CATALINA DERMATOLOGY

Please Print in Blue or Black Ink and Complete Entire Form

PATIENT INFORMATION

First Name_____ M.I.____ Last Name_____
Date of Birth_____ Gender __M __F SS#_____
Home Phone_____ Work Phone_____
Cell Phone_____ E-Mail Address_____
Marital Status __S __M __W __Sep
Address_____
Employer_____ Occupation_____
Referring Physician_____ Race/Ethnicity _____

RESPONSIBLE PARTY INFORMATION

First Name_____ M.I.___ Last Name_____
Date of Birth_____ SS#_____
Home Phone_____ Work Phone_____
Employer_____ Occupation_____
Relationship to Patient_____

EMERGENCY CONTACT

First Name_____ M.I.____ Last Name_____
Address_____
Telephone_____

INSURANCE INFORMATION

Primary Insurance Company _____
ID#_____ Policy #_____ Group #_____
Policyholder's Name_____ Relationship to Patient_____
Date of Birth_____ Policy Holder's Employer_____
Secondary Insurance Company_____
ID#_____ Policy#_____ Group #_____
Policyholder's Name_____ Relationship to Patient_____
Date of Birth_____ Policy Holder's Employer _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services rendered or to be rendered in the future, without obtaining my signature on each claim submitted, and the signature will bind me as though I personally signed the claim. I also authorize the release of any medical information necessary. I UNDERSTAND AND I AM RESPONSIBLE FOR ALL CHARGES. If this account should be referred to a collection agency, I will be responsible for any collection and/or legal fees. I have read and understand the office policy and procedure.

_____ _____
Responsible Party Signature Date

ACKNOWLEDGEMENT OF RECIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of CATALINA DERMATOLOGY'S "Notice of Privacy Practices." This Notice describes how CATALINA DERMATOLOGY may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____
Signature of Patient or Personal Representative Date

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Thank you for choosing Catalina Dermatology as your healthcare provider!

The medical services you seek here imply an obligation on your part to ensure payment in full is made for services you receive. This **Patient Financial Responsibility Agreement** will assist you in understanding that financial responsibility.

Consent: I consent to treatment and services ordered by my Physician or Physician Assistant at Catalina Dermatology. I understand my healthcare provider may perform medically necessary services, as well as "elective" services, according to current standard of care guidelines. I do have the right to consider or decline services prior to them being performed. My consent to undergo treatment and/or services will be considered a non-verbal agreement to pay for the services provided to me.

Responsibility: I understand that I am ultimately responsible for all payment obligations arising out of my treatment and care and I guarantee payment for these services. I am responsible for deductibles, co-payments, co-insurance, or any other patient responsibility amounts indicated by my insurance carrier, pursuant to my particular plan. I am also responsible for any services not covered by my insurance.

Insurance Policy: It is my responsibility to know and understand my insurance policy, both the coverage benefits and the policy limitations. I understand that I am personally responsible for payment when: (i) my health plan requires prior authorization/referral by a primary care physician (PCP) before receiving services, and I have not obtained such an authorization or referral; (ii) I receive services in excess of the authorization/referral; (iii) my health plan determines the services I received are not medically necessary and/or not covered by my insurance plan; (iv) my coverage has lapsed/expired at the time services are rendered; (v) I have chosen to utilized my out-of-network benefits; or (vi) I have chosen not to use my health plan coverage for services I receive.

Payment Arrangements: Whether I have insurance or I am self-pay, payment of my account balance is due within ten (10) days of receipt of my billing statement. I understand if I need to make special payment arrangements, I may contact the billing staff to arrange a mutually agreeable payment plan. I agree to make payments on this plan pursuant to the plan agreement until my account is paid in full. If my account is over sixty (60) days past due, my account will be in default and may be referred to a collection agency or attorney.

Payments Accepted: I understand that I can make payments by check, cash, money order, debit card or credit card (Visa, MasterCard, American Express or Discover).

Payment by Check: If my check payment is returned or declined for any reason, my account will be charged a surcharge of $35.00 in addition to any costs assessed or charged by the bank. After two (2) returned checks have been received by Catalina Dermatology, my personal checks will no longer be accepted and I will be responsible for using another method of payment.

Non-Payment on Account: Should collection proceedings or other legal action become necessary to collect my overdue or delinquent account, I understand Catalina Dermatology has the right to disclose to an outside collection agency or attorney all relevant personal and account information necessary to collect payment for services rendered. I am responsible for all costs of collection, including, but not limited to: (i)

late fees and charges and interest due as a result of such delinquency; (ii) interest of 18% per year accrued on the principal balance owing; and (iii) all attorney/court costs and fees incurred in the collection process. I acknowledge that if my account is referred to a collection agency or attorney, or when the past due status is reported to a credit reporting agency, it may have an adverse impact on my credit history. Once my account is placed with a collection agency or attorney, I am responsible for communicating with their offices for payment. I may lose my ability to be seen at Catalina Dermatology as a result of my account being sent to a collection agency or attorney.

Minor Patients: The parent/guardian presenting with a minor for care is the responsible party for the payment of the minor's account balance regardless of any court order or arrangement to which the parents may have agreed. Catalina Dermatology will not act as administrator to resolve financial agreements.

Authorization to Contact: I authorize Catalina Dermatology, or any collection agency or attorney hired by Catalina Dermatology, to communicate with me by mail, answering machine message, text message or email. I may be contacted for purposed related to my account, including debt collection, using any information I have provided, including contact information, email addresses, cell phone numbers, and landline numbers. I authorize Catalina Dermatology to use this information in any manner consistent with the information I have provided, including mail, telephone calls, e-mails, or text messages. I expressly understand that this contact may result in charges to me and may include the use of text message, automated dialing machines or other telephone technology, including the use of live, pre-recorded or artificial voice messages.

Acknowledgement: I understand I am ultimately responsible for payment of services I receive at Catalina Dermatology, regardless of my health insurance coverage. I understand that Catalina Dermatology will not act as administrator to resolve my personal financial agreements in regard to my medical care. I have had the opportunity to read this Patient Financial Responsibility Agreement in its entirety and have had the opportunity to ask questions regarding the details of this Agreement. Any questions have been answered to my satisfaction.

I consent and agree to the aforementioned policies of Catalina Dermatology and understand they may be altered without notice.

Signed and agreed to this date: _____

_____	_____
Patient Name	Parent/Guardian Name
_____	_____
Signature	Signature
_____	_____
Date of Birth	Date of Birth

CATALINA DERMATOLOGY
RONALD M. MANN, M.D., F.A.A.D.
7355 E. TANQUE VERDE
TUCSON, AZ 85715
Phone: 520-529-8883 Fax: 520-290-0039

CANCELLATION AND NO SHOW POLICY

Should it become necessary for you to cancel or reschedule your appointment, we request 24 hours notice. This allows us to offer appointments to other patients who are scheduled in the future and necessitate being seen sooner, or patients who need to be seen on an urgent basis.

A patient who fails to show for a scheduled appointment or a patient who cancels his/her appointment with less than 24 hours notice will be charged a fee as follows:

Established patients	**$50.00**
New Patients	**$150.00**
Procedure/MOHS	**$150.00-$300.00**

Thank you for courtesy and cooperation,

Catalina Dermatology

By signing below, I agree that I have read and understand the above policy.

_____ _____
Signature of Patient Date

_____ _____
Witness Signature Date

CATALINA DERMATOLOGY
RONALD M. MANN, M.D., F.A.A.D.
Board Certified in Dermatology Mohs Micrographic Surgery

Patient's Authorization Request Form

You may give Catalina Dermatology and Dr. Mann (the Practice) written authorization to disclose your protected health information (PHI) to anyone you designate and for any purpose. If you wish to authorize a person or entity to receive your PHI, please complete the information below. Completion of this form will not change the way the Practice communicates with you as a patient. For example, the Practice will send statements, appointment reminders, give pathology results, etc. when appropriate.

Patient Name:_____ Date of Birth: _____

Patient SSN# _____

At my request, I authorize this Practice to disclose my Protected Health Information to :
(enter name of person/entity who will receive you PHI)

1. _____ 2. _____
Name Relationship to patient Name Relationship to patient

Please provide the following information to the person you have authorized so that we may verify the person's identity and authority to receive your information: 1. Your SSN 2. Your date of birth.

I authorize this Practice to release the following information to the person/entity listed above.
Check all that apply:

__ Account Information
__ All claims information
__ Explanation of insurance (EOB) info
__ Pathology Reports
__ Laboratory Reports
__ Any requested information
__ Other: (Please list specific health information): _____
_____

I would like this authorization to expire on (enter date) __/__/__. (If no expiration date is listed, this authorization will expire one year from date of receipt.)

I understand that I may revoke this authorization at any time by giving the Practice written notice. However, if I revoke this authorization, I also understand that the revocation will not affect any action the Practice took in reliance upon this authorization before the Practice received my written notice.

I also understand that the Practice will not condition the way medical treatment will be given because of this authorization.

(continued on reverse)

I also understand that if the persons or entities I authorize to receive my PHI are not *health plans, covered health care providers or health care clearinghouses subject to Health Insurance Portability and Accountability Act (HIPPA) or other federal health information privacy laws*, they may further disclose the PHI and it may no longer be protected by HIPPA or federal health information privacy laws.

_____ _____

Signature of patient Date

If signed by personal representative,

Print your full name: _____

Describe your authority to act for the patient (e.g power of attorney, court order, parent of a minor, etc.): _____

Please attach legal docmumentation naming you as the personal representative.

Note: Catalina Dermatology and Dr. Mann will consider the effective date of this authorization to be the date the Practice enters this authorization into its system, typically 5 business days following receipt. If you would like this authorization to become effective on a date after the practice enters the authorization into its system, please insert the date here: __/__/__.

If you chose to decline this authorization, please sign below.

_____ _____

Signature Date

CATALINA DERMATOLOGY

RONALD M. MANN, M.C., F.A.A.D.

Board Certified in Dermatology Mohs Micrographic Surgery

Patient Name:_____ Date:_____

Patient Phone No: _____ Ins. Co.:_____

Referring Physician: _____ Primary Care Physician: _____

Drug Allergies: _____

Medications presently taking: _____

Do you have a personal history of any of the following: (Circle Yes or No)

Diabetes_____	Yes	No	Radiation Therapy_____	Yes	No
High Blood Pressure_____	Yes	No	HIV Infection_____	Yes	No
Heart Disease_____	Yes	No	Kidney Disease_____	Yes	No
Type_____			Pacemaker_____	Yes	No
Lung Disease_____	Yes	No	Implanted Defibrillator_____	Yes	No
Arthritis_____	Yes	No	Artificial Heart Valve_____	Yes	No
Hepatitis_____	Yes	No	Joint Replacement_____	Yes	No
Type_____					
Cancer (Other than skin)__	Yes	No	Bleeding Disorders_____	Yes	No
Type_____			Neurologic Disease_____	Yes	No
Skin Cancer_____	Yes	No	Seizures_____	Yes	No
Type_____			Auto-Immune Disease_____	Yes	No
Keloidal Scars_____	Yes	No	Type_____		
Liver Disease_____	Yes	No	Tobacco Use_____	Yes	No
Organ Transplant_____	Yes	No	Alcohol Use_____	Yes	No

List any other significant health problems: _____

Have you had a history of problems with surgery/or anesthesia?_____

What previous surgeries have you had and when?_____

_____

FAMILY HISTORY

Do your parents, siblings or grandparents have any of the following?

Skin Cancer_____	Yes	No	Type_____
Skin Disease (e.g. eczema, psoriasis)___	Yes	No	Type_____
Other Cancers_____	Yes	No	Type_____
Diabetes_____	Yes	No	
Arthritis_____	Yes	No	
Heart Disease_____	Yes	No	
Other_____	Yes	No	Type_____

SOCIAL HISTORY

Are you married or single?_____	M	S	
Do you live alone?_____	Yes	No	
Do you exercise routinely?_____	Yes	No	
Do you have a drug or alcohol habit?__	Yes	No	
Flu Shot?_____	Yes	No	Date_____
Pneumonia Vaccine?_____	Yes	No	Date_____

(continued on reverse)

REVIEW OF SYSTEMS

Do you have any significant problems in any of the following areas?

Head, ears, eyes, nose, throat

Eyes_____	Yes	No	Ears_____	Yes	No
Mouth_____	Yes	No	Throat_____	Yes	No
Sinus Problems_____	Yes	No	Head_____	Yes	No

If you answered yes to any of the above, please explain:_____

Cardiovascular

Chest Pains_____	Yes	No	Pain in Legs_____	Yes	No
Irregular Heart Rate_____	Yes	No	Blood Pressure_____	Yes	No

If you answered yes to any of the above, please explain:_____

Gastrointestinal

Swallowing_____	Yes	No	Heartburn_____	Yes	No
Nausea_____	Yes	No	Frequent stomach discomfort_	Yes	No
Diarrhea_____	Yes	No	Rectal Bleeding_____	Yes	No
Bloody or Black Stool_____	Yes	No	Vomiting_____	Yes	No

If you answered yes to any of the above, please explain:_____

Genital/Urinary

Difficulty Urinating_____	Yes	No	Blood in Urine_____	Yes	No
Menstrual Problems_____	Yes	No			

If you answered yes to any of the above, please explain:_____

Musculoskeletal

Joint Pains_____	Yes	No	Muscle Pain_____	Yes	No
Back Problems_____	Yes	No	Arm in motion problems_____	Yes	No
Hand Movement Problems_	Yes	No	Problems Walking_____	Yes	No

If you answered yes to any of the above, please explain:_____

Neurologic

Seizures_____	Yes	No	Frequent Headaches_____	Yes	No
Problems with Speech_____	Yes	No	Stroke_____	Yes	No

If you answered yes to any of the above, please explain:_____

Respiratory

Breathing Problems_____	Yes	No	Coughing_____	Yes	No
Coughing up Blood_____	Yes	No	Shortness of Breath_____	Yes	No

If you answered yes to any of the above, please explain:_____

Skin

Rash_____	Yes	No	Changing Moles_____	Yes	No
Frequent Hives_____	Yes	No	Persistent Itching_____	Yes	No
Easily Bleeding Sore_____	Yes	No			

If you answered yes to any of the above, please explain:_____

If you take aspirin or aspirin containing medications or nonsteroidal medications, please inform the physician. We thank you for taking the time to complete this form.

Patient Signature:_____

CATALINA DERMATOLOGY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE REVIEW IT CAREFULLY

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US

Protected health information about you is obtained as a record of your contacts or visits for healthcare services with CATALINA DERMATOLOGY. This information is called protected health information. Specifically, "Protected Health Information" is information about you, including demographic information (i.e., name, address, phone number, etc.) that may identify you and relates to your past, present or future physical or mental health condition and related health care services.

CATALINA DERMATOLOGY is required to follow specific rules on maintaining the confidentiality of your protected health information, how our staff uses your information, and how we disclose or share this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your protected health information. It also describes how we follow those rules and use and disclose your protected health information to provide your treatment, obtain payment for services you receive, manage our health care operations, and for other purposes that are permitted or required by law.

If you have any questions about this Notice, please contact or Privacy Manager at (520) 529-8883

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office:

Treatment: We may use or disclose your health information to provide, coordinate, or manage your health care and any related services. We could disclose your protected health information to a physician or other healthcare provider providing treatment to you, to a pharmacy filling your prescriptions, or to family and friends you approve.

We may also call you by name in the waiting room when the physician is ready to see you, and contact you by telephone to remind you of your appointment or inform you of test results.

Payment: We may use and disclose your health information to obtain payment for services we provide to you. This may include also include certain activities that your health insurance plan may undertake before it approves or pays for the services we recommend, such as making a determination of eligibility or coverage.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

OTHER PERMITTED AND REQUIRED USES AND DISCLOSURES

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for <u>any purpose</u>. You also have the right to request restrictions on disclosure of PHI (Personal Health Information),or alternative means of communication to ensure privacy.

Marketing Health-Related Services: We will **not** use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law or by national security activities. This may include disclosing protected health information in the course of judicial or administrative proceedings, in response to a court order or discovery request, or for law enforcement purposes.

For Public Health: We may disclose your protected health information for public health activities and purposed to a public health authority that is permitted by law to collect or receive the information.

In Cases of Abuse or Neglect: We may disclose your health information to appropriate authorities when we suspect abuse or neglect.

To the Food and Drug Administration: We may disclose your protected health information to a person or company required by the FDA to report adverse events, product defects or problems, or biologic product deviations in order to track products, enable product recalls, make repairs or replacements, or conduct post marketing surveillance, as required.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders
(Such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Copy of this Notice of Privacy Practices: We are required to follow the terms of this notice. We reserve the right to change the terms of our notice at any time. If needed, new versions of this notice will be effective for all protected health information that we maintain at the time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

Access: You have the right to look at or get copies of your health information with limited exceptions. If you request copies, we will charge you a reasonable fee to locate and copy your information, and postage if you want the copies mailed to you.

Use and Disclosure: You have the right to authorize or deny any use or disclosure of protected health information not specified in this notice. You may revoke an authorization at any time, in writing, except to the extent that your physician or our office has taken an action in reliance on the use or disclosure indicated in the authorization.

Personal Representative: You may designate a person with the delegated authority to consent to or authorize the use or disclosure of protected health information.

Restrictions and Amendments: You have the right to request us not to use or disclose any part of your protected health information. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care. You may also request that we amend your health information.

Disclosure Accountability: You have the right to request a listing of your protected health information disclosures we have make to entities or persons outside of our office.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have any questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us with the U.S. Department of Health and Human Services. A Privacy/Contact Officer has been designated for this office. The Privacy Officer can be contacted by simply contacting the office and asking to speak to the Office Manager who serves as the Privacy Officer.
