WELLSPRINGS INSTITUTE

Last Name: _____ First: _____ Initial: _____

Mailing Address: _____
(apt # or suite #) (city, state & zip)

Date of Birth: ____ - ____ - ____ Social Security: _____

Sex (Circle One): Male Female Marital Status (Circle One): M S W D

Preferred Phone: (____) ____ - ____ (____) ____ - ____

Emergency Contact: _____ Phone: (____) ____ - ____

Employer Name: _____ Employer Phone: (____) ____ - ____

Email Address: _____

Pursuant to HIPAA Regulations, for any of our patients over the age of 18, we are unable to give any information, whether medical or financial, to any family member. This includes information about your spouse or your child, 18 years of age or older. Please read below and consider carefully who you want to have access to your medical/billing information.

*We **will not** leave messages with anyine except the patient or legal guardian. We **will not** leave any information on an answering machine. We **will not** leave any messages on a voice mail.* ***...UNLESS WE HAVE YOUR WRITTEN PERMISSION TO DO SO.***

I, _____ , give WellSprings Dermatology permission to leave phone messages regarding my medical care and/or lab/path results at the following numbers. My medical care/billing account may be discussed with the person(s) listed below.

Initials: _____ (My initials give permission to leave phone messages on my cellular phone voice mail)

Initials: _____ (My initials give permission to leave phone messages on my home phone answering machine)

Initials: _____ (My initials give permission to leave phone messages on my office/work voice mail)

Initials	Name	Relationship	Home Phone #	Cell Phone #
		SPOUSE	( ) -	( ) -
			( ) -	( ) -
			( ) -	( ) -

Primary Ins. Name: _____ Ins. Member ID#: _____

Group #: _____ Effective Date: ____ - ____ - ____

Policy Holder Name: _____ Date of Birth: ____ - ____ - ____

Social Security #: ____ - ____ - ____ Relationship to Patient: _____

Secondary Ins. Name: _____ Ins. Member ID#: _____

Group #: _____ Effective Date: ____ - ____ - ____

Policy Holder Name: _____ Date of Birth: ____ - ____ - ____

Social Security #: ____ - ____ - ____ Relationship to Patient: _____

Please provide your insurance card(s) to the receptionist when you register.

It is the policy of WellSprings Dermatology to collect co-payments at time of service.

PATIENT'S PROCEDURES AND RULES POLICY

Effective July 1, 2017

1. If you have any new information since your last office visit, (name change, address, phone number, or insurance information) please notify the front desk staff when you arrive for your appointment.
2. It is your responsibility to determine if the provider you are seeing is covered by your insurance plan prior to the office visit.
3. It is your responsibility to know what procedures are covered by your insurance policy. If your insurance requires referrals to a specialist or a procedure requires being pre-certified (s-rays, CT's, MRI's, etc.) please notify one of our staff members before the procedure or test is scheduled. If your insurance requires you to for to a particular facility or have specimens sent to a particular laboratory, please notify our staff before anything is scheduled or sent. You will need to check your benefits before any testing is done to make sure your tests are covered.
4. Only the patient will be allowed back to the exam room, unless it is a child under 18, spouse, or an elderly patient who requires assistance. This allows the doctor to concentrate on the patient, without interruptions from others in the room.
5. In consideration for those patients who already have scheduled appointments, please call in advance to schedule your appointment. This is for your convenience and ours, as the daily schedule fills quickly.
6. Self-pay patients are required to make payment arrangements or pay in full on the day of your office visits.
7. If you have a previous balance on your account, you must pay this amount or make payment arrangements before your office visit.
8. If your insurance requires you to pay a co-pay or has a deductible that has not been met, you will be required to pay the amount at the date of service.
9. You agree, in order for us to service your account, notify you of information pertaining to your account, or for the purposes of collection, we may contact you by telephone at any number provided by you including wireless telephone number. Methods of contact may include the use of pre-recorded and artificial voice messages and/or use of an automated dialing service.

NOTICE OF PRIVACY PRACTICES

I further acknowledge that the Practice provided me with a copy of its Notice of Privacy Practices. I have read, understand, and agree to the Notice of Privacy Practices for protected health information as provided to me by WellSprings Institute, PLLC.

MEDICARE/INSURANCE uniform of assignment, release of information and financial disclosure:

ASSIGNMENT OF BENEFITS: I hereby assign or transfer payment benefits made to me and my behalf to WellSprings Dermatology, PLLC for any services furnished to me by this physician. I further agree that I am responsible for payment or changes incurred by me that are not covered by my insurance or for which my insurance has paid me.

RELEASE OF INFORMATION: I hereby authorize WellSprings Dermatology, PLLC to release information acquired during the course of my examination or treatment to my referring physician, my primary care doctor or to an appropriate insurance carrier. If Medicare patient I further authorize release of the Center of Medicare Services and its agents any information needed to determine benefits payable for related charges.

I HAVE READ AND UNDERSTAND ALL OF THE ABOVE

Signature of Patient: _____ Date: ____ - ____ - _____

Signature of Patient: _____ Date: ____ - ____ - _____

WellSprings Dermatology

History and Intake Form: Please fill out completely and bring in the day of your appointment.

Patient Name		Date of Birth	- -

(Place an X in the box that answers History)

Past Medical History	*YES*	*NO*	*Past Medical History*	*YES*	*NO*	*Past Medical History*	*YES*	*NO*
Anxiety			Depression			Leukemia		
Arthritis			Diabetes			Lung Cancer		
Artificial joints			End Stage Renal Disease			Lymphoma		
Asthma			GERD (Acid Reflux)			Pacemaker		
Atrial fibrillation			Hearing Loss			Prostate Cancer		
BPH (Benign Prostatic Hyperplasia)			Hepatitis			Radiation Treatment		
Bone Marrow Transplantation			Hypertension			Seizures		
Breast Cancer			HIV/AIDS			Stroke		
Colon Cancer			Hypercholesterolemia			Valve Replacement		
COPD (Emphysema)			Hyperthyroidism					
Coronary Artery Disease			Hypothyroidism			NONE		

OTHER: _____

Past Surgical History	*YES*	*NO*	*Past Surgical History*	*YES*	*NO*
Appendix Removed			Kidney Biopsy		
Bladder Removed			Kidney Removed *circle one* (Right, Left)		
Mastectomy *circle one* (Right, Left, Bilateral)			Kidney Stone Removal		
Lumpectomy *circle one* (Right, Left, Bilateral)			Kidney Transplant		
Breast Biopsy *circle one* (Right, Left, Bilateral)			Ovaries Removed: Endometriosis		
Breast Reduction			Ovaries Removed: Cyst		
Breast Implants			Ovaries Removed: Ovarian Cancer		
Colectomy: Colon Cancer Resection			Prostate Removed: Prostate Cancer		
Colectomy: Diverticulitis			Prostate Biopsy		
Colectomy: IBD			TURP		
Gallbladder Removed			Skin Biopsy		
Coronary Artery Bypass			Basal Cell Cancer Surgery		
PTCA			Squamous Cell Carcinoma Surgery		
Mechanical Valve Replacement			Melanoma Surgery		
Biological Valve Replacement			Spleen Removed		
Heart Transplant			Testicles Removed *circle one* (Right, Left, Bilateral)		
Joint Replacement, Knee *circle one* (Right, Left, Bilateral)			Hysterectomy: Fibroids		
Joint Replacement, Hip *circle one* (Right, Left, Bilateral)			Hysterectomy: Uterine Cancer		
Joint Replacement last 2 years			NONE		

OTHER: _____

Skin Disease History	*YES*	*NO*	*Skin Disease History*	*YES*	*NO*	*Skin Disease History*	*YES*	*NO*
Acne			Dry Skin			Poison Ivy		
Actinic Keratosis			Eczema			Precancerous Moles		
Asthma			Flaking or Itchy Scalp			Psoriasis		
Basal Cell Skin Cancer			Hay fever/Allergies			Squamous Cell Skin Cancer		
Blistering Sunburns			Melanoma			None		

OTHER: _____

(Circle YES or NO to the following questions)

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(s)?
Any other family history?			

Medication: (Please enter all current medications)

Medication	Dosage (mg)	Frequency

Medication Allergies:

Cigarette Smoking: (Place X beside correct answer)

	Never Smoked
	Quit: Former Smoker
	Smokes Less Than Daily
	Smokes Daily

Alcohol Use: (Place X beside correct answer)

	YES- Alcohol Use
	NO- Alcohol Use

Language: (Place X beside correct answer)

	English
	Spanish
	Other:

Race: (Place X beside correct answer)

	White
	Black/African American
	Asian
	American Indian or Native Alaskan
	Native Hawaiian/Pacific Islander

Ethnicity: (Place X beside correct answer)

	Hispanic/Latino
	Non-Hispanic/Latino

Pharmacy Information:

Pharmacy Name	
Pharmacy Address Include street City, state & zip	

How often do you exercise? (place X beside correct answer)

	Once a day
	A few times a week
	A few time a month
	Never

What is your caffeine use? (place X beside correct answer)

	Once a day
	A few times a week
	A few times a month
	Never

Marital Status: (place X beside correct answer)

	Married
	Single
	Widow
	Divorced

Medical Provider Information:

Primary Care Provider

Name	Phone
	( ) -
	( ) -

Referring Provider

Name	Phone
	( ) -
	( ) -

WellSprings Institute, PLLC
d/b/a WellSprings Dermatology
2721 West Park Drive, Paducah, Kentucky 42001
Phone: 270.554.7546 Fax: 270.554.0316

NOTICE OF PRIVACY PRACTICES

Effective Date: September 1, 2013
This Notice was most recently revised on September 12, 2018

THIS NOTICE DESCRIBES HOW MEDICAL INFIRMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN GET ACCES TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE OR IF YOU NEED MORE INFORMATION, PLEASE CONTACT OUR PRIVACY OFFICER:

Privacy Officer:	Courtney Lowery
Mailing Address:	2721 West Park Drive, Paducah, Kentucky 42001
Telephone:	270.554.7546 Ext. 422
Fax:	270.534.6457

About This Notice

We are required by law to maintain the privacy of Protected Health Information (PHI) and to give you this Notice explaining our privacy practices with regard to that information. You have certain rights – and we have certain legal obligations by the terms of the current version of this Notice.

What is Protected Health Information (PHI)?

Protected Health Information (PHI) is information that individually identifies you and that we create or get from you or from another health care provider, a health plan, your employer or a health care clearinghouse and that relates to (1) your past, present or future physical or mental health or conditions, (2) the provision of health care to you, or (3) the past, present or future payment for your health care.

How We May Use and Disclose Your PHI

We may use and disclose your PHI in the following circumstances:

For Treatment. We may use PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, we may disclose PHI to doctors, nurses, technicians or other personnel who are involved in taking care of you, including people outside our practice, such as referring or specialist physicians.

For Payment. We may use and disclose PHI so that we can bill for the treatment and services you get from us and can collect payment from you, an insurance company or another third party. For example, we may need to give your health plan information about your treatment in order for your health plan to pay for that treatment. We also may tell your health plan about a treatment you are going to receive to find out if your plan will cover the treatment. If a bill is overdue we may need to give PHI to a collection agency to the extent necessary to help collect the bill, and we may disclose an outstanding debt to credit reporting agencies.

For Health Care Operations. We may use and disclose PHI for our health care operations. For example, we may use PHI for our general business management activities, for checking on the performance of our staff in caring for your, for our cost-management activities, for audits or to get legal services. We may give PHI to other health care entities for their health care operations, for example, to your health insurer for its quality review purposes.

Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.

Minors. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.

Personal Representative. If you have a personal representative, such as a legal guardian (or an executor or administrator of your estate after your death), we will treat that person as if that person is you with respect to disclosures of your PHI.

As Required by Law. We will disclose PHI about you when required to do so by international, federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.

Business Associates. We may disclose PHI to our business associates who perform functions on our behalf or provide us with services if the PHI is necessary for those functions or services. For example, we may use another company to do our billing, to provide transcription or consulting services for us. All of our business associates are obligated, under contract with us, to protect the privacy of your PHI.

Organ and Tissue Donation. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation – such as an organ donation bank – as necessary to facilitate organ or tissue donation and transplantation.

Military and Veterans. If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

Workers' Compensation. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.

Public Health Risks. We may disclose HI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction for the Food and Drug Administration ("FDA") for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and (8) the appropriate government authority if we believe a patient may have been the victim of abuse, neglect or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.

Health Oversight Activities. We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure and similar activities that are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves if you sue us.

Law Enforcement. We may release PHI if asked by a law enforcement official for the following reasons: in response to a court order, subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness, or missing person; about the victim of a crime if; about a death we believe may be the result of criminal

conduct; about criminal conduct on our premises; and in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description, or location of the person who committed the crime.

National Security. We may release PHI to authorized federal officials for national security activities authorized by law. For example, we may disclose Phi to those officials so they may protect the President.

Coroners, Medical Examiners and Funeral Directors. We may release HI to a coroner, medical examiner or funeral directory so they can carry out their duties.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

Uses and Disclosures That Require Us to Give You and Opportunity to Object and Opt Out

Individuals involved in Your Care or Payment for Your Care. We may disclose PHI to a person who is involved in your medical care or helps pay for your care, such as a family member or friend, to the extent it is relevant to that person's involvement in your care or payment related to your care. We will provide you with an opportunity to object to and opt out of such a disclosure whenever we practicable can do so.

Disaster Relief. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.

Your Written Authorization is Required for Other Uses and Disclosures

Uses and disclosures for marketing purposes and disclosures that constitute a sale of PHI can only be made with your written authorization. Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. Disclosures that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

Special Protections for HIV, Alcohol and Substance Abuse, Mental Health and Genetic Information

Special privacy protections apply to HIV-related information, alcohol and substance abuse, mental health and genetic information. Some parts of this general Notice of Privacy Practices may not apply to these kinds of PHI. Please check with our Privacy Officer for information about the special protections that do apply. For example, if we give you a test to determine if you have been exposed to HIV, we will not disclose the fact that you have taken the test to anyone without your written consent unless otherwise required by law.

Your Rights Regarding Your PHI

You have the following rights, subject to certain limitations, regarding your PHI:

Right to Inspect and Copy. You have the right to inspect and/or receive a copy of PHI that may be used to make decisions about your care or payment for your care. But you do not have a right to inspect or copy psychotherapy notes. We may charge you a fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

Right to an Electronic Copy of Electronic Medical Records. If your PHI is maintained in one or more designated record sets electronically (for example an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity.

We may charge you a reasonable, cost-based fee for the labor associated with copying or transmitting the electronic PHI. If you chose to have your PHI transmitted electronically, you will need to provide a written request to this office listing the contact information of the individual or entity who should receive your electronic PHI.

Right to Receive Notice of a Breach. We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breach of your Unsecured PHI.

Right to Request Amendments. If you feel that PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. We may deny your request if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) was not created by us, (2) is not part of the medical information kept by us for us, (3) is not information that you would be permitted to inspect and copy, or (4) is accurate and complete. If we deny your request, you may submit a written statement of disagreement of reasonable length. Your statement of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. We are not required to list certain disclosures, including (1) disclosures made for treatment, payment and health care operations purposes, (2) disclosures made with your authorization, (3) disclosers made to create a limited data set and (4) disclosures made directly to you. You must submit your request in writing to our Privacy Officer. Your request must state a time period which may not be longer than six years before your request. Your request should indicate in what form you would like the accounting (for example, on paper or by e-mail). The first account of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.

Right to Request Restrictions. You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment or health care operations. You also have the right to request a limit on the PHI we disclose about you to someone who is involved in your care or the payment of your care, like a family member or friend. We are not required to agree to your request. If we agree, we will comply with your request unless we terminate our agreement or the information is needed to provide you with emergency treatment.

Right to Restrict Certain Disclosures to Your Health Plan. You have the right to restrict certain disclosures of PHI to a health plan if the disclosure is for payment or health care operations and pertains to a health care item or service for which you have paid out of pocket in full. We will honor this request unless we are otherwise required by law to disclose this information. This request must be made at the time of service.

Right to Request Confidential Communications. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a special address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you. We will accommodate all reasonable requests. We will not ask you the reason for your request.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may request a copy of this Notice at any time. You can get a copy of this Notice at our website: **http://www.wellspringsderm.com.**

How to Exercise Your Rights

To exercise your rights described in this Notice, send your request, in writing, to our Privacy Officer at the address listed at the beginning of this Notice. We may ask you to fill out a form that we will supply. To get a paper copy of this notice,

contact our Privacy Officer by phone or mail.

Change To This Notice

The effective date of the Notice is stated at the beginning. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact our Privacy Officer at the address listed at the beginning of this Notice. All complaints must be made in writing and should be submitted within 180 days of when you knew or should have known of the suspected violation. There will be no retaliation against you for filing a complaint.

Optional Provisions to be Included as applicable:

Foreign Language Version. If you have difficulty reading or understanding English, you may request a copy of this Notice in Spanish.

Medical Residents and Medical Students. Medical residents or medical students may observe or participate in your treatment or use your PHI to assist in their training. You have the right to refuse to be examined, observed or treated by medical residents or medical students.

Newsletters and Other Communications. We may use your PHI to communicate to you by newsletters, mailings or other means regarding treatment options, health related information, disease management programs, wellness/ programs, or other community based initiatives or activities in which our practice is participating.

Psychotherapy Notes. Under most circumstances, without your written authorization we may not disclose the notes a mental health professional took during a counseling session. However, we may disclose such notes for treatment and payment purposes, for state and federal oversight of the mental health professional, for the purposes of medical examiners and coroners, to avert a serious threat to health or safety, or as otherwise authorized by law.

Research. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, as long as they do not remove, or take a copy of, any PHI. We may use and disclose a limited data set that does not contain specific readily identifiable information about you for research. But we will only disclose the limited data set if we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which it was provided, (2) ensure the security of the date and (3) not identify the information or use it to contact any individual.