BAY AREA DERMATOLOGY

Biopsy, Electrodessication and Curettage (ED&C), Cryosurgery Consent Form

While under the care of Bay Area Dermatology, I consent to biopsy, ED&C, and/or cryosurgical procedures as recommended by the provider. In addition, we will also obtain verbal consent prior to performing any of the above procedures.

1. I understand that a biopsy requires obtaining a sample of tissue for diagnostic purposes and is a surgical procedure. I understand that this is a sample of tissue and may not remove the entire lesion and that additional procedures may be deemed necessary for complete treatment of the condition. I understand that ED&C may not remove the entire lesion and after pathology is reviewed, further treatment may be deemed necessary.
2. I understand that cryosurgery is destruction of tissue with liquid nitrogen. I understand that a sample of tissue is not submitted for pathology. I understand that multiple treatments may be required to resolve all of a lesion(s).
3. I understand that all medical and surgical procedures involve some degree of risk. These risks include allergic reaction, bleeding, infection, blister/crust formation, injury to nerves or numbness, and scar formation; which may be thickened, depressed, keloid, or could be lighter/darker that the color of the surrounding skin.
4. I authorize the appropriate medical staff to administer local anesthetics as may be necessary or advisable by the provider responsible for this service.
5. I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedure or treatment. I understand that although the benefits are judged to outweigh the risks, if any of the previously mentioned complications occur they could be permanent.

I understand that all tissue samples will be sent for examination by a pathologist at an independent laboratory. You may receive a separate bill from the laboratory. Please contact the LAB with any billing questions.

*****I certify that I have read and understand the contents of this form. My signature below acknowledges that I voluntarily give my authorization and consent to the performance of the procedure(s) described above by my provider and/or his/her trained staff.*

Patient/Agent/Guardian	date	Witness	date
Signature		Signature	

BAY AREA DERMATOLOGY

Patient Assignment of Benefits & Acknowledgement and Authorizations

Patient Assignment of Benefits:

This allows us to bill and accept direct payment from your insurance company or other payer.

Bay Area Dermatology will bill all primary and secondary insurances, but I am ultimately responsible for payment for the services and any supplies/equipment I receive. I hereby assign to Bay Area Dermatology any insurance or other third party benefits available for healthcare services provided to me. I understand that Bay Area Dermatology has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Bay Area Dermatology, I agree to forward to Bay Area Dermatology all health insurance and other third party payments that I receive for services rendered to me immediately upon receipt. I understand that my signature requests that payment be made directly to Bay Area Dermatology. I authorize release of medical information necessary to pay the claim. A photo copy of this assignment is considered as the original.

Patient Acknowledgement and Authorizations:

This allows us to evaluate and treat you, and to bill and communicate with your insurance company.

I authorize Bay Area Dermatology to conduct examinations and perform procedures as are medically required and administered treatment and medications as deemed necessary or advisable. I authorize Bay Area Dermatology to release a complete report of services rendered, diagnosis, findings, and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's worker's compensation insurance company, or other third party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations, or other intermediaries responsible for payment of services rendered. The release of information consent may be revoked at any time by giving written notice. If release of information is refused, the patient will be held responsible for payment of all charges for services rendered. I authorize that payment of benefits be made on my behalf to Bay Area Dermatology furnished to me. I understand that I am financially responsible to Bay Area Dermatology for charges not covered by this assignment and/or charges for services without an appropriate referral by a Primary Physician when required by my insurance plan.

I authorize any holder of medical information about me to release to the insurance company and its agents and information needed to determine these benefits or the benefits payable for related services, including (if any):

-Alcohol and drug abuse records protected under the regulation in 42 code of Federal Regulation, Part 2

-Psychiatric/psychological services records, social work records, and:

-Any information regarding serious communicable diseases and infections as defined by the Michigan Department of Public Health Code (Act 368 or 1978 as revised), which includes venereal disease, tuberculosis, HIV, AIDS, or ARC.

I understand that if my physician, or any person employed by or under the direction and control of my physician, is directly exposed to my bodily fluids in any manner which may, according to the then current guidelines for the Center for Disease Control, transmit the human immunodeficiency virus (HIV) or hepatitis B or C viruses, that I am deemed by law to have consented to testing for infection with HIV or hepatitis B or C viruses. I further understand that by law I will have deemed to have consented to the release of these test results to the person who is exposed to my bodily fluids.

I HAVE READ THE ABOVE PATIENT ASSIGNMENT OF BENEFITS, PATIENT ACKNOWLDEGEMENT AND AUTHORIZATIONS, AND UNDERSTAND ALL OF THE INFORMATION ABOVE. I UNDERSTAND THE TERMS AND CONDITIONS OUTLINED HEREIN AS CONFIRMED BY MY SIGNATURE BELOW. I UNDERSTAND THAT MY SIGNATURE CONSTITUTES CONSENT TO THE CONDITIONS OUTLINED HEREIN AND IS APPLICABLE TO ANY VISISTS TO BAY AREA DERMATOLOGY UNTIL SUCH A TIME AS I PROVIDE WRITTEN RECOVATION OF MY CONSENT.

*****NOTICE: If a patient is a minor (under 18 years of age) the parent or responsible party must complete and sign the Consent for Treating a Minor Form.*

Patient/Agent/Guardian Signature	date	Witness	date

BAY AREA DERMATOLOGY

HIPAA-Patient Acknowledgement of Having Read or Been Read the Notice of Privacy

I have been provided the opportunity to read, or it has been read to me, the Notice of Privacy Practices at Bay Area Dermatology. I understand that Bay Area Dermatology is committed to treating and using protected health information about me responsibly.

I understand my rights as is relates to my records at Bay Area Dermatology and understand how information about me may be used and disclosed.

I understand that my health record is the physical and legal property of Bay Area Dermatology, but the information belongs to me. I may have access to inspect, amend, or obtain a copy of my health information. Costs will incur for copies of my records, and appointments must be made with the Privacy Officer to inspect, assess, or amend my health information.

I understand that Bay Area Dermatology is required to maintain the privacy of my health information. Bay Area Dermatology will require my authorization to release my health information to outside sources with the exception of disclosures for purposes of Treatment, Payment and Healthcare Operation, and fulfillment of prescription medication orders. Examples of disclosures that do not require my authorization may include access to my health information by Bay Area Dermatology staff, physicians, and billing to myself and/or a third-party payer. In addition, business associates of Bay Area Dermatology from time to time, have access to my health information, but, I am assured that proper Business Associates Agreements are in place insuring the protection of my health information. Upon the physicians' best judgment, Bay Area Dermatology may disclose to a family member or close personal friend (or any other persons I identify) health information relevant to that persons involvement in my care. My healthcare information may also be used for research data, organ procurement, FDA, public health or legal authorities, and/or law enforcement purposes.

Bay Area Dermatology may contact me regarding appointment reminders, chances, or cancellations by the following means: by mail-using postcards or letters, by telephone calls to my home or place of employment-leaving a message with a person answering the phone if I do not personally answer, and by leaving a voicemail at my home or place of employment.

*****I have read and understand the Notice of Privacy Practices at Bay Area Dermatology*

Patient/Agent/Guardian date	Witness date
Signature	Signature

Name:_____ Date:_____

Birth Date:_____

Medical History

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation (Irregular Heartbeat)
Bone Marrow Transplant
BPH (Enlarge Prostate)
Cancer List: _____
_____
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid Reflux)
Hearing Loss
Hepatitis (Liver Disease)
HIV/AIDS
High Cholesterol
High Blood Pressure
Thyroid (Overactive /Underactive)
Radiation Treatment
Seizures
Stroke
None
Other: _____

Past Surgical History: (Please circle all that apply)

Appendix
Bladder (Cystectomy)
Breast: Mastectomy
Colon (Colectomy)
Gall Bladder (Chole-Cystectomy)
Heart (Bypass/Valve Replacement/Transplant)
Joint Replacement: List
_____
Kidney Transplant
Liver Transplant
Ovaries: Oophorectomy
Pancreas: Pancreatectomy
Prostate (Prostatectomy)
Prostate: TURP
Skin Cancer: Basal Cell
Squamous Cell
Melanoma
Spleen (Splenectomy)
Testicles (Orchiectomy)
Uterus (Hysterectomy)

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratosis
Basel Cell Cancer
Blistering Sun Burns
Eczema
Flaky Scalp
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Cancer
Other
_____

Do you wear **Sunscreen**? (Yes / No)
Any **tanning bed** use? (Yes / NO)
Do you have a **family History of Melanoma**? (Yes / No) Who? _____

Please list your **Current Medications:**

_____

_____

_____

Name:_____ Date:_____

Do you have any **ALLERGIES**? Please list: _____

Social History:
Smoker/Former Smoker? (Yes / No)

Alcohol History:
(none) (1 drink per day) (2-3 per day)
(3 or more per day)

Review of Systems: Do you currently have any of the following?

Problems with bleeding (yes / no)
Problems with healing (yes / no)
Problems with scarring/keloid (yes / no)
Rash (yes / no)
Immunosuppression (yes / no)
Fever or Chills (yes / no)
Night Sweats (yes / no)
Unintentional weight loss (yes / no)
Thyroid problems (yes / no)
Sore throat (yes / no)
Abdominal pain (yes / no)
Joint aches (yes / no)
Neck stiffness (yes / no)
Headaches (yes / no)
Anxiety (yes / no)
Depression (yes / no)

Allergy to adhesive (yes / no)
Allergy to lidocaine (yes / no)
Allergy to topical antibiotic oint (yes / no)
Artificial heart valve (yes / no)
Artificial joint with past 2 years (yes / no)
Blood thinners (yes / no)
Defibrillator (yes / no)
MRSA (yes / no)
History of Hepatits (yes / no)
History of HIV or AIDS (yes / no)
Pacemaker (yes / no)
Rapid heartbeat w/epi (yes / no)
Pregnancy or planning (yes / no)
West Africa travel (yes / no)
Ebola Risk (yes / no)

Immunizations:

Have you had the following vaccines? Please list approximate dates as well
Influenza (Flu) _____
Pneumonia _____
Shingles (Varicella) _____