The Toledo Clinic | Dermatology & Dermatologic Surgery

My primary care doctor is: _____ Date: _____ age: _____

The doctor who referred me is: _____ Name: _____

Pharmacy _____ Ins: _____

Indicate any of the following medical conditions you have had or currently have:

- ☐ Thyroid disorder
- ☐ Cataracts or Glaucoma?
- ☐ Heart Problems_____
- ☐ Rheumatoid Arthritis
- ☐ Artificial Joints
- ☐ Arthritis
- ☐ Eczema
- ☐ Diabetes
- ☐ Kidney Problems
- ☐ Intestinal disorder
- ☐ Rheumatic Fever
- ☐ Hepatitis
- ☐ Internal Cancer
- ☐ Radiation Therapy
- ☐ HIV/AIDS
- ☐ Artificial Heart Valve
- ☐ High Blood Pressure
- ☐ Pacemaker/defibrillator
- ☐ Tuberculosis
- ☐ Skin Cancer
- ☐ Keloids

Previous SURGERIES_____

Are you *currently* experiencing any of the following?

- ☐ Fevers
- ☐ Shaking chills
- ☐ Night sweats
- ☐ Unexplained weight loss
- ☐ Bleeding problems
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Excess thirst
- ☐ Insomnia
- ☐ Skin itching
- ☐ Sunburns
- ☐ Joint pain
- ☐ Chest pain
- ☐ Short of breath
- ☐ Palpitations
- ☐ Ankle swelling
- ☐ Depression
- ☐ Anxiety
- ☐ Headaches
- ☐ Numbness
- ☐ Seizures
- ☐ Hearing problem
- ☐ Urinary Problems
- ☐ Irregular menses

Are you pregnant or breastfeeding? _____

What medications do you take? Please list dosage and how often you take. _____

_____ _____ _____

_____ _____ _____

Height_____ Weight_____

Do you take antibiotics before dental visits? ☐ No ☐ Yes, why? _____

Do you take Aspirin? ☐ No ☐ Yes, why? Do you take blood thinners? _____

Allergies/reactions *to medications*? Tobacco Use? Former __ Current __ Never __

_____ Do you drink alcohol? _____

_____ Marital Status? _____

Allergy to Latex? _____ Occupation? _____ Hobbies? _____

Do you have an Advance Directive? Yes No_____

Have any of your blood relatives had skin cancer? _____

If yes, whom and what type of cancer? _____

Mother deceased? _____ Father deceased? _____

Any comments or other important information the Doctor should know? _____

DATE	ACCOUNT NUMBER

DOCTOR	PRIMARY CARE PHYSICIAN & CITY

PATIENT / ACCOUNT INFORMATION
THE TOLEDO CLINIC

Use Black Ink Only

A. PATIENT INFORMATION

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	AGE	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

MAIDEN/PREVIOUS NAME	ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS	MARITAL STATUS	SPOUSES NAME

EMERGENCY CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

ADDITIONAL CONTACT	RELATIONSHIP	PHONE EXT	CELLULAR PHONE

PREFERRED METHOD OF CONTACT
- ☐ CELLPHONE
- ☐ HOME PHONE
- ☐ E-MAIL
- ☐ TEXT

RACE
- ☐ AMERICAN INDIAN OR ALASKA NATIVE
- ☐ ASIAN
- ☐ BLACK OR AFRICAN AMERICAN
- ☐ HAWAIIAN OR PACIFIC ISLANDER
- ☐ WHITE
- ☐ OTHER
- ☐ UNKNOWN
- ☐ DECLINED

ETHNICITY
- ☐ HISPANIC OR LATINO
- ☐ NOT HISPANIC OR LATINO
- ☐ UNKNOWN
- ☐ DECLINED

LANGUAGE
- ☐ ARABIC
- ☐ CHINESE
- ☐ ENGLISH
- ☐ FRENCH
- ☐ JAPANESE
- ☐ SPANISH
- ☐ VIETNAMESE
- ☐ UNKNOWN
- ☐ DECLINED

B. PERSON RESPONSIBLE FOR PAYMENT - IF PATIENT IS A CHILD, THE PERSON WHO HAS CUSTODY

NAME LAST	FIRST	INITIAL	DATE OF BIRTH	SEX ☐ M ☐ F	SOCIAL SECURITY NUMBER

ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE	CELLULAR PHONE	E-MAIL ADDRESS

C. INSURANCE INFORMATION

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT

INSURANCE COMPANY	POLICY NUMBER	GROUP NUMBER

ADDRESS	CITY	STATE	ZIP CODE

NAME OF POLICY HOLDER	DOB OF POLICY HOLDER	EFFECTIVE DATE	RELATIONSHIP TO PATIENT

INSURANCE EMPLOYER NAME	PCP CO-PAYMENT AMT	SPECIALIST CO-PAY AMT

I CONFIRM THAT THE ABOVE INFORMATION IS CORRECT:

SIGNATURE _____ DATE _____

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.

Toledo Clinic Inc.'s Notice of Privacy Practices for Protected Health Information

I. Uses and Disclosures of Your Medical Information.

A. Treatment, Payment, and Operations. Toledo Clinic, Inc. (sometimes referred to as "we" or "us") is permitted to use your medical information for purposes of treating you, to obtain payment for providing medical services to you, and to assist in its health care operations. We may also use your medical records to assess the appropriateness and quality of care that you received, improve the quality of health care, and achieve better patient outcomes. An understanding of what is in your health records and how your health information is used helps you: ensure its accuracy and completeness; understand who, what, where, why, and how others may access your health information; and make informed decisions about authorizing disclosures to others.

(i) Use of your protected health information for treatment purposes. A physician or another member of your health care team will record information in your record to diagnose your condition and determine the best course of treatment for you. We will also provide your primary physician, other health care professionals, or a subsequent health care provider, copies of your records to assist them in treating you.

(ii) Use and disclosure of your protected health information for purposes of payment. We may send a bill to you or to a third-party payer, such as a health insurer. The information on or accompanying the bill may include information that identifies you, your diagnosis, treatment received, and supplies used.

(iii) Use and disclosure of your protected health information for healthcare operations. Health care operations consist of activities that are necessary to carry out our operations as a healthcare provider, such as quality assessment and improvement activities. For example, members of our medical staff, the risk or quality improvement manager, or members of the quality assurance team may use information in your health record to assess the care and outcomes in your cases and the competence of the caregivers. We will use this information in an effort to continually improve the quality and effectiveness of the health care and services that we provide.

B. Appointment Reminders. We may contact you at home to provide appointment reminders unless you specify otherwise in writing to us.

C. Other purposes for which we can use your protected health information without written authorization from you. In addition to using your protected health information for purposes of treatment, payment, and health care operations, we may use or disclose you protected health information without you written authorization and without giving you an opportunity to object in the following situations:

(i) As Required by Law. We may use or disclose your protected health information as required by law. We will limit the disclosure to those portions relevant to the requirements of the law.

(ii) Public Health Activities. We may use or disclose your protected health information to public health entities authorized to collect information for the purposes of controlling or preventing disease (including sexually transmitted diseases), injury, or disability. We may also disclose to governmental agencies authorized to receive reports of child abuse or neglect. We may disclose protected health information to the Food and Drug Administration relative to adverse effects/events with respect to food, drugs, supplements, product or product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacement.

(iii) Medical Surveillance of the Workplace and Work-related Injuries. We may provide your protected health information to your employer if we are asked by your employer to provide medical services to you for purposes of medical surveillance of the workplace or a work-related illness or injury.

(iv) Victims of Abuse, Neglect, or Domestic Violence. To the extent authorized or required by law, and in the exercise of our doctor's professional judgment, we believe the disclosure is necessary to prevent harm, we may disclose protected health information to law enforcement officials.

(v) Health Oversight Activities. We may disclose your protected health information to a governmental health oversight agency overseeing the health care system, governmental benefit programs or compliance with governmental program standards.

(vi) Judicial and Administrative Proceedings. We may disclose your protected health information in response to an order of a court or a valid subpoena.

(vii) Law Enforcement Purposes. We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena or we may provide limited information for identification or location purposes.

(viii) Information About Deceased Individuals. We may disclose your protected health information to coroners and medical examiners to carry out their official duties, and to funeral directors as necessary to carry out their duties to the deceased individual.

(ix) Organ, Eye, or Tissue Donation. We may disclose protected health information to organ procurement agencies for the purpose of facilitating organ, eye, or tissue donation or transplantation.

(x) Research Purposes. We may disclose protected health information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.

(xi) Avoidance of Serious Threat to Health or Safety. We may disclose protected health information if we believe in good faith that such disclosure is necessary to prevent or lessen a serious and immediate threat to health and safety of a person or the public.

(xii) Certain Specialized Governmental Functions. If you are Armed Forces or foreign military personnel, we may disclose your protected health information to your appropriate military command. We may disclose your protected health information to a governmental agency as authorized by the National Security Act or for the protection of the President of the United States, as required by law.

(xiii) Correctional Instututions. If you are an inmate, we may disclose your protected health information to the correctional institution or law enforcement in the course of providing care to you or the health and safety of others responsible for your custody or other inmates.

(xiv) Disclosures for Workers' Compensation. We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

D. Other uses and disclosures of your protected health information will only be made with your prior written authorization. This includes, but is not limited to: (i) uses and

disclosures of psychotherapy notes (if applicable); (ii) certain uses and disclosures for marketing purposes, including direct or indirect remuneration to Toledo Clinic; (iii) uses and disclosures that constitute a sale of your protected health information; and (iv) other uses and disclosures not described herein. You may revoke an authorization at any time, provided you do so in writing. We will honor such a revocation except to the extent that we had already taken action in reliance upon your prior authorization.

II. Your Individual Rights. You have the following rights under federal law with respect to your protected health information and may exercise them in the following manner:

A. The Right to Request Restrictions on the Use of Protected Health Information. You have the right to request that we restrict the use of your protected health information. You have the right to request that we limit our disclosure of your protected health information to treatment, payment, and healthcare operations and disclosures to individuals (family members) involved in your care. Such a restriction, if agreed to by us, will not prevent permitted or required uses and disclosures of protected health information. We are not required to agree to any requested restriction. You also have the right to restrict certain disclosures to a health plan if and when you pay out of pocket and in full for the health care item or service.

B. The Right to Receive Confidential Communications of Protected Health Information by Alternative Means. We must accommodate a reasonable written request by you to receive communications of your protected health information by alternative means (e.g., via e-mail) or at an alternative location (e.g., at your place of employment rather than at home).

C. The Right to Inspect and Copy your Medical Records. You have the right to inspect and obtain a copy from us of your protected health information in our possession, including an electronic copy of your protected health information that we maintain electronically in a designated record. We may impose a reasonable cost-based fee for the labor involved and supplies used for creating the copy of your medical records.

D. The Right to Amend Protected Health Information. You have the right to have us amend protected health information in our possession. You must make the request in writing and provide supporting reason(s) for the requested amendment. If we grant the request, we will notify you, and we will make the correction and distribute the correction to those who need it and those whom you identify to us that you want to receive the corrected information.

E. The Right to Receive an Accounting of Disclosures of Protected Health Information. You have the right to obtain an accounting of disclosures by us of your protected health information, other than for purposes of treatment, payment, and health care operations. Depending on whether your particular doctor has incorporated electronic health records into his or her medical practice, you may have the right to obtain an accounting of all disclosures of protected health information. The first accounting in any 12-month period is free. Thereafter, we reserve the right to charge a reasonable, cost-based fee.

F. The Right to Obtain a Paper copy of this Notice Upon Request. You have the right to receive a paper copy of this Notice upon request.

G. The Right to Opt-Out of Fundraising Commiunications. In the event we choose to contact you for purposes of fundraising, you will be given the opportunity to opt out of such fundraising communications.

III. Our Duties to Safeguard Your Protected Health Information.

A. Our Duties to You. We are required by federal law to maintain the privacy of protected health information and to provide you with notice of its legal duties and privacy practices with respect to your protected health information. We will maintain the privacy of your health information, including implementing reasonable and appropriate physical, administrative, and technical safeguards to protect the information. We have the duty to mitigate any breach of privacy regarding your protected health information. In the event of any breach of privacy regarding your protected health information, the Toledo Clinic is required to notify you.

B. Privacy Notice. The Toledo Clinic is required to abide by the terms of its Privacy Notice as currently in effect.

C. Complaints. You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may obtain and file a Patient Privacy Complaint with our Privacy Officer. You will not be retaliated against for filing a complaint.

D. Contact Person and Telephone Number. If you have questions and/or would like additional information, you may contact Toledo Clinic's Privacy Officer at 419-473-3561.

E. Effective Date. This privacy Notice is Effective March 31, 2013.

WE RESERVE THE RIGHT TO CHANGE THE TERMS OF OUR NOTICE OF PRIVACY PRACTICES AND TO MAKE THE NEW NOTICE PROVISIONS EFFECTIVE FOR ALL PROTECTED HEALTH INFORMATION THAT WE MAINTAIN. IF WE CHANGE OUR INFORMATION PRACTICES, WE WILL POST THE REVISED NOTICE IN THE OFFICE AND PROVIDE YOU WITH A COPY UPON REQUEST.

ACKNOWLEDGMENT OF RECEIPT OF TOLEDO CLINIC'S NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received Toledo Clinic's Notice of Privacy Practices effective April 14, 2003, rev 03/31/2013

Staff Use Only

PATIENT CHART NUMBER_____

_____

Signature of Patient

_____

Printed Name of Patient

_____

Date of Birth

_____

Signature of Parent/Guardian of Minor

_____

Date

Staff use only

Good Faith Effort to Obtain Acknowledgment

The above named patient refused to sign the acknowledgment after being requested to do so.

_____

Staff Member Signature

Date:_____

PERSONS THAT ARE ALLOWED TO GIVE/RECEIVE MY PRIVATE HEALTH INFORMATION

METHOD OF ALLOWED RELEASE: _____ VERBAL _____ WRITTEN

Name	Relationship	Phone#

The Toledo Clinic

4235 Secor Road
Toledo, Ohio 43623

Financial Policy

We are committed to providing our patients with the best possible medical care and also minimizing administrative costs. This financial policy has been established with these objectives in mind and to avoid any misunderstanding or disagreement concerning payment for professional services.

- Our practice participates with numerous insurance companies. For patients who are beneficiaries of one of these insurance companies, our billing office will submit a claim for services rendered. All necessary insurance information, including special forms, must be completed by the patient prior to leaving the office.
- If a patient has insurance in which we do not participate, our office is happy to file the claim upon request; however, payment in full is expected at the time of service.
- It is the patient's responsibility to pay any deductible, copayment, or any portion of the charges as specified by the plan at the time of visit. Payments for medical services not covered by an individual's insurance plan are the patient's responsibility, and payment in full is due at the time of visit.
- Payment for professional services can be made with cash, check, or credit card.
- Patients who do not have insurance are expected to pay for professional services at the time of service.
- It is the patient's responsibility to ensure that any required referrals for treatment are provided to the practice prior to the visit. Visits may be rescheduled, or the patient may be financially responsible due to lack of the referral.
- It is the patient's responsibility to provide us with current insurance information and to bring his/her insurance card to each visit. If claims are rejected by insurance company due to untimely filing limits, and the delay is a result of the patient not providing insurance information timely, the patient will be responsible for all charges.
- Our staff is happy to help with insurance questions relating to how a claim was filed, or regarding any additional information the payer might need to process the claim. Specific coverage issues, however, can only be addressed by the insurance company member services department. The telephone number is printed on the insurance card.
- The adult accompanying a minor and the parents (or guardians of the minor) are responsible for payment at the time of service. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized or payment by credit card, cash, or check at the time of service has been verified. Statements indicating any patient responsible balance will be mailed monthly. Payment in full is due within 30 days.
- Patient balances over 30 days will be subject to a late payment charge equal to 1.25% (15% annual percentage rate) of the balance as of the end of each month.
- Patients will be asked to pay all patient responsible balances in full when they are seen in the office at their next visit.
- Patients with outstanding balances may not be seen by the physician absent medical necessity and are subject to discharge from the practice.
- In the unanticipated event you are unable to pay your bill when due, please contact us as informal arrangements may be worked out.
- Any prepayments resulting in a credit balance to an account will first be applied to any outstanding debt prior to being refunded.

Our practice firmly believes that a good physician-patient relationship is based upon understanding and good communications. Questions about financial arrangements should be directed to the Business Services department at 419-479-5398. We are happy to help you.

I hereby authorize The Toledo Clinic to submit to my insurance plan all covered services rendered by the physician(s) and to furnish complete information (including Medical Records, if necessary) to my plan regarding services rendered. I understand that in signing this form, The Clinic will not release to anyone, including those processing my Clinic claim, any information that the law specifically protects and for which a special consent is required. For those records to be released, I will need to sign a separate consent. I authorize and direct my insurance carrier to issue payment check(s) directly to the physician(s) rendering covered services unless otherwise notified.

AUTHORIZED SIGNATURE

I have read this form or had it read to me. I understand it.

_____ _____

Signature of Patient/Authorized Representative Relationship (if other than patient)

Patient Name _____ Date _____

Chart # _____