VALLEY DERMATOLOGY, LLC

Keith Knoell, M.D.   Eli Crisler, FNP, DCNP   Emily Hivick, PA-C – Suite 1

Yara White, PA-C – Suite 7

2611 West Main Street
Waynesboro, VA 22980
Phone: 540-221-6702
Fax: 540-221-6704

PATIENT DEMOGRAPHICS

Patient Full Name: ____ DOB: _______________

Birth Gender: Male or Female Language: ________________ Race: ________________

Marital Status (of patient)**:** ______________________ Social Security Number: ________________

Home Phone: _________________ Cell Phone: ____________________ (Mark preferred with *)

(May we send text messages? Y or N)

EMAIL address: ____

Mailing Address____

____

Physical Address (if different from above) ____

____

Preferred Pharmacy: _____________________________ Location: ________________________

Primary Care Physician: ____

Referring Physician: ____

Emergency Contact: ____________________________________ Phone: ___________________

INSURANCE:

Insurance:1) _________________________________2) _________________________________

DOB of cardholder: _______________________________

Guarantor: (If patient is under 18 years old --- Person responsible for the account)

Guarantor Name: ________________________ Guarantor's date of birth: _______________

Guarantor Address (if different from above) ____

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NOTICE OF PRIVACY PRACTICES

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. This notice is a summary only. You may request a detailed account of our privacy policy from our front desk personnel.

- **HOW WE MAY USE AND DISCLOSE YOUR HEATLH INFORMATION**. We use health information about you for treatment, payment and for administrative purposes, and to evaluate the quality of care that you receive. Our office policy engages rules to detect, prevent and mitigate identity theft in connection with new and existing accounts. Beyond these situations, we will ask for your written authorization before using or disclosing your health information. If you sign an authorization to disclose information, you can later revoke it to stop any future uses or disclosures.
- **YOUR RIGHTS.** You have the right to look at or get a copy of your health information that we use to make decisions about you. We ask for a preliminary request and legally we have 10 business days in which to respond. If you request copies, we may charge you a cost-based fee. You also have the right to request a list of certain types of disclosures of your information that we have made. If you believe your health information is incorrect, or information is missing, you have the right to request that we correct the existing information or add the missing information. The medical record of your care legally belongs to the Practice.
- **OUR LEGAL DUTY**. We are required by law to protect the privacy of your health information, provide this notice about our privacy practices, follow the privacy practices that are described in this notice, and seek your acknowledgment of receipt of this notice. We may change our privacy policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time. For more information about our privacy policies, contact the person listed below.
- **PRIVACY COMPLAINTS**. If you are concerned that we have violated your privacy rights, our privacy policies, or you disagree with a decision we made about access to your health information, you may contact the person listed below. You also may send a written complaint to:

U.S. Department of Health and Human Services
200 Independence Ave, S.W.
Washington, D.C. 20201

If you have any questions or complaints, please contact
Jennifer Brooks, Practice Administrator,
Valley Dermatology, 2611 West Main Street, Ste 1
Waynesboro, VA 22980. (540) 221-6702.

I have received this summary notice of the Privacy Practices of Valley Dermatology.

____ ____________________________

Signature of patient (Parent/Legal Guardian of minor) Date

VALLEY DERMATOLOGY, LLC

Disclosures to Family Members and Friends

Patient Name: ____

I hereby give my permission to disclose personal information about my treatment to the following individuals:

Name: ____________________________________ Relationship: __________________________

Name: ____________________________________ Relationship: __________________________

May we leave a personal medical information on your answering machine at home: YES NO

How did you hear about us? (Circle one) Doctor Referral Website Friend or Family Member

Other: ____

SUMMARY OF FINANCIAL RESPONSIBILITY

- I authorize Valley Dermatology, LLC to file my insurance carrier(s), but I understand any charges not paid by my insurance carrier(s) remain my responsibility.
- I authorize the release of medical information for the purpose of treatment, payment, organizational purposes or as required by the law.
- I authorize payment for my insurance company to be made directly to Valley Dermatology, LLC.
- I understand that I am responsible for obtaining proper (pre)authorization from my insurance company if necessary. I accept responsibility for payment if authorization is not obtained.
- You authorize us, our successors or assigns, to email, call you or send text messages to you at any number of electronic address you provide or at any number at which we reasonably believe we can contact you, including calls to mobile, cellular, or similar devices, and including calls using automatic telephone dialing systems and/or prerecorded messages, for any lawful purpose, including but not limited to: (1) suspected fraud or identity theft; (2) obtaining information necessary or desirable; (3) your account transactions or servicing; and (4) collecting on your account. Numbers you provide include numbers you give us and/or numbers from which you call us, our successors or assigns. You agree to pay any fee or charges(s) that you may incur for incoming calls from us, and/or outgoing calls to us, to or from any such number, without reimbursement from us.
- I understand that any bill not paid will be turned over to a collection agency, unless other arrangements have been made. If my account becomes assigned to a collection agency, I further understand that I am responsible for paying a collection agency fee equal to 25% of the principal balance, together with all costs, expenses and 18% interest per annum; and reasonable attorney's fees, necessary for the collection of my account. Finally, I understand that my delinquent account may be reported to one or more of the national credit bureaus.

______________________________________ ______________________

Patient/Guardian Signature Date

Blank

HISTORY AND INTAKE FORM:

Last Flu Vaccine: ____________________________________

Last Pneumonia Vaccine: _____________________________

Past Medical History: (Please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH (Prostate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Other______________________________________

Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
None

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection, Diverticulitis
Spleen Removed
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Hysterectomy: Fibroids, PTCA, Uterine Cancer
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement (Knee, Hip) (Right, Left, Bilateral)
Kidney Biopsy
Kidney Removed (Right, Left)

Kidney Stone Removal
Kidney Transplant
Kidney Transplant
Ovaries Removed - Endometriosis,
Cyst, Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate biopsy
TURP
Testicles Removed (Right, Left, Bi)

NONE
Other__________________________

SKIN DISEASE HISTORY: (please circle all that apply)

Acne	Hayfever
Actinic Keratoses	Melanoma
Basal Cell Skin Cancer	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Psoriasis
Eczema	Squamous Cell Skin Cancer
Flaking or Itchy Scalp	None

Other____

Do you wear sunscreen?YES NO
If yes, what SPF? ____________________
Do you tan in a tanning salon: YES NO

Do you have a family history of Melanoma: YES NO
If yes, which relative? ____

SOCIAL HISTORY: (Please circle all that apply)

Cigarette Smoking:
- Never smoked
- Quit: Former smoker
- Smokes less than daily
- Smokes daily

Illicit Drug Use:
- None
- Drug Use
- IV Drug use

Alcohol Use:
- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Safety:
- I feel safe at home.
- I do not feel safe at home.

Medication List

1. Prescription Drugs
2. Over the Counter Products (Pain relievers, antihistamines, lotions, laxatives, etc)
3. Supplements (Herbal, Vitamin or Mineral and Dietary)

Medication Name	Dosage	How Often

Drug Allergies:

Drug: ________________________________ Reaction: __________________________________

Drug: ________________________________ Reaction: __________________________________

Drug: ________________________________ Reaction: __________________________________

NKDA: No Known Drug Allergies