

Patient Name:		(Preferred	l Name)			
Address:						
Street		ity	State		Zip	
Home Phone:	Cell Phone:	ll Phone:Email:				
Date of Birth:	Social S	Social Security #:			Male or Female	
Race and Ethnicity:	Langua	Language Spoken:		Marital Status: S M W D		
In Case of Emergency Contact:						
	N	ame		Phone	2	
Primary Care Physician:		Referred By	v:			
Na	me Ci	ity/State		Name	2	
Pharmacy:						
Employer:		Full Time/Part Ti	me/Retired	Phone:		
Responsible Party/Parent or Gua	rdian Informa	tion if under 18				
Name:	I	Date of Birth:		SSN:		
Home Phone:		Cel	l Phone:			
A ddwara.						
Street		ty	State		Zip	
and disclose such information for th upon my providing a written revoca	tion of the cons	ent.		and/or Med	icare. This consent will end	
Patient Signature:				Date		
	PA	AST MEDICAL H	ISTORY			
☐ Anxiety/Depression		ry Artery Disease		☐ Lung Cancer		
☐ Arthritis	Diabete			Lymphoma		
Asthma		8		Prostate Ca	ancer	
☐ Bone Marrow Transplant		☐ High Blood Pressure		Seizures		
□ Breast Cancer	•	E		Stroke		
□ COPD		□ HIV/AIDS		Thyroid Problems: Hyper or Hypo		
☐ Colon Cancer	Leuker	nia		Other:		
	PA	ST SURGICAL H	HSTORY			
☐ Appendix Removed		Heart Transplant		□ Т	esticles Removed (R, L, Both	
□ Bladder Removed		Joint Replaceme			lysterectomy: Fibroids	
☐ Mastectomy (R, L, Both)		Kidney Remove			lysterectomy: Uterine Cancer	
□ Colon Surgery		Kidney Transpla			Consillectomy	
☐ Gall Bladder Removed		Ovaries Remove			Vone	
☐ Coronary Artery Bypass		Prostate Remove				
☐ Heart Valve Replacement		Spleen Removed			Other	

		S	KIN DISEASE HISTORY			
_ Acne			ay Fever/Allergies		Squamous Cell	Skin Cance
Basal Cell Skin Car		$\overline{}$ M	elanoma	_	None	
<ul><li>Blistering Sunburns</li></ul>		_ Pr	recancerous Moles		Other	
☐ Eczema			oriasis			
Do you have a family histor If Yes, which relatives?	y of Melanoma? N	Yes/No				
OVER 65, have you had th	e Pneumonia vac	cine? Ye	s or No			
Medications: (List all current	nt medications, inc	cluding d	osage and frequency OR give lis	st to	staff to copy)	
Medication Name			Dosage		requency	
	-			4_		
				4		
				+		
				+-		
				+-		
				T		
				_		
				-		
				+		
Allergies: (List all allergies)		-				
Aneigies. (List all alleigies)						
Family History: (Only first	degree relatives w	ith relatio	n to you)			
		SC	OCIAL HISTORY			
<ul><li>Currently smoke</li></ul>			rmer smoker	- 1	Never smoked	
Do you consume alcohol?	☐ Yes ☐ No	If Yes,	how often? — Occasionally	t	Trequently	
			IEW OF SYSTEMS			
Are you currently experienci		_				
Problems with bleeding	☐ Yes		Unintentional weight los	SS	_ Yes	
Problems with healing			Thyroid problems		_ Yes	
Problems with scarring			Joint aches		_ Yes	_ No
Rash	= Yes	□ No	Muscle weakness		= Yes	
Immunosuppression	□ Yes		Headaches		_ Yes	_ No
Hay Fever	□ Yes	_ No	Shortness of breath		∃ Yes	
Chest pain	□ Yes	_ No	Anxiety/Depression		Yes	
Fever or Chills	□ Yes	_ No	Other			
		- n.	ALERTS		_	
Allergy to adhesive			ood thinners		Pregnant	
Allergy to Lidocaine			cemaker		Trying to becom	e pregnant
Describe skin problem:						
Area of skin problem:					in the rest.	700 T NI-
How long have you had this					-	
Does anyone in your family	nave inis problem:	∟ res	No If Yes, who:			

## **Notice of Privacy Practices** Hill Dermatology, PLLC

## THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, rights to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.
Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
<ul> <li>Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.</li> <li>The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.</li> </ul>
We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.
The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:  Most uses and disclosure of psychotherapy notes;
Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;  Disclosures that constitute a sale of PHI under HIPAA; and  Other uses and disclosures not described in this notice.
You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.
You may have the following rights with respect to your PHI:
The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
☐ The right to inspect and copy your PHI.
☐ The right to amend your PHI.
☐ The right to receive an accounting of disclosures of your PHI.
☐ The right to obtain a paper copy of this notice from us upon request.
The right to be advised if your protected PHI is intentionally or unintentionally disclosed.
If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to

This notice if effective as of July 25, 2014 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Sherri Sauret at (918) 214-8888 for more information, in person or in writing.

By Oklahoma law we are required to notify you that the information for release may include records that may indicate presence of a communicable or venereal disease which may include, but is not limited to, hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as the Acquired Immune Deficiency Syndrome (AIDS).



Name:	PATIENT AGREEM	ENT	
Date of Birth:			
Physician: Tamara L. Hill, M.D./Denise Blaylock, M.	I.D./Kori Sauer,NP/Amy West	., PA	
AUTHORIZATION FOR MEDICAL TREATMENT Office Practice/Clinic personnel at Hill Dermatology, PLLC necessary or advisable. I have the right to consent or refuse	are hereby authorized to administer consent to any proposed procedure	r any medical, diagnostic, or therap or therapeutic course, absent emerg	neutic treatment as may be deemed gency or extraordinary circumstances.
DISCLOSURE OF INFORMATION I understand that my medical records and billing information PLLC may use and disclose medical information for operations are in place to discourage improper access. Hill insurance carrier, workers compensation carrier, or self-insurance carrier, workers compensation carrier, or self-insurance who is or may become involved with my care. Oklahoma/K disclosure may include information which may indicate the palcohol abuse. By signing this agreement, you are consenting who inquire about me by name.	ons, functions, and to any other phy Dermatology, PLLC and its medica red employer group liable for any p ansas law requires that Hill Dermat presence of a communicable or non-	sician or health care personnel invo- I staff are authorized to disclose all art of Hill Dermatology, PLLC's clology, PLLC advise you that the in- communicable disease, or related	olved in my continuum of care.  I or part of my medical record to any harges and to any health care provider formation authorized for use or to mental health, or drug, substance, or
ASSIGNMENT OF INSURANCE BENEFITS I agree that physician benefits otherwise payable to the insur applied to any unpaid bills for which I am liable, subject to t cash, check, or credit card at time of service.	red are to be made to the physician(she rules of coordination of benefits.	s) responsible for my care. Any pa Refusal to authorize assignment o	yment received for this period may be f benefits will require payment in full b
PRECERTIFICATION POLICY I understand that Hill Dermatology, PLLC will assist with in which it may have on insurance payment.	surance precertification requiremen	ts, but will not assume responsibili	ty for precertification or any impact
<b>FINANCIAL RESPONSIBILITY</b> As consideration for the services provided, I (the patient or r PLLC.	esponsible party) guarantee paymer	nt for any amount due for such serv	ices provided by Hill Dermatology,
<b>CERTIFICATION</b> I hereby certify that I have read each of the above statements Patient Agreement. I further certify that I am the patient or chas the same effect as an original.			
Patient or Patient's Legal Representative (Signature)	Relationship to Patient	Date Signed	Witness
Patient Name (Please print)	Account #		
RELEASE OF PROTECTED HEALTH INFORMATIO Information may be released to the following individual(s)	) N		
Name	Relationship	Phone #	
Name	Relationship	Phone #	
Please check the appropriate box: $\Box$ I authorize <b>OR</b> $\Box$ I do	NOT authorize limited confidentia	l medical messages to be left on m	y:
Home Phone # Cell	Phone #	Work Phone #	
ACKNOWLEDGEMENT OF NOTICE OF PRIVACY I A complete description of how your medical information wi you have received. A copy is posted in this office/practice.	ll be used and disclosed by Hill Der	matology, PLLC is in our NOTICI	E OF PRIVACY PRACTICES, which
I have received a copy of NOTICE OF PRIVACY PRAC	TICES.		

Relationship to Patient

Patient or Patient's Legal Representative (Signature)

Witness

Date Signed