THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA , PLLC

3700 JOSEPH SIEWICK DR. SUITE 404/402, FAIRFAX , VA 22033

(703)620-8900 FAX : (703)620-2288

ELECTRONIC SIGNATURES

By typing your name on the signature lines of this document and sending it to us electronically, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manually/handwritten signature on this Agreement. By typing your name on the signature line, you consent to the legally binding terms and conditions of this Agreement. You further agree that your signature on this document (hereafter referred as your "E-Signature") is as valid as if you signed the document in writing. You also agree that no certification authority or other third party verification is necessary to validate your E-Signature, and that the lack of such certification or third party verification will not in any way affect the enforceability of your E-Signature or any resulting agreement between you and The Clinical Skin Center of Northern Virginia, PLLC. You are also confirming that you are the person or their authorized representative entering into this Agreement.

Definitions: "Electronic" means technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities. "Electronic Signature" means and electronic symbol or process attached to, or logically associated with, a record and used by a person with the intent to sign the record.

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PATIENT REGISTRATION FORM

PATIENT INFORMATION Today's Date ____/____/____
Month Day Year

Name: _____Jr. , Sr. Other _____
Last First M.I.

Mailing Address: _____
Street # Street Name Apt #

_____
City State Zip

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

Date of Birth ____/____/____ Sex: ◯ Male ◯ Female Marital Status _____
Month Day Year

Military Rank/Rate: _____

Referring Physician _____City_____Phone_____

Primary Physician _____City_____Phone_____

In case of Emergency, who should be notified? _____ Phone _____

I give my permission and consent for my private medical information to be released to:

_____ , _____.
Full Name Relationship to patient

INSURANCE INFORMATION

Primary Ins: ◯ Self ◯ Spouse ◯ Dependent **Secondary** Ins: ◯ Self ◯ Spouse ◯ Dependent

Policyholder's name_____ Policyholder's name_____

_____ _____/_____/_____
Signature of Patient or Responsible Party Date

Please present insurance cards and photo ID to the receptionist so copies can be made.

Rev 05/21

THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA , PLLC

MEDICAL HISTORY

Patient Name:_____ **Date:**____/_____/_____

What skin issue are you here for: _____

Are you ALLERGIC to LATEX? ◯ YES ◯ NO If Yes, explain reaction:_____

Have you ever had a SKIN CANCER? ◯ YES ◯ NO If YES, Circle Type:

☐ MELANOMA ☐ BASAL CELL CARCINOMA ☐ SQUAMOUS CELL CARCINOMA

Is there a FAMILY HISTORY of MELANOMA: ◯ YES ◯ NO Who?_____

Is there a FAMILY HISTORY of Other SKIN CANCER : ◯ YES ◯ NO Who? _____

Have you ever been diagnosed with HIGH BLOOD PRESSURE (hypertension) or DIABETES? : ◯ YES ◯ NO

Are you taking ASPIRIN, MULTI-VITAMINS, FISH OIL or HERBAL SUPPLEMENTS?: ◯ YES ◯ NO

Do you currently use Nicotine? ◯ YES ◯ NO How many yrs? _____ ☐ Tobacco ☐ Vaping electronic pen

Are you ALLERGIC to any medicines? ◯ YES ◯ NO If Yes, please list:

MEDICATION ALLERGY	REACTION
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS and SUPPLEMENTS/HERBALS you are currently taking : ☐ NONE

1_____	5_____	9_____
2_____	6_____	10_____
3_____	7_____	11_____
4_____	8_____	12_____

Do you have any MEDICAL PROBLEMS / SURGICAL HISTORY? (Not Skin) ◯ YES ◯ NO If Yes, please list:

_____

_____

History of SKIN PROBLEMS?: ☐ NONE List:_____

CURRENT OCCUPATION: _____

THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA , PLLC

PATIENT FINANCIAL POLICY AND SIGNATURES ON FILE

Patient Name:_____ Date _____/_____/_____

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.

PAYMENT POLICIES:
MEDICARE: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible, paying for the co-payment and charges for non-covered /cosmetic services. If we participate with your secondary/supplemental carriers we will file a claim for you. However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. I authorize any holder of medical or other information about me to be released to the Social Security Administration, Center for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PPO, HMO, TRICARE, OR OTHER MANAGED CARE PATIENTS : If **we participate (are contracted)** with an **insurance plan** under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic service. In the event that we are not aware that a particular service is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

NON-MEDICARE PATIENTS WHO HAVE INSURANCE COVERAGE WITH A CARRIER THAT WE DO NOT HAVE A CONTRACT (PARTICIPATE) WITH: Patients covered by private, commercial plans in which our physicians are not members will be responsible for payment in full at the time of service, regardless of the benefits and payment policies of your carrier. We will *NOT* file claims directly with your insurance company. Patients may elect to independently seek reimbursement from their carrier, if so we can provide you documentation of the services performed.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient or Responsible Party Signature_____ Date _____/_____/_____

If you have a **SUPPLEMENTAL POLICY** to which your **MEDICARE** carrier automatically "crosses over": I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related service.

Patient or Responsible Party Signature _____Date _____/_____/_____

THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA , PLLC

HIPAA CONSENT AGREEMENT AND NON DISCRIMINATION POLICY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement in order to the use and disclose individually identifiable health information (IIHI), as long as it is only shared with others who are treating you or supporting us in providing you quality health care.

However, it is Important to have your consent to allow us to use and/or disclose your IIHI to health care plans to ensure accurate and timely payments for the services we render. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. Please refer to our Privacy Notice (this document is available from the front desk) for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements:

I have been offered an opportunity to review a Privacy Notice and I understand my rights regarding individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

The obligation to notify patients if there is a breach of their Protected Health Information (PHI) has been clarified under the new rule. The subjective “harm” standard in the interim final rule has been eliminated. Under the “harm” standard, a breach did not occur unless the access, use, or disclosure posed “a significant risk of financial, reputational, or other harm to an individual.” Now, any acquisition, access, use, or disclosure of unsecured PHI not permitted under HIPAA is presumed to be a breach unless it is determined that there is a low probability that the PHI has been compromised based on a four-factor risk assessment:

1. The nature and extent of PHI involved;
2. The unauthorized person who used the PHI or to whom the disclosure was made;
3. Whether PHI was actually acquired or viewed; and
4. The extent to which the risk to PHI has been mitigated (e.g., assurances from trusted third parties that the information was destroyed).

Individuals have a right to access and to obtain a copy of PHI within 30 days of their request. Under the new rule, if an individual requests a copy of PHI that is maintained electronically, the provider must, with limited exception, give the individual access to the PHI in an electronic format.

At an individual’s request, a health care provider may not disclose the individual’s PHI to a health plan, if the disclosure is not required by law, the request relates to payment or health care operations, and the individual has paid for the item or service out of pocket in full. If an individual makes such a request, providers will want to document the request and ensure that the patient understands that no claims will be submitted by the provider to the patient’s insurer. Providers will also need to employ some method to flag medical records with respect to the PHI that has been restricted.

Under the new rule, providers may disclose PHI to family members of a decedent who were involved in the person’s care prior to his or her death, unless doing so is inconsistent with any prior expressed preference of the individual that is known to the covered entity.

THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA , PLLC

HIPAA CONSENT AGREEMENT AND NON DISCRIMINATION POLICY CONTINUED

The law allows us to make disclosures for payment purposes, treatment and permitted disclosures to patients in exchange for a reasonable fee.

OUR OFFICE DOES NOT AND WILL NOT SELL YOUR HEALTH INFORMATION TO ANYONE. Federal law requires us to tell you that your individual authorization is required before any information is sold.

OUR OFFICE DOES NOT AND WILL NOT CONDUCT FUNDRASING ACTIVITIES. Federal law requires us to tell you that you would have the opportunity to opt-out of receiving fundraising communications.

The new rule permits a provider to combine an authorization for the disclosure of PHI for research purposes that requires the signing of that form for the patient to be treated with an authorization for the use of PHI for other purposes that does not include the same conditions, provided that the authorization allows the individual to opt in to the unconditioned activities, and the research does not involve the use or disclosure of psychotherapy notes. These authorizations may also encompass future research, which was not permitted under the existing rules.

The definition of "marketing" has been modified to encompass communications by a provider for purposes of treatment and health care operations about health-related products or services if the provider receives financial remuneration for making the communication from or on behalf of the third party whose product or service is being described. A provider must obtain an individual's written authorization prior to sending marketing communications to the individual.

Clinical Skin Center Notice: Nondiscrimination and Accessibility Requirements

Discrimination is Against the Law, and Clinical Skin Center complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Clinical Skin Center does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

In accordance with Affordable Care Act section 1557. We provide free aids and services to people with disabilities to communicate effectively such as qualified sign language interpreters, written information in other formats, and language services to people whose primary language is not English. If you need these services, you can contact the office manager, Ms. C. Chapman.

If you believe the Clinical Skin Center has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance in person or by mail, or fax. Assistance in these matters is available to you if you need it. Contact: Ms. C Chapman, Clinical Skin Center, 3700 Joseph Siewick Dr. #404 Fairfax, VA 22033. 703-620-8900.

You can also file a complaint with U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the online Office for Civil Rights Complaint Portal, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue, SW, Room 509F, HHH Building, Washington, D.C. 20201. 800-368-1019.

Signature:_____ Date:_____

THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA , PLLC

CONSENT FOR OFFICE VISITS AND IN-OFFICE PROCEDURES PERFORMED DURING COVID-19 / PANDEMIC SITUATIONS

Patient: _____ **Date** _____/_____/_____

On March 11, 2020, the World Health Organization declared the COVID-19 disease a pandemic. There are risks to patients who visit a healthcare provider and/or undergo medical procedures during the COVID-19 pandemic. These risks include but are not limited to exposure to other patients, healthcare staff, and healthcare facilities.

I understand that COVID-19 is very contagious. It is most likely spread by person-to-person contact. I understand that my doctor and his or her staff will follow all laws and recommendations from local, state, and national health officials.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

Some risks are not yet known. I understand that if I have one or more of these conditions, I may have a higher chance for 1) getting COVID-19 and 2) health problems if I get COVID-19. I understand that these problems may be serious.

I understand that possible exposure to COVID-19 before, during, or after my visit, procedure or surgery may result in: a COVID-19 diagnosis, a long quarantine or self-isolation, more tests, being in the hospital, intensive care treatment, intubation/ventilator support, short-term or long-term intubation, other complications, and the risk of death. Also, after office visit, procedure or surgery, I may need to go to an emergency room or a hospital for care. I have been given the option to wait until a later date to have my office visit and/ or procedure/surgery.

There may be other ways to meet with your doctor/provider and be treated. You could have a phone evaluation or a telehealth evaluation. These other options may or may not be right for you. This depends on your health problem and overall health. If remote assessment and treatment are not appropriate, your doctor will explain why you need and in-person visit.

_____ This consent form provided information about COVID-related risks. By signing this form, I acknowledge that I understand the facts provided to me, the risks and choices. I give my consent for in-office evaluation, treatment and/or any elective procedures and surgeries. I agree that no one has given me any guarantees, that I have had the opportunity to ask questions, and that all of my questions have been answered.

_____ _____

Patient signature /Guardian **Date and Time**

_____ _____

Witness **Date and Time**

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PATIENT AUTHORIZATION AND INFORMED CONSENT FOR TELEMEDICINE (OPTIONAL)

Patient Name: _____ Date of Birth: _____

1. I understand that my health care provider will engage with me in a telemedicine consultation.
2. My health care provider has explained to me how the video, audio and still photographic conferencing technology will be used to affect such a consultation. I understand that this will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to provide medical support and/or technical assistance. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. During the public health crisis, by order of Department of Health Human Services HHS, a limited waiver on HIPAA Privacy rules is in effect. This allows medical practices to facilitate easier and better communication with patients and enable widespread use of telemedicine consultation. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. This health information may not be protected under the Health Insurance Portability and Accountability Act (HIPAA) and may not be 100 percent secure.
6. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
7. I understand that the practice of Dermatology often involves physical tests which may only be conducted during in-person visits in our office. I agree that is my responsibility to follow-up in a timely manner for any tests or biopsies as ordered or directed by my provider. I understand that any remaining medical concerns, persistent or worsening lesions, rashes or symptoms require further prompt evaluation in-person.
8. I understand that billing will occur from my practitioner just as it would for an in-office visit and I will be responsible for any applicable copays and/or deductibles as determined by my insurance carrier.
9. I have had the opportunity to ask questions in regard to this form and this procedure. My questions have been answered to my satisfaction and I understand the risks, benefits and any practical alternatives to a Telemedicine Consultation.

_____ _____

Patient's/parent/guardian signature Date

_____ _____

Provider Date