GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

REFERRED BY: ☐ Insurance ☐ Our Website ☐ Newspaper ☐ TV/Radio ☐ Other: _____

☐ Referring Doctor: _____Phone: ( )_____

Name:_____ Email: _____
Last First MI

Date of Birth: _____/_____/_____ SSN: _____ Sex: ☐ Male ☐ Female

Address: _____
Street City State Zip

Home Phone: ( )_____ Cell Phone: ( )_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

PARENT, SPOUSE, OR RESPONSIBLE PARTY *If different from patient*

Name: _____ Phone: ( )_____
Last First MI

Date of Birth: _____/_____/_____ SSN: _____ Sex: ☐ Male ☐ Female

Address: _____
Street City State Zip

INSURANCE COVERAGE

1) **PRIMARY**: _____

2) **SECONDARY**: _____

PREFERRED PHARMACY: _____
Name Street City

Phone: ( )_____ Fax: ( )_____

– ATTACH A COPY OF PATIENT'S ID & INSURANCE CARDS (BOTH SIDES) –

GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

HEALTH HISTORY

Name: _____ Date of Birth: _____/_____/_____

Have you ever had any of the following?

☐ Skin Cancer _____

_____

_____

Cancer Type *Location* *Date of Treatment*

☐ Blood Transfusions _____
list dates

☐ Surgery _____
list with dates

_____

☐ Asthma	☐ High Blood Pressure	☐ Heart Disease
☐ Eczema	☐ Diabetes	☐ Kidney/ Liver Disease
☐ Psoriasis	☐ PCOS	☐ Hepatitis B or C
☐ Vitiligo	☐ Thyroid Disease	☐ Tuberculosis

Other medical problems: _____

_____

FAMILY HISTORY: Have any of your relatives ever had any of the following?

☐ Psoriasis	☐ Vitiligo
☐ Skin Cancer (Basal Cell, Squamous Cell)	☐ Eczema/Rashes
☐ Melanoma	☐ Asthma/ Hay fever

ALLERGIES: to Medications, Foods, Environmental (pollen, dust, animals, etc.) *List with symptoms caused*

_____

_____

MEDICATIONS & VITAMINS: _____

_____

_____

FEMALES (Check all that apply)

☐ Are you pregnant?

☐ Are you breastfeeding?

☐ Last Menstrual Period: ____/____/____

☐ Are you on **Birth Control/Hormones**?
Eg: oral contraceptive pill, IUD, Nuvaring etc

List name: _____

GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU (AS A PATIENT OF THIS PRACTICE) MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION.

PLEASE REVIEW THIS NOTICE CAREFULLY.

A. OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your individually identifiable health information (IIHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We also are required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning IIHI. By federal and state law, we must follow the terms of the notice of privacy practices that we have in effect at the time.

We realize that those laws are complicated, but we must provide you with the following important information:

- How we may use and disclose you IIHI
- Your privacy rights in your IIHI
- Our obligations concerning the use and disclosure of your IIHI

The terms of this notice apply to all records containing your IIHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. Any revision or amendment to this notice will be effective for all of your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice in our offices in a visible location at all time, and you may request a copy of our most current Notice at any time.

B. IF YOU HAVE QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:

Privacy Officer at 44215 15th Street West Suite 309, Lancaster, CA 93534 (661) 949-0004

C. WE MAY USE AND DISCLOSE YOUR INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (IIHI) IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your IIHI.

1. **Treatment**. Our practice may use your IIHI to treat you. For example, we may ask you to have laboratory tests (such as blood or urine tests), and we may use the results to help us reach a diagnosis. We might use your IIHI in order to write a prescription for you, or we might disclose your IIHI to a pharmacy when we order a prescription for you. Many, of the people who work for our practice-including, but not limited to, our doctors and nurses-may use or disclose your IIHI in order to treat you or to assist others in your treatment. Additionally, we may disclose your IIHI to others who may assist in your care, such as your spouse, children or parents.
2. **Payment**. Our practice may use and disclose your IIHI in order to bill and collect payment for the services and items you may receive from us. For example, we may contact your health insurer to certify that you are eligible for benefits (and for what range of benefits), and we may provide your insurer with details regarding your treatment to determine if your insurer will cover or pay for your treatment We also may use and disclose your IIHI to obtain payment from third parties that may be responsible for such costs, such as family members. Also, we may use your IIHI to bill you directly, for services and items.
3. **Health Care Operations**. Our practice may use and disclose your IIHI to operate our business.

OPTIONAL

4. **Appointment Reminders/Treatment options**. Our practice may use and disclose your IIHI to contact you and remind you of an appointment, and to inform you of potential treatment options or alternatives.
   Health-Related Benefits and Services. Our practice may use and disclose you IIHI to inform you of health-related benefits or services that may be of interest to you.
   Release of information to Family/Friends. Our practice may release your IIHI to a friend or family member that is involved in your care, or who assists in taking care of you. For example, a parent or guardian may ask that a babysitter take their child to the pediatrician's office for treatment of a cold. In this example, the babysitter may have access to this child's medical information.
5. **Disclosures Required by Law.** Our practice will use and disclose your IIHI when we are required to do so by federal, state or local law.

D. USE AND DISCLOSURE OF YOU IIHI **IN CERTAIN SPECIAL CIRCUMSTANCES**

The following categories describe unique scenarios in which we may use or disclose your identifiable health information:

1. **Public Health Risks.** Our practice may disclose your 11141 to public health authorities that are authorized by law to collect information for the purpose of:
   - Maintaining vital records such as births and death
   - Reporting child abuse or neglect
   - Preventing or controlling disease, injury or disability
   - Notifying a person regarding potential risk for spreading or controlling a disease or condition
   - Notifying a person regarding a potential risk for spreading or contracting a disease or condition
   - Reporting reactions to drugs or problems with products or devices
   - Notifying individuals if a product or device they may be using has been recalled
   - Notifying appropriate government agency(ies) and authority(ies) regarding the potential abuse or neglect of an adult patient (including domestic violence); however, we will only disclose this information it the patient agrees or we are required or authorized by law to disclose this information
   - Notifying your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance
2. **Health Oversight Activities.** Our practice may disclose your IIHI to a health oversight agency for activities authorized by law. Oversight activities can Include, for example, investigations, inspections, audits, surveys, licensure and disciplinary actions; civil, administrative, and criminal procedures or actions; or other activities necessary for the government to monitor government programs, compliance with civil rights laws and the health care system in general.
3. **Lawsuits and Similar Proceedings**. Our practice may use and disclose your IIHI in response to a court or administrative order, if you are involved in a lawsuit or similar proceeding. We also may disclose your IIHI in response to a discovery request, subpoena, or other lawful process by another party involved in the dispute, but only if we have made an effort to inform you of the request or to obtain an order protecting the information the party has requested.

GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.
I may keep a copy of the Notice of Privacy Practices (pg. 1-2), and may also contact GunterMD Dermatology for a copy.

Name: _____ Date of Birth: _____/_____/_____

_____ Date: _____/_____/_____
Signature of Patient/Legal Representative

_____
Relationship to Patient

GunterMD Dermatology cannot promise that the person(s)/entity you permit to share your health information with will not share your health information with someone else you may not want to have your health information.

This authorization will expire 2 years from the date listed above and may updated as needed.

☐ YES ☐ NO *Is patient currently enrolled in Hospice?*

☐ YES ☐ NO *Do you have a Power of Attorney to assist in your medical care decisions?*

If yes, Name of P.O.A. _____ Relationship: _____

Phone: (_____) _____

EMERGENCY CONTACT: I give permission to GunterMD Dermatology to use the names listed below as my emergency contact(s) and/or to share my health information with via telephone or in person:

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

Name: _____ Relationship: _____ Phone: (_____) _____

I give permission to GunterMD Dermatology to share my health information with my primary care physician/provider. If agreed, please complete the following:

PRIMARY CARE PHYSICIAN: _____ Phone: ( )_____

Address: _____
Street *City* *State* *Zip*

GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

CONSENT TO PHOTOGRAPH

I understand that photographs, videotapes, digital or other images may be recorded to document my care, and by signing this form, I am consenting to this. I understand that Dr. Jeffrey Gunter and/or Stephanie Bui, MSPAS, PA-C will retain the ownership rights to these photographs, videotapes, digital or other images. I understand that these images will be stored in a secure manner that will protect my privacy. I understand that these images may be kept for whatever duration the above providers deem necessary for treatment. Images that identify me will be released only upon written authorization from me or my legal representatives.

This consent does not authorize the use of images for other purposes, such as teaching or publicity. A separate consent form will be used for such purposes.

_____ Date: _____/_____/_____

Signature of Patient/Legal Representative

_____

Relationship to Patient

_____

Witness

GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

TELEMEDICINE SERVICES

Name:_____ **Date of Birth**: _____/_____/_____
Last First MI

Location of Patient: _____, Texas

Physician Name: Dr. Jeffrey Ross Gunter, MD, FAAD **Location**: California

Consultant Name: Stephanie Bui, MSPAS, PA-C **Location**: Texas

Consultant Name: _____ **Location**: _____

Date of Content Discussed: _____/_____/_____

Introduction

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy follow-up and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output data from medical devices and sound and video files

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her specialist's office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. Poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors;

Please initial after reading this page: _____

GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternate methods of medical care may be available to me, and that I may choose one or more of these at any time. My dermatologist has explained the alternatives to my satisfaction.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my dermatologist of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.

INFORMED CONSENT FOR TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be delegated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I may keep a copy of the Telemedicine Services, and may also contact GunterMD Dermatology for a copy.

I hereby authorize Stephanie Bui, MSPAS, PA-C to use telemedicine in the course of my diagnosis and treatment.

_____ Date: _____/_____/_____

Signature of Patient/Legal Representative

_____

Relationship to Patient

_____

Witness

GunterMD Dermatology

GEORGETOWN | TEMPLE | WACO | GATESVILLE

MEDICARE INFORMATION

Name: _____ Date of Birth: _____/_____/_____
Print your name as it appears on your Medicare Card

MEDICARE AUTHORIZATION: I authorize any holder of medical or other information about me to release the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ Date: _____/_____/_____
Signature of Patient/Legal Representative

_____
Relationship to Patient

PAYMENT POLICY

- **Medicare**: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients who are responsible for meeting their annual $100.00 deductible and paying for the 20% copayment. We do file secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance.
- Note**:** If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Please read each of the following and answer as they apply to you.

Yes	No	
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare secondary?
☐	☐	Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?
☐	☐	Do you or your spouse work and have coverage through the insurance at your job?
☐	☐	Are you eligible for any benefits under the Federal Black Lung Program?
☐	☐	Are you coming to this office for an illness, accident or injury that is the result of an automobile accident?
☐	☐	Are you coming to this office due to Medicare disability coverage?
☐	☐	Are you covered by the Federal End Stage Renal Disease Program?
☐	☐	Are you presently receiving Workers' Compensation?
☐	☐	Is the illness or injury you are coming to this office for the result of work-related causes?
☐	☐	Do you have medical assistance through Welfare or state-aid?

If you answered YES to ANY of the above questions: _____
Explain

MEDIGAP SUPPLEMENTAL INSURANCE

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ Date: _____/_____/_____
Signature of Patient/Legal Representative

– ATTACH A COPY OF PATIENT'S ID, MEDICARE, MEDIGAP/SUPPLEMENTAL CARDS (BOTH SIDES) –