# Patient Information Sheet

Name:______________________________________________________________________________
Last First MI

Date of Birth:____________________________ Age____________ Gender: ____________

Marital Status: _____________________Occupation:__________________________

Address:_______________________________City:_____________________State:_____Zip:______

Home Phone:_____________________________________Cell Phone:_________________________

Work Phone:______________________________________Preferred Contact Phone: Home Cell Work

Email Address______________________________________________________________________

Emergency Contact_Name_________________________________Telephone________________Relationship___

## Primary Insurance

Insurance Plan Name_______________________ Subscriber ID#___________________________

## Secondary Insurance

Insurance Plan Name_______________________Subscriber ID#____________________________

## Medical History

List reason for visit ____________________________________________________________________

List current medications _______________________________________________________________

List allergies to medications ____________________________________________________________

History of skin cancer? Y N If yes, type ________________ Location _________________________

Name of dermatologist ________________________________ Phone __________________________

_________________________________________________________________________________

I certify that the above information is correct to the best of my knowledge.

I authorize Array Skin Therapy to bill my insurance company for services provided to me. I authorize the release of any medical information necessary to process my claim.

I authorize payment of medical benefits directly to Array Skin Therapy.

I understand that all charges are ultimately my financial responsibility including denied claims, deductibles, copays and coinsurance. By typing my name below and on each consecutive page, I am signing electronically. I understand and agree that my electronic signature is the legal equivalent of my handwritten signature.

X_________________________________________________________________________________

Signature of Patient or Legal Guardian Date

Print name and relationship to patient if not signed by patient:

_________________________________________________________________________________

# Patient Questionnaire

Patient: ______________________________________________ DOB_________________

Answering the following questions will help us provide the best care for you. Please check all the symptoms that apply to you.

## GENERAL

- ☐ Feeling ill
- ☐ Fatigue
- ☐ Fever
- ☐ Chills
- ☐ Night sweats
- ☐ Decreased appetite
- ☐ Unexplained weight changes

## SKIN

☐ Pain

*Rate your pain*
*(0-no pain, 10-worst pain)*
0 1 2 3 4 5 6 7 8 9 10

*Location of pain:* ____________________
__________________________________
__________________________________

☐ Itching

*Rate your itching*
*(0-no itching, 10-worst itching)*
0 1 2 3 4 5 6 7 8 9 10

*Location of pain:* ____________________
__________________________________
__________________________________

- ☐ Redness
- ☐ Burning
- ☐ Cracking/Fissuring
- ☐ Scale/Peeling
- ☐ Bleeding
- ☐ Nail changes (pitting, lifting, thickening, discoloration)
- ☐ Hives
- ☐ Bumps
- ☐ Discoloration
- ☐ White patches/Decreased pigment

## MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness
- ☐ Swelling in the joints
- ☐ Reduced range of motion
- ☐ Muscle aches/Pain
- ☐ Multiple bone fractures
- ☐ Pain in your heel

Patient Signature _______________________________________ Date _______________

Reviewed by ___________________________________________ Date _______________

# Digital Photography Policy and Consent

It is Array Skin Therapy's policy to take before and after photographs for documentation purposes. The photographs are kept confidential as part of the patient's medical record. Photographs are stored securely in line with HIPAA compliance. Only Array Skin Therapy staff and the patient or patient's guardian views photographs, unless permission is obtained for other uses.

I have been informed of the photography policy and I grant permission for Array Skin Therapy to take before and after photographs for documentation purposes:

_______________________________________________________________Date____________
Patient Signature (Parent or guardian if patient is a minor)

_____________________________________________________________________________
Patient Name (please print)

## Optional Consent

I give permission for Array Skin Therapy to use my photographs and/or other media for the following purposes: (leave the spaces below blank if no further consent is given)

____________ Email to referring physician if requested
(Initials)

____________ Educational purposes for physicians and health care professionals
(Initials)

____________ Raise awareness of the benefits of light therapy through print and digital materials
(Initials)

Identifying _____ Non-identifying _____

# Notice of Privacy Acknowledgement

HIPAA (Health Insurance Portability and Accountability Act) regulations require us to provide to you, the patient or personal representative, a copy of our Notice of Privacy Practice and for you to sign as acknowledgement of receipt of this information.

_______________________________________ _____________________________

Print Name of Patient, or if a Minor, Parent or Guardian    Relationship to Patient

_______________________________________ _____________________________

Signature of Patient or Representative    Date

How may we contact you and still provide the privacy and security you require as we protect your health and personal information? Contacts may include results, appointment reminders, billing statements as well as other activities relating to your health care.

**PLEASE INITIAL:**

___________ Telephone and message to your answering device

___________ Telephone and message to another person (please name ___________________)

___________ Mail

___________ Email

___________ Contact you at work

___________ Designated caregiver, legal guardian or relative (please specify _______________)

Name and relationship of additional persons authorized to receive information regarding patient:

______________________________________________________________________________

______________________________________________________________________________

REV 6-25-21

# Billing Policy

BILLING POLICY:

Array Skin Therapy will bill the patient's insurance company for services provided.

Array Skin Therapy will verify benefits and coverage before treatment. However, please be advised that this is not a guarantee of payment from the insurance. It is the ultimate responsibility of the insured to know the terms and coverage of their medical insurance plan.

Deductibles, copays and coinsurance are the patient's responsibility. Array Skin Therapy has a contractual obligation to insurance companies and Medicare to collect this from the patient. Copays and deductibles are due at the time of the visit. Coinsurance amounts will be billed to the patient after insurance claim processing.

For convenience, Array Skin Therapy accepts all major credit cards and debit cards.

I have read and accept the above billing policy:

_______________________________________________________________________

Signature of patient or guarantor Date

_______________________________________________________________________

Patient Name

# Clinician-Patient Arbitration Agreement

**Article 1: Agreement to Arbitrate:** It is understood that any dispute as to medical malpractice, that is as to whether any medical services rendered under contract were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered, will be determined by submission to arbitration as provided by California law, and not by a lawsuit or resort to court process except as California law provides for judicial review of arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional rights to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration.

**Article 2: All Claims Must be Arbitrated:** It is the intention of the parties that this agreement bind all parties whose claims may arise out of or relate to treatment or service provided by the physician or nurse including any spouse or heirs of the patient and any children, whether born or unborn, at the time of occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient herein shall mean both the mother and the mother's expected child or children. All claims for monetary damages exceeding the jurisdictional limit of the small claims court against the physician, and the physician's partners, associates, association, corporation or partnership, and the employees, agents and estates of any of them, must be arbitrated including, without limitation, claims for loss of consortium, wrongful death, emotional distress or punitive damages. Filing of any action in any court by the physician to collect any fee from the patient shall not waive the right to compel arbitration of any malpractice claim.

**Article 3: Procedures and Applicable Law:** A demand for arbitration must be communicated in writing to all parties. Each party shall select an arbitrator within thirty days and a third neutral arbitrator shall be selected by the arbitrators appointed by the parties within thirty days of a demand for a neutral arbitrator by either party. Each party to the arbitration shall pay such party's pro rata share of the expenses and fees of the neutral arbitrator, together with other expenses of the arbitration incurred or approved by the neutral arbitrator, not including counsel fees or witness fees, or other expenses incurred by a party by such party's acting in the capacity of arbitrator under this contract. The immunity shall supplement, not supplant, any other applicable statutory or common law. Either party shall have the absolute right to arbitrate separately the issues of liability and damages upon written request to the neutral arbitrator. The parties consent to the intervention and join in the arbitration of any person or entity which would otherwise be a proper additional party in a court action, and upon such intervention and join any existing court action against such additional person or entity shall be stayed pending arbitration.

**Article 4: Revocation:** This agreement may be revoked by written notice delivered to the office within 30 days of Signature. It is the intent of this agreement to apply to all medical services rendered any time for any condition.

**Article 5: Retroactive Effect:** If patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below: Effective as of the date of first medical services________

If any provision of this arbitration agreement is held invalid or unenforceable, the remaining provisions shall remain in full force and shall not be affected by the invalidity of any other provision.

NOTICE: BY INITIALLING IN THE SPACE BELOW YOU ARE AGREEING TO HAVE ANY DISPUTE ARISING OUT OF THE MATTERS INCLUDED IN THE ARBITRATION OF DISPUTES' PROVISION DECIDED BY NEUTRAL ARBITRATION AS PROVIDED BY CALIFORNIA LAW AND YOU ARE GIVING UP ANY RIGHTS YOU MIGHT POSSESS TO HAVE THE DISPUTE LITIGATED IN A COURT OR JURY TRIAL. IF YOU REFUSE TO SUBMIT TO ARBITRATION AFTER AGREEING TO THIS PROVISION, YOU MAY BE COMPELLED TO ARBITRATE UNDER THE AUTHORITY OF THE CALIFORNIA CODE OF CIVIL PROCEDURE. YOUR AGREEMENT TO THIS ARBITRATION PROVISION IS VOLUNTARY. _________ (Patient Initials)

I HAVE READ AND UNDERSTAND THE FOREGOING AND AGREE TO SUBMIT DISPUTES ARISING OUT OF THE MATTERS INCLUDED IN THE ARBITRATION OF DISPUTES' PROVISION TO NEUTRAL ARBITRATION_________ (Patient Initials)

BY: _________________________________ ___________
Patient or Representative's Signature DATE

BY: ARRAY SKIN THERAPY ______________________
DATE

BY: ______________________________________________
Print Patient's Name

___________________________________________
Clinician's or authorized representative's signature

# A MESSAGE TO OUR PATIENTS ABOUT ARBITRATION

The attached form is an arbitration agreement. By signing this agreement we are agreeing that any dispute arising out of the medical service you receive is to be resolved in binding arbitration rather than a suit in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that the method of resolving disputes by arbitration is one of the fairest systems for both patients and providers. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts.

By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then selects a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and providers. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication. Therefore, if you have any questions about your care, please ask us.

# Notice of Privacy Practices

HIPAA the Health Insurance Portability and Accountability Act of 1996 has recently been formalized and will help govern the relationship between patients and their providers of Health Care to provide all entitled Medical Services in the most efficient way.

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU, AS THE PATIENT, MAY GET ACCESS TO THIS INFORMATION**

If you have any questions about this notice, please contact our Privacy Office. We appreciate the trust that patients place in us and we recognize the importance of protecting the confidentiality of non-public personal information that we have in our possession. This information will be used only to ensure accuracy in carrying out treatments for you and in keeping your records. In conducting transactions with patient's health carriers or affiliates they designate, we will always endeavor to use information that is absolutely necessary to comply. If we change this policy, we will notify you in advance.

This notice describes the information privacy practices that are followed by our employees, physicians, and all other office personnel.

## YOUR HEALTH INFORMATION

This notice applies to the information and records we have about your health, health status, and the health care/services you receive at this office. It also reviews the way in which your health information may be disclosed to other entities and it describes your rights and our obligations in managing the privacy and integrity of your care. We are required by law to give you this notice and to help you understand its intent.

## PATIENT'S RIGHT TO REVIEW PERSONAL HEALTH INFORMATION

You may and are encouraged to review your entire health care record maintained in this office by making an appointment with our administrator. Please feel free to discuss and put in writing any discrepancies you feel may be present so that we can meet and resolve any issues or questions of care and service.

## HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU:

**FOR YOUR TREATMENT REQUIREMENTS** we may use your health information to provide you with medical treatment and necessary services. In addition, we may need to disclose your health information to physicians and other caregivers such as nurses, technician, and office or other personnel who are involved in your health care and medical requirements. For example, your physician may be treating you for a condition that requires health information from other health care experts who may have already cared for you or are required to be consulted in the full scope of providing you with the most complete care for your particular condition(s). Thus, the doctor team may decide what alternatives are optimal for you. However, for personal health information to be sent to another office that is outside the treatment endeavors of this office, your written consent will be required.

Different personnel in our office may share information about you and disclose information to healthcare personnel who are not located in our office, but still involved in your immediate care. Designated family members and other healthcare providers may require information about you as well, such as surgical supply houses, case managers and social workers, or perhaps visiting nurses.

**FOR PAYMENT PURPOSES** we may be required to disclose health information about you such as diagnoses and treatment modalities in order for this office to be reimbursed for the services provided to you. Other personal health information and identifying information may be appropriately disclosed such as social security numbers, driver license numbers so relevant health plans can settle all or a portion of your account with this office. We may share information with your health plan concerning treatment recommended in order to receive their prior approval.

**<u>FOR HEALTHCARE OPERATIONS</u>** we may use and disclose health information about you in order to evaluate our office operations and monitor the quality of our care. For example, we may use and disclose health information about you in order to evaluate the performance and quality our staff provides in servicing your needs. Such information may also be used to determine what additional services we can and must offer to increase the effectiveness of treatment.

**SITUATIONS REQUIRING RELEASE OF PERSONAL INFORMATION**

- To avert a serious threat to public safety
- Information may be released by requirements of an appropriate subpoena or be required to do so by Federal, State or Local law enforcement agencies
- Military, Veterans, National security and intelligence
- Worker's Compensation
- Public Health Access in order to prevent or control disease, injury or disability' report births, death, suspected abuse or neglect
- Health Oversight Activities
- Lawsuits and Legal Disputes
- Law Enforcement
- Coroners, Medical Examiners and Funeral Directors
- Information Not Personally Identifiable
- We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you
- Family and Friends if we obtain your verbal agreement. In situations where you are not capable of giving consent (due to your incapacity or medical emergency) we may, using our professional judgement, determine that a disclosure to your family member or friend is in your best interest.

**OTHER USES AND DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION**

We will not use or disclose your health information for any purpose other than those identified in the previous sections without your specific *written authorization*. We must obtain your authorization **separate** from any consent we may have obtained from you. If you give us authorization to use or disclose health information about you, you may revoke that authorization in writing at any time. If you revoke your authorization we will no longer use or disclose information about you for the reasons covered by your written authorization, but we cannot take back any uses or disclosures already made with your permission.

We reserve the right to recall a patient to sign a special consent regarding any ambiguities.

If we have HIV or substance abuse information about you, we cannot release that information without a special signed, written authorization from you (different from the authorization and consent mentioned above). In order to disclose these types of records for purposes of treatment, payment or health care operations, we will have to have both your signed consent and a special written authorization that complies with the law governing HIV or substance abuse records.

**YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU**

You have the following rights regarding health information we maintain concerning you.

1. **Right to inspect and copy.** You have the right to inspect and copy your health information **<u>that we use to make</u>** decisions about your care. This includes medical and billing records. You must submit a written request to the Privacy Officer in order to inspect and/or copy your health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, and or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If the law requires such a review, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request, and we will comply with the outcome of the review.
2. **Right to amend.** If you believe health information we have about you is incorrect or incomplete, you may ask us to amend the information, you have the right to request an amendment, as long as this office keeps the information. To request an amendment, complete and submit a Medical Record Amendment/Correction Form to our Privacy Office. We

may deny your request for an amendment 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:

   a. We did not create, or the person or entity that created the information is no longer available to make the amendment.
   b. It is not part of the health information we keep.
   c. You would not be permitted to inspect and copy.
   d. The record is accurate and complete.

3. **Right to an accounting of disclosures.** You may have the right to request a list of disclosures of medical information we made about you for the purposes other than treatment, payment and health care operations. To obtain this list, you must submit a request in writing. It must state a time period, which may not be longer than six (6) years and may not include dates before April 14, 2003. Your request should indicate in what format you want the list. We may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
4. **Right to request restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment, or healthcare operations. You also have a right to request a limit on health information we disclose about you to someone who is involved in your care or the payment for it, such as a family member or friend.
5. **We are not required to accept your request**. If we do agree, we will comply with your request unless information is needed to provide you emergency treatment.
6. **Right to request confidential communications**. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may ask that we only contact you at work or by mail. We will not ask you the reason for your request and we will accommodate all reasonable requests.
7. **Right to a paper copy of this notice.** You have the right to a paper copy of this notice and you may ask us to give you a copy of this notice at any time, even if you have agreed to receive it electronically. To obtain such a copy, contact our Privacy Office.

## CHANGES TO THIS NOTICE

We reserve the right to change this notice and make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. We will post a summary of the current notice in the office with its effect date in the top right hand corner. You are entitled to a copy of the notice currently in effect.

## COMPLAINTS

If you believe your rights have been violated, you may file a complaint with our office or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. To file a complaint with our office contact our Privacy officer. You will not be penalized for filing a complaint.


Array Skin Therapy
A Medical Corporation
arrayskin.com
Privacy Office: Ann Beyer