PATIENT INFORMATION

sierraderm

❑ New Patient ❑ Name Change ❑ Address Change ❑ Insurance Change Date_____

Name _____
Last First Middle Initial

Date of Birth_____ Age_____ Social Security #_____ ❑ Male ❑ Female

Race: (**Please Check One**): ❑ White ❑ Native Hawaiian or Other Pacific Islander ❑ Black or African American ❑ Asian ❑ American Indian or Alaska Native ❑ Some other race

Ethnicity (**Please Check one**) ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Mailing Address_____
Street City State Zip

Physical Address_____
Street City State Zip

Home Phone ( )_____ Work Phone ( )_____ Cel Phone ( )_____

Email Address_____

Marital Status ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated Occupation_____

Referred By _____ **Primary Care Physician**_____

Pharmacy of Choice_____ Other Family Members that are Patients_____

PARENT, SPOUSE OR RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

Name _____
Last First Middle Initial

Date of Birth_____ Age_____ Social Security #_____ ❑ Male ❑ Female

Mailingl Address_____
Street City State Zip

Home Phone ( )_____ Work Phone ( )_____ Cel Phone ( )_____

INSURANCE COVERAGE (PRIMARY)

Insurance Company Name _____

Name of Policy Holder _____

Relationship to Policy Holder
❑ Spouse ❑ Mother ❑ Father ❑ Other_____

INSURANCE COVERAGE (SECONDARY)

Insurance Company Name _____

Name of Policy Holder _____

Relationship to Policy Holder
❑ Spouse ❑ Mother ❑ Father ❑ Other_____

PAYMENT POLICY

We accept payment by cash, check VISA or Mastercard (we do not take American Express). SIERRADERM requires social security numbers for all patients who choose to have us bill their insurance. If this is not acceptable we can still see you as a patient but cash is due at time of service. In the event that your account must be turned over to a collection agency, a 10% annual interest fee will be added to your account. For patients who are seeing Dr. Muellenhoff for the first time, insurance billing will reflect a consultation or a new patient visit. This also applies to patients who have not been seen in over three years. Procedures (i.e. liquid nitrogen, biopsy, surgery) are considered and billed separate from patient visits and may or may not be able to be performed on the same day as evaluation depending on time allotted and insurance coverage.

I understand the billing procedures of SIERRADERM. I authorize payment of medical benefits and agree to pay any balances that are my responsibility including unmet deductibles, non-covered services and copayments. My signature below acknowledges my understanding and willingness to comply with this policy.

_____ _____
Signature of Patient Date

PATIENT MEDICAL HISTORY

sierraderm

Rev.05/01/2012

Date_____

Name_____ Age_____ Date of Birth _____

Medical History (Please circle all that apply)

Anxiety	GERD (Reflux Disease)	Seizures
Arthritis	Hearing Loss	Stroke
Asthma	Hepatitis	None
Atrial Fibrillation	Hypertension	Other _____
BPH (Enlarged Prostate)	HIV/AIDS	_____
Bone Marrow Transplantation	Hypercholesterolemia	_____
Breast Cancer	Hyperthyroidism	_____
Colon Cancer	Hypothyroidism	_____
COPD	Leukemia	_____
Coronary Artery Disease	Lung Cancer	_____
Depression	Lymphoma	_____
Diabetes	Prostate Cancer	_____
End Stage Renal Disease	Radiation Treatment	

Past Surgeries (Please circle all that apply)

Appendix Removed	Mechanical Valve Replacement	Prostate Removed: Prostate Cancer
Bladder Removed	Biological Valve Replacement	Prostate Biopsy
Mastectomy (Right, Left, Bilateral)	Heart Transplant	TURP (Prostate Surgery)
Lumpectomy (Right, Left, Bilateral)	Joint Replacement, Knee(Right/Left/Bilateral)	Skin Biopsy
Breast Biopsy (Right, Left, Bilateral)	Joint Replacement, Hip(Right/Left/Bilateral)	Basal Cell Cancer Surgery
Breast Reduction	Joint Replacement within last 2 years	Squamous Cell Carcinoma Surgery
Breast Implants	Kidney Biopsy	Melanoma Surgery
Colectomy: Colon Cancer Resection	Kidney Removed (Left/Right)	Spleen Removed
Colectomy: Diverticulitis	Kidney Stone Removal	Testicles Removed: (Right/Left/Bilateral)
Colectomy: IBD	Kidney Transplant	Hysterectomy: Fibroids
Gallbladder Removed	Ovaries Removed: Endometriosis	Hysterectomy: Uterine Cancer
Coronary Artery Bypass	Ovaries Removed: Cyst	None
PTCA (Coronary Angioplasty)	Ovaries Removed: Ovarian Cancer	Other

Skin Disease History (Please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	Cancer
	Other:	None

Do you wear sunscreen Yes No Do you tan in a tanning salon? Yes No

If yes, what SPF? _____

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)?_____

CONTINUED ON REVERSE

PATIENT MEDICAL HISTORY (continued)

Medications: (Please enter all current medications)

Name	Dosage
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies: (Please enter all allergies)

_____

_____

_____

_____

_____

_____

_____

Social History: (Please circle all that apply)

Currently Smokes - daily

Currently Smokes - not daily

Former smoker

Has never smoked

Drug Use:

Other:_____

_____

PATIENT NOTICE OF PRIVACY PRACTICES/ RELEASE OF INFORMATION AUTHORIZATION/ CANCELLATION POLICY

sierraderm
Revised 9/17/14

This notice describes how medical information about you may be disclosed. Please review it carefully.

SIERRADERM will use your medical information for the following:

1. **Treatment:** Including providing your medical records to consulting clinicians and insurance companies.
2. **Payment:** Filing necessary insurance claims in your name to obtain payment. They may request part or all of your medical record to pay the claim.
3. **Healthcare Operations:** Any others involved in your healthcare.

The entire NOTICE OF PRIVACY PRACTICES for SIERRADERM is posted in the waiting room for your review. A copy can be provided to you by request. In conjunction with these privacy practices you will need to provide us with the following information:

1. Individuals we are authorized to contact in case of emergency or to discuss your health care and medical treatment.

Name	Relation	Phone Number

2. May we leave a message regarding your health or an upcoming appointment on your answering machine? ❑ Yes ❑ No

Cancellation Policy: Our office expects 48 hours notice for cancellations or rescheduling. Please allow us the opportunity to schedule another patient in your place. A fee of $50.00 will be charged for repeat missed appointments. Multiple missed appointments may result in dismissal from the practice.

SIERRADERM reserves the right, at any point in time, to terminate the physician-patient relationship.

ALL PATIENTS (Please read and sign the following statement)
I have read the NOTICE OF PRIVACY PRACTICES for SIERRADERM and authorize the release of medical information to my primary care or referring physician, consultants and as necessary to process insurance claims, insurance applications and prescriptions. I have read and understand the cancellation/termination policy for SIERRADERM.

Name of Patient (Print)	Signature of Patient or Legal Guardian	Date

Name of Legal Guardian	Relationship to Patient

Medicare Patients Only (Please read and sign the following statement)
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or it's intermediaries or carriers 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.

Signature	Date

NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures

Treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

Payment. Your health information may be used to seek payment from your health plan or from other sources of coverage such as an automobile insurer. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of SIERRADERM. For example, information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement. Your health information may be disclosed to law enforcement agencies to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, we are required to report certain communicable diseases to the state's public health department.

Lawsuits and Similar Proceedings. Our practice may use and disclose your health information in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding.

Serious Threats to Health or Safety and National Security. Our practice may use and disclose your health information when necessary to reduce or prevent serious threat to your health and safety or the health and safety of another individual or the public. We also may disclose your health information to federal officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations.

Additional Uses of Information

Appointment Reminders. Your health information may be used by our staff to contact you and remind you of an appointment.

Information About Treatments. Your health information may be used to send you information that you may find interesting on the treatment and management of your medical condition. We may also send you information describing other health-related products and services that we believe may interest you.

If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision to revoke your authorization.

Individual Rights

You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information.
2. The right to receive confidential communications concerning your medical condition and treatment.
3. The right to inspect or copy your protected health information.
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed.
6. The right to receive a printed copy of this notice.

SIERRADERM Duties

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices

As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Upon request, we will provide you with the most recently revised notice on any office visit. The revised policies and practices will be applied to all protected health information we maintain.

Requests to Inspect Protected Health Information

You may generally inspect or copy the protected health information that we maintain. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Medical Assistant or Practice Manager. Your request will be reviewed and will generally be approved unless there are legal or medical reasons to deny the request.

Complaints, Comments or More Information

If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your questions/ concerns to: SIERRADERM, Attention: Practice Manager, 126 Glasson Way, Grass Valley, CA 95945 or calling (530) 272-2303.

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint

For more information about our privacy practices contact:
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This notice is effective on or after September 1, 2004 (Rev 10/14/09)