ Joint Replacement: Hip (Both)
- ❑ Joint Replacement: Hip (Left)
- ❑ Joint Replacement: Hip (Right)
- ❑ Joint Replacement: Knee (Both)
- ❑ Joint Replacement: Knee (Left)
- ❑ 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
- ❑ 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
- ❑ Other:

Draper DERMATOLOGY
The art and science of skin care

Skin Disease History

Have you had any of the following skin conditions?

- ❑ None
- ❑ 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
- ❑ Other:

Do you wear sunscreen?

❑ Yes ❑ No SPF:

Do you tan in a tanning salon?

❑ Yes ❑ No

Do you have a family history of melanoma?

❑ Yes ❑ No

If yes, which relative(s)?

Allergies

Please list any known allergies here:

Draper DERMATOLOGY
The art and science of skin care

Patient Registration Form

Today's Date _____

Current Medications

Reason for Use	Medication Name	Strength	How many times a day?	When? AM/PM/With Meals/As Needed	Prescription Start Date	Prescription End Date
Example: Acne	Solodyn	85mg	1	PM	9/1/16	9/30/16
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20						

Draper DERMATOLOGY
The art and science of skin care

Social and Family History	
Smoking Status (Please write "N/A" if this does not apply):	
Started (mm/dd/yy):	Stopped (mm/dd/yy):
Number of packs per day:	Total years smoking:
Additional Details:	

Social History Details:

- ❑ None
- ❑ Not sexually active
- ❑ Sexually active with one partner
- ❑ Sexually active with more than one partner
- ❑ Same sex partner
- ❑ Drug use
- ❑ Intravenous Drug Use
- ❑ Intravenous Drug Use Within Past 12 Months
- ❑ Alcoholic drinks; none
- ❑ Alcoholic drinks; less than 1 drink per day
- ❑ Alcoholic drinks; 1-2 drinks per day
- ❑ Alcoholic drinks; 3 or more drinks per day
- ❑ Patient feels safe at home
- ❑ Patient feels unsafe at home
- ❑ Other (please explain):

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?

Draper DERMATOLOGY
The art and science of skin care

74 E Kimballs Lane, Suite 230
Draper, UT 84020-5005
1-800-Skincare 801-232-6556
Privacy Official: Ryan Cooksey, Practice Administrator
Email: ryan@draperderm.com
Phone: (801) 201-4338

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review it carefully.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share

- You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
  - We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
  - We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Utah Code Ann. § 78B-5-618 Patient access to medical records - Third party access to medical records
If a health care provider is considered a covered entity under HIPAA, a patient or personal representative may inspect or receive a copy of the patient's record from that provider in accordance with 45 C.F.R. Parts 160 and 164. If a health care provider is not considered a covered entity under HIPAA, a patient or personal representative may inspect or receive a copy of the patient's records unless access to the records is restricted by law or judicial order.

Any health care provider who provides a copy of a patient's records must comply with the deadlines required by HIPAA (45 C.F.R. 164.524(b)), and may charge a reasonable cost-based fee that only includes the cost of copying (including supplies for and labor of copying), and postage (when the patient or representative requested that the copy be mailed).

Any health care provider or other person authorized to provide records who provides a copy of a patient's records to an authorized third party must provide a copy within 30 days after receipt of notice and may charge a reasonable fee to cover the provider's costs of up to $20 per request for locating the records, copying charges up to $0.50 per page for pages 1-40 and up to $0.30 per page for pages 41 and above, the cost of postage (when the third party requested that the copy be mailed), and any sales tax owed. Current as of June 2015

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Date of Current Notice: July 12, 2016