Greenbrae Dermatology

Benjamin Nichols, MD • Cheryl Tanasovich, MD • John Maddox, MD • Kara Reinke, M.D.

Patient's Name: ______________________ Name you prefer to be called: ____________

Date of Birth: ______________________ ☐ Male ☐ Female Language: ____________

Address: ______________________

City: ______________________ State: ____________ Zip: ____________

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ African American ☐ Caucasian ☐ Hispanic or Latino
☐ Native Hawaiian or Other Pacific Islander ☐ Other Race ☐ Unknown ☐ Decline to specify

Occupation: ______________________ Employer: ______________________

Preferred Reminder Notifications: ☐ Email Reminder ☐ Phone (Voice) Reminder ☐ Phone (Text) Reminder

Check preferred phone:

☐ Cell: ____________ ☐ Home: ____________ ☐ Work: ____________

Email: ______________________

Is it okay to leave a detailed message on your phone? ☐ YES ☐ NO

Would you like to sign up for the Patient Portal to access your records? ☐ YES ☐ NO

If yes, your email address will be your username. You will be sent an email to activate your portal account.

Primary Insurance Subscriber: ☐ Individual Policy **OR** ☐Company Policy - Employer: ____________

Relationship to Primary Subscriber: ____________

**Subscriber's Full Name: ____________ **Subscriber's Date of Birth: ____________

Address (If different): ____________ City: ____________

State: ____________ Zip: ____________ Phone #: ____________

OFFICE POLICY: Assignment of Benefits - Financial Agreement - I hereby give lifetime authorization for payment of insurance benefits to be made directly to Greenbrae Dermatology, A Medical Corporation. I understand that I am financially responsible for all charges whether or not they are covered by insurance. In the event of default, I agree to pay all costs of collection, and the reasonable attorney's fees. I hereby authorize the health care provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be valid as the original.

Your Signature: ______________________ Date: ____________

Preferred Pharmacy:______________________	**Primary Care Physician:**______________
City:______________ Street/Location:__________	Location:______________________

Past Medical History: (Please circle all that apply)

Anxiety	Depression	HIV/AIDS	Prostate Cancer
Arthritis	Diabetes	High Cholesterol	Radiation Treatment
Asthma	End Stage Renal Disease	Hyperthyroidism	Seizures
Atrial Fibrillation	GERD	Hypothyroidism	Stroke
Transplant: __________	Hearing Loss	Leukemia	Other:__________
Breast Cancer	Hepatitis:__________	Lung Cancer	______________
Colon Cancer	High Blood Pressure	Lymphoma	______________

Past Surgical History: (Please circle all that apply)

Breast Cancer	Joint Replacement, Hip (R / L / B)	Prostate Removed: Prostate Cancer
Coronary Artery Bypass	Kidney Removed (Right / Left)	Spleen Removed
Mechanical Valve Replacement	Kidney Transplant	Uterine Cancer
Heart Transplant	Liver Transplant	Cervical Cancer
Joint Replacement, Knee (R / L / B)	Ovaries Removed: Ovarian Cancer	Other:________________

Skin Disease History: (Please circle all that apply)

Acne	Blistering Sunburns	Flaking or Itchy Scalp	Poison Oak
Actinic Keratoses	Dry Skin	Hay Fever / Allergies	Precancerous Moles
Basal Cell Skin Cancer	Eczema	Melanoma:________	Psoriasis
Other:______________________		______________	Squamous Cell Skin Cancer

Do you wear sunscreen? ☐ YES ☐ NO
Do you use tanning beds? ☐ YES ☐ NO
Do you have a Family History of **Melanoma**? ☐ YES ☐ NO, If yes, which relative(s)?:________________
Are you pregnant or currently breastfeeding? ☐ YES ☐ NO

Medications: (Please enter all current medications or provide a list if available)

____

____

Allergies: (Please enter all medication allergies & reactions)

____

____

Cigarette Smoking: ☐ Daily ☐ Some days ☐Former smoker ☐Never smoked
Family History of Cancer (Only 1st degree relatives & type of cancer): ________________________

Acknowledgement of Receipt of Notice of Privacy Practice for Greenbrae Dermatology

Chiara Solari & Daphne Fox, Privacy Officers (415) 925-0550

I hereby acknowledge that I received a copy of the "Notice of Privacy Practices." and that I will be offered a copy of any amended Notice of Privacy Practices.

Please carefully read and understand each item below. If you wish to make changes to a section, please notify the front desk so your file is noted properly in our system. Please sign and date the bottom of the page.

- I acknowledge that I have received a copy of the office's Privacy Practices.
- I give permission for the staff to identify themselves as a doctor's office when calling my home or office. I understand that no test results or other identifiable medical information will be left, just the time and date of the appointment. I give permission to leave a message to contact our office. The following exceptions apply: ______________________________
- I authorize the following person(s) (i.e. a spouse, family member or friend) to have access to my medical information, such as being able to receive my test results, take advice regarding my condition, and make my appointments. I may change this at anytime by signing a new form.

  Name: ______________________ Relationship to Patient: ______________

  Their telephone number: ______________________________

- Greenbrae Dermatology physicians, upon request, or as he/she sees appropriate, will keep my primary care or referring physician notified of my condition/progress.
- I authorize the staff to release pertinent records to any physician that Greenbrae Dermatology refers me to for further care.
- I understand that my records will not be released to third-party marketers without my explicit agreement.
- I understand that business associates such as billing processors may have access to some aspects of my medical information, but these entities have shown that they adhere to strict privacy practices. Any breach of this privacy will be reported.
- I understand I may request copies of my medical records and they can be copied at a charge and delivered within 30 days. Electronic records may be sent electronically.

Print Patient Name: ______________________________ Date: ______________

Signature: ______________________ Relationship to Patient: ______________

Notice of Privacy Practices for Greenbrae Dermatology

Benjamin Nichols M.D. | Cheryl Tanasovich M.D. | John Maddox M.D. | Kara Reinke, M.D.

Daphne Fox & Chiara Solari, Privacy Officers

Effective Date: October 14, 2019

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

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A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and or computer. This is your medical record. The medical record is the property of this practice, but the information in the medical record belongs to you. The law permits us to use or disclose you health information for the following purposes.

1. **Treatment.** We use medical information about you to provide you with medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. With your permission, we may also disclose medical to members of your family or others who can help you when you are sick or injured.

2. **Payment.** We used to disclose medical information about you to obtain payment for the services we provide. For example, we give our health plan the information it requires before it will pay us. We may disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. **Health Care Operations.** We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical review, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates", such as our billing service, that perform administration services for us. We have a written contract with each of these business associates that contain terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under California law all recipients of health care information are prohibited from re- disclosing it except as specifically required or permitted by law. We may also share your information with other healthcare providers, healthcare clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce healthcare costs, their review of competence, qualifications and performance of healthcare professionals, their training programs, their accreditation, certification or licensing activities or there healthcare fraud and abuse detection and compliance efforts.

4. **Appointment reminders.** We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. **Notification and communication with family.** Under usual circumstances we will obtain your authorization prior to disclosing your health information. However, in the event you become critically ill or die, we may disclose your health information to a family member, your personal representative or another person responsible for your care about our location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

6. **Required by law.** As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence or respond to judicial or administrative proceedings or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

7. **Public health.** We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability, reporting child, elder or dependent adult abuse or neglect, reporting domestic violence, reporting to the Food and Drug Administration problems with products and reactions to medications, and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse of harm.

8. **Health oversight activities.** We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and California law.

9. **Judicial and administrative proceedings.** We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

10. **Law enforcement.** We may, and are sometimes required by law, to disclose your health information to law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grant jury subpoena and other law enforcement purposes.

11. **Coroners.** We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

12. **Organ or tissue donation.** We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

13. **Public safety.** We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public, ex. a patient with seizure disorders should not drive.

14. **Specialized government functions.** We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

15. **Worker's compensation.** We may disclose your health information as necessary to comply with worker's compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

16. **Change of Ownership.** In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

17. **Research.** We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approval by an Institutional Review Board or a privacy board, in compliance with governing law.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. We may, however, use or disclose your health information if we have removed and information that might reveal who you are. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. **Right to Request Special Privacy Protection.** You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use of disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.

2. **Right to Request Confidential Communications.** You have the right to request that you receive you health information in a

specific way or at a specific location. For example, you may ask that we send information to the particular post office box or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. **Right to Inspect and Copy.** You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by California law. We may deny your request under limited circumstances.

4. **Right to Amend or Supplement.** You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reason you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of you to 250 words concerning any statement or item you believe to be incomplete or incorrect.

5. **Right to an Accounting of Disclosures.** You have the right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1. (Treatment), 2. (Payment), 3. (health care operations), 6. (Notification and communication with family), and 16. (specialized government functions) of Section A of this Notice of Privacy Practice or disclosures for purposes of research of public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. **Right to a paper copy of this Notice of Privacy Practice.** If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of theses rights, contact our Privacy Officer listed at the top if this Notice of Privacy Practice.

D.Change to this Notice of Privacy Practice We reserve the right to amend this Notice of Privacy Practice at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area.

E.Complaints Complaints about this Notice of Privacy Practice or how this medical practice handles your health information should be directed to your Privacy Officer listed at the top if this Notice of Privacy Practices. I you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

Department of Health and Human Services Office of Civil Rights
Hubert H. Humphrey Bldg. 200 Independence Avenue, S.W.
Room 509F HHH Building Washington, DC 20201

You will not be penalized for filing a complaint.