To Our Valued Patients:

We apologize in advance for the increased paper work, specifically the “bubble sheet”; you are required to fill out.

As mandated by the Federal Government, we are in the process of converting our manual records to EMR (Electronic Medical Records). Ironically, going paperless may initially require increased paperwork for some of our patients.

Although EMR will lead to better medical care in the future, we understand that the benefit is hard to see while you are filling out all of this paper work.

Please know that we sympathize with you, and assure you that your turn to see the Provider will not be delayed because of the time you take in filling out the required information.

We thank you in advance for your cooperation and understanding. In the future you may choose to update your information via our patient portal found on our website at www.thomasderm.com

Sincerely,

Thomas Dermatology
**PATIENT HISTORY**

PATIENT NAME: __________________________________________ PATIENT #________________________

PATIENT REFERRED BY: ____________________________________________________________

**PHARMACY HEALTH INFORMATION**

PLEASE BRING A LIST OF ALL MEDICATIONS THAT YOU MAY BE TAKING AND STRENGTH OF MEDICATION

<table>
<thead>
<tr>
<th>PHARMACY NAME:</th>
<th>PHARMACY STORE PHONE NUMBER:</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th>PHARMACY CROSS STREET:</th>
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</table>

<table>
<thead>
<tr>
<th>LIST OF MEDICATIONS:</th>
<th>REASONS FOR USE:</th>
<th>VITAMINS/HERBS/SUPPLEMENTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</table>

**ALLERGIES TO THE FOLLOWING**

<table>
<thead>
<tr>
<th>MEDICATION ALLERGIES:</th>
<th>REACTION:</th>
<th>TOPICAL ANTIBIOTICS YES OR NO</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>(i.e. POLYSPORIN, NEOSPORIN)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LOCAL ANESTHETICS YES OR NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>TAPE YES OR NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LATEX YES OR NO</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do you need antibiotics before surgery or dental work? Y N</td>
</tr>
</tbody>
</table>

**Family History of:**

<table>
<thead>
<tr>
<th>Females only:</th>
<th></th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Eczema</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Asthma</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Allergies/Hayfever</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Hives</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>Skin Cancers</td>
<td>Y</td>
<td>N</td>
</tr>
<tr>
<td>If yes, what type:</td>
<td></td>
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</tr>
</tbody>
</table>

**Would you like a FREE skincare consultation with our Skin Specialist, Jaye, to learn about products we carry? (Obagi, Revision, Latisse)**

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
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<tbody>
<tr>
<td>Y</td>
<td>N</td>
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</table>

**Would you like a FREE consultation with one of our Aestheticians, Sabina or Reyлина, to learn about the Aesthetic procedures we offer? (Facials, Laser Hair Removal, Microdermabrasion, etc.)**

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<tbody>
<tr>
<td>Y</td>
<td>N</td>
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**Would you like to schedule a time to discuss Cosmetic Procedures (Laser Treatments, Botox, Dysport, Radiesse, Sculptra, etc.) with your Provider?**

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<tbody>
<tr>
<td>Y</td>
<td>N</td>
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</table>

I, the undersigned, do hereby authorize my insurance carrier(s) to pay directly to Thomas Dermatology the insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for any charges not covered by said insurance carrier(s), including copay and/or deductible amounts. I, the undersigned, do hereby also give my permission to Thomas Dermatology to furnish my insurance carrier(s) any and all information pertaining to my medical records.

**SIGNATURE OF PATIENT OR AUTHORIZED PERSON ____________________________ DATE ____________________________**
### PATIENT INFORMATION

<table>
<thead>
<tr>
<th>PATIENT NAME:</th>
<th>Date of Birth:</th>
<th>AGE:</th>
<th>SEX:</th>
<th>MARITAL STATUS:</th>
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</thead>
<tbody>
<tr>
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<td></td>
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</tr>
<tr>
<td>HOME ADDRESS:</td>
<td></td>
<td>CITY, STATE AND ZIP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOME PHONE #:</td>
<td>CELL PHONE#:</td>
<td>SS#:</td>
<td>EMPLOYER/OCCUPATION:</td>
<td></td>
</tr>
<tr>
<td>SPOUSE NAME:</td>
<td>Date of Birth:</td>
<td>AGE:</td>
<td>SEX:</td>
<td>EMPLOYER/OCCUPATION:</td>
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<tr>
<td>CELL PHONE #:</td>
<td>SS#:</td>
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</table>

### RESPONSIBLE PARTY OF INSURANCE

<table>
<thead>
<tr>
<th>PRIMARY INSURED NAME:</th>
<th>Date of Birth:</th>
<th>SS#:</th>
<th>SEX:</th>
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<tr>
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<tr>
<td>HOME ADDRESS:</td>
<td></td>
<td>CITY, STATE AND ZIP</td>
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</tr>
<tr>
<td>PRIMARY INSURANCE CO:</td>
<td></td>
<td>POLICY #</td>
<td>GROUP #</td>
</tr>
<tr>
<td>SECONDARY INSURED NAME:</td>
<td>Date of Birth:</td>
<td>SS#:</td>
<td>SEX:</td>
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<tr>
<td>HOME ADDRESS:</td>
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<td>CITY, STATE AND ZIP</td>
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<tr>
<td>SECONDARY INSURANCE CO:</td>
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<td>POLICY #</td>
<td>GROUP #</td>
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### INSURANCE INFORMATION (PLEASE BRING CARDS TO APPOINTMENT)

### PARENT INFORMATION IF PATIENT IS A MINOR

No need to fill in the address if it is the same as the patient

<table>
<thead>
<tr>
<th>MOTHER'S NAME:</th>
<th>Date of Birth:</th>
<th>SS#:</th>
<th>PHONE #:</th>
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<tbody>
<tr>
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</tr>
<tr>
<td>HOME ADDRESS:</td>
<td></td>
<td>CITY, STATE AND ZIP</td>
<td></td>
</tr>
<tr>
<td>FATHER'S NAME:</td>
<td>Date of Birth:</td>
<td>SS#:</td>
<td>PHONE #:</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOME ADDRESS:</td>
<td></td>
<td>CITY, STATE AND ZIP</td>
<td></td>
</tr>
</tbody>
</table>

### PLEASE CIRCLE ONE THAT BEST FITS:

**PATIENT RACE:** AMERICAN INDIAN, ALASKA NATIVE, ASIAN, NATIVE HAWAIIAN, OTHER PACIFIC, BLACK, AFRICAN AMERICAN, WHITE, HISPANIC, OTHER, REFUSE TO REPORT

**PATIENT ETHNICITY:** HISPANIC OR LATIN, NOT HISPANIC OR LATIN, REFUSE TO REPORT

**LANGUAGE:** ENGLISH, SPANISH, RUSSIAN, INDIAN, OTHER

**PATIENT E-MAIL:** ________________________________

**NEAREST FRIEND/RELATIVE (NOT LIVING WITH YOU) NAME:** ________________________________

**ADDRESS:** ________________________________ **PHONE NUMBER:** ________________________________

**RELATIONSHIP:** ________________________________

**SIGNATURE OF PATIENT OR AUTHORIZED PERSON** ________________________________ **DATE** ______________________
FINANCIAL POLICY

Thank you for choosing the physicians and staff at Thomas Dermatology as your healthcare providers. Our mission is to provide the highest quality dermatologic care - every patient, every appointment, every day.

Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our financial policy, which you are required to read and sign prior to treatment.

- ALL PATIENTS MUST COMPLETE OUR PATIENT INFORMATION, PATIENT HISTORY, AND HIPPA POLICY FORMS BEFORE SEEING A PROVIDER.
- CURRENT INSURANCE CARDS AND A PHOTO ID MUST BE PRESENTED AT CHECK-IN TO BE SCANNED INTO OUR SYSTEM.
- FULL PAYMENT IS DUE AT THE TIME OF SERVICE FOR CASH PATIENTS, UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
- CO-PAYS, CO-INSURANCE, AND DEDUCTIBLE PAYMENTS ARE DUE AT TIME OF CHECK-OUT FOR INSURED PATIENTS.
- WE ACCEPT CASH, CHECK, VISA, MASTERCARD, AMERICAN EXPRESS AND DISCOVER, AS WELL AS DEBIT CARDS.
- ANY BALANCE DUE FROM PRIOR VISITS MUST BE PAID PRIOR TO ANY SUBSEQUENT VISIT.
- ALL ACCOUNTS 90 DAYS PAST DUE WILL BE AUTOMATICALLY ASSIGNED TO A COLLECTION AGENCY UNLESS PRIOR ARRANGEMENTS HAVE BEEN MADE.
- IF THE ACCOUNT IS TURNED OVER TO A COLLECTION AGENCY, PATIENT AGREES TO PAY ALL EXPENSES OUR PRACTICE MAY INCUR IN COLLECTING THE DELINQUENT BALANCE. COLLECTION FEES ARE BETWEEN 40% AND 50% OF THE BALANCE OWING, AND WILL BE DUE IN ADDITION TO THE OUSTANDING BALANCE.
- IN ADDITION, ALL ACCOUNTS 90 DAYS PAST DUE WILL BE SUBJECT TO INTEREST AT THE RATE OF 2% PER MONTH.
- ANY PATIENT WHO FAILS TO SHOW UP FOR THEIR APPOINTMENT, AND DOES NOT CALL TO CANCEL AT LEAST 24 HOURS IN ADVANCE, MAY BE CHARGED $25.00.
- PLEASE KNOW THAT WAIVING DEDUCTIBLE AND CO-PAYMENT CHARGES IS ILLEGAL, AND A BREACH OF CONTRACT WITH THE INSURANCE COMPANIES.

Insurance Coverage

If your insurance company requires a referral from your primary care physician, it is your responsibility to obtain the referral/referral number from your primary care physician and bring it with you to your visit. If you do not have a referral/referral number and your insurance company requires it, we may have to reschedule your appointment.

Thank you for your understanding and cooperation. Please let us know if you have any questions or concerns.

I have read the Financial Policy described above, and understand and agree to all of its provisions.

_______________________________  ________________________
Signature of the Patient or Responsible Party  Date

_______________________________
Print Name of Patient or Responsible Party
HIPPA NOTICE of PRIVACY PRACTICES

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

INTRODUCTION
At Thomas Dermatology, we are committed to treating and using protected health information about you responsibly. This notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This notice is effective, and applies to all protected health information as defined by federal regulations.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice’s Privacy Officer, Carl Fredericksen at 702-430-5333. If you believe your privacy rights have been violated, you can file a complaint with the practice’s Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is: Office for Civil Rights, U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Room 509F, HHH Building, Washington, D.C. 20201.

Acknowledgement of Receipt of Privacy Notice
I have been presented with a copy of Thomas Dermatology’s Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:
____________________________________________________________________________
____________________________________________________________________________
____________________________________________________________________________

Please allow access to my Protected Health Information (PHI) to my:

Spouse   Child   Parent   Guardian   Other: _________________________________________________

Signed ______________________________________________________ Date ____________________________

Relationship___________________________________________________________________________________