VIBRANT
DERMATOLOGY

skinbar MD
BY VIBRANT DERMATOLOGY

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT
Authorization to use and disclose patient information

As a patient of Vibrant Dermatology you have the right to know how we may use and disclose information about you. Information about our disclosure is provided in our Notice of Privacy Practices. A copy of this notice is available upon request. You have the right to review our notice before signing this form. As our notice of privacy practices explains, we need your authorization to use or disclose information about you for any purpose other than treatment, payment or normal healthcare operations.

By signing this, you understand that this your information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change it Notice of Privacy practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Private Practices. I understand that I may request in writing that you restrict how my private information is used or Disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

588 Providence Hwy
Dedham, MA 02021

(p) 781-708-9299
(f) 855-699-6813

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Combined Service Notification

Patient Name: _____ Date of Service: _____

I understands that I scheduled to be seen today for a:

- Medical Appointment that will be billed to insurance if provided
- Cosmetic Appointment that will not be billed to insurance

However, during my visit I have requested that an additional concern be addressed which is unrelated to my scheduled appointment. My additional concern is for the following reason:

- Medical Appointment that will be billed to insurance if provided
- Cosmetic Appointment that will not be billed to insurance

Please initial each item below.

___ I have been informed by Vibrant Dermatology that if I am seen for any medical reason including but not limited to medical consultation, my insurance will be billed for the visit. I will be expected to pay my office co pay, if any, as per my agreement with my insurance provider, as well as any outstanding balances on my account as per my agreement with Vibrant Dermatology.

___ I understand that if it is a cosmetic reason for which I am being seen, I am responsible for paying for that service at the time of my visit. I also understand that these charges are only my responsibility and will not be billed to insurance.

My initials above and my signature below acknowledge that I have read and understand the above office policies.

Patient Signature: _____ Date: _____
Staff Witness: _____ Date: _____

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Credit Card on File

To streamline our billing and payment system and to provide a seamless, convenient way for patients to pay their bills, Vibrant Dermatology uses a credit card on file system.

Circumstances when your card would be charged include but are not limited to:

- missed or canceled sessions with less than 24-hour notice
- missed co-payments
- deductible and co-insurance
- any non-covered services and/or denial of services.

Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing the amount of your total patient responsibility. You will typically receive the EOB before we do, so if you disagree with the patient responsibility balance owed, it is your responsibility to contact your insurance carrier immediately.

When we receive the EOB, we will enter all pertinent payment information into our system. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be sent to you.

If the credit card we have on file for you changes, please notify us immediately by phone or email. It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. That is quite understandable. If we run your credit card and it is denied for any reason, we will call you for updated information. This new credit card number will become your new card on-file, subject to the same financial policy as the card you gave us in-person when you were in our office. We reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days.

If there is a problem with your bill/claim and it is brought to our attention after your credit card payment processes, we will investigate it and if we owe you the money, we will refund it to the same card in a timely manner.

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CONSENT AND AUTHORIZATION FOR USE AND DISCLOSURE OF MEDIA

I understand that under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), I have certain rights regarding the use and disclosure of my Protected Health Information. I have *received, reviewed and understand* the Notice of Privacy Practices provided by Joyce Imahiyerobo-Ip, M.D. acknowledge that this Consent and Authorization for Use and Disclosure of Media is, and is being provided, consistent with such Notice of Privacy Practices.

I hereby authorize **Dr. Joyce Imahiyerobo-Ip**, and or her associates or licensees to use pre-procedural, procedural, and post-procedural photographs, slides, and/or videotapes for professional medical or promotional purposes as deemed appropriate by them including but not limited to display of these images on public or commercial television, electronic digital networks, scientific medical publications, lay publications, social media, or during lectures to medical or lay groups for the purposes of informing the medical community or the general public about aesthetic or medical treatment procedures. Neither I nor any member of my family will be identified by name at any time. Unless it is necessary to include it, my face will not appear in the images. I understand that in some instances the images may portray features which could make my identity recognizable.

I understand that I will not be entitled to monetary payment or any other consideration as a result of any use of these images and I hereby grant this consent as a voluntary contribution in the interest of medical education. I hereby waive all claims for compensation or damage for such use and disclosure that are consistent with this authorization. I understand that I am under no obligation to provide my authorization and that my treatment, payment, enrollment or eligibility for benefits will not be impacted in any way by my refusal to provide such authorization. I understand that information disclosed pursuant to this authorization may be subject to redisclosure by a recipient and would no longer be subject to this authorization. I may revoke this authorization at any time and for any or no reason by writing to Dr. Joyce Imahiyerobo-Ip.

_____ _____
Print Name Date of Birth

_____ _____
Signature Date

_____ _____
Witness Date

I am the parent or guardian of the patient. I am authorized by law to provide, and my signature below constitutes my consent to and authorization for use of such minor child's media as described above.

_____ _____
Parent/Guardian Signature *(if patient is a minor)* Date

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Medical History Intake Form

Name: _____ Age:____ DOB: ___/___/_____ Date: _____
Reason for Today's visit:
1._____ 2. _____
3._____ 4. _____

Past Medical History (Check each box that applies)

Condition	Personal	Family
Acne		
Anxiety		
Arthritis		
Artificial joints		
Asthma		
Atopic dermatitis		
Autoimmune disease (explain)		
Bleeding disorder		
Clotting disorder		
Cancer (explain)		
Crohn's/Colitis		
Celiac Disease		
Diabetes		
Hay fever/Allergies		
High blood pressure		
High cholesterol		
HIV/AIDS		
Keloids		
Liver disease		
Lung disease		
Multiple sclerosis		
Psoriasis		
Radiation treatment		
Rosacea		
Thyroid disorder		
Transplant		
Other surgeries		

Name: _____ Age:____ DOB: ___/___/_____ Date: _____

Dermatology/Skin Cancer History

	Circle:
-Have you seen a dermatologist before?	Yes/No
-Have you had an atypical mole removed before?	Yes/No
-Have you ever had a skin cancer?	Yes/No

If yes, please explain type (basal cell, squamous cell, melanoma, etc.), location, date of diagnosis and treatment:

_____

-Do you have a first degree relative with melanoma?	Yes/No
-Have you had actinic keratoses/pre-cancer?	Yes/No
-Do you have a history of blistering sunburns?	Yes/No
-Do you have a history of tanning bed use?	Yes/No
-Do you use sunscreen? If yes, what SPF? _____	Yes/No

Other Medical History

Have you had any joints replaced in the past 2 years?	Yes/No
Do you have a pacemaker/defibrillator?	Yes/No
Did you have heart surgery as an infant/child?	Yes/No
Do you have an artificial heart valve?	Yes/No
Have you ever had an infected heart valve?	Yes/No
Do you get cold sores?	Yes/No

Allergies

Latex	Yes/No
Neomycin/Neosporin	Yes/No
Adhesive	Yes/No
Nickel	Yes/No
Lidocaine	Yes/No
Medication: _____	Yes/No
(Type of reaction:_____	
Other: _____	Yes/No

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Name: _____ Age:____ DOB: ___/___/_____ Date: _____

Medications

Please list all medications, including supplements, IUD, patches, etc.

1. 2.
3. 4.
5. 6.
7. 8.

Social History

Occupation: _____
Hobbies: _____
Recreational drug use: Yes/No
If yes, please explain: _____
Do you consume alcohol? Yes/No
If yes, drinks per week: _____
Do you use tobacco products? Yes/No
Please explain type and frequency: _____

Family Planning (females only):

Are you pregnant? Yes/No
Are you planning to become pregnant? Yes/No
Are you nursing? Yes/No
Are you using contraception? Yes/No
If yes, what type:_____
Do you have regular periods? Yes/No
If no, please explain: _____

Other important medical information:

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New Patient Registration Form

Name:_____ Today's Date _____

Social Security Number: _____-_____-_____Date of Birth: _____/_____/_____

Sex: _____

Marital Status_____Married _____Single _____Separated _____Divorced _____Partnered

Address: _____

_____Apt/Floor_____

City_____State_____Zip_____

Preferred Phone: (_____) _____-_____Home/Office/Cell (Circle)

Are we authorized to leave a message at the phone number above? Yes /No (Circle)

Other phone: (_____)_____-_____Home/Office/Cell (circle) Authorized to leave text or voice message? Yes/No (circle)

Email address_____ Authorized to leave message? Yes/No (circle)

Occupation_____

Primary Care Physician: _____Phone Number (_____) _____

Doctor's Hospital Affiliation: _____

Referring physician: _____Send consult note? Yes/No (circle)

Were you a patient of Dr. Imahiyerobo-Ip's at a previous practice? Yes/No (circle)

Are other family members patients of Dr. Imahiyerobo-Ip's? If yes, please list: _____

If you were not referred by a doctor, please tell us how you heard about our practice_____

Emergency Contact Name: _____ Relationship: _____

Phone number: (____) _____-_____

Preferred Pharmacy Information:

Local Pharmacy: _____Pharmacy address _____

_____Pharmacy phone number (___) _____-_____

Mail order Pharmacy if used_____

Primary Insurance Information

Plan Name: _____ I.D.#: _____

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Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-_____-_____

Secondary Insurance Information

Plan Name: _____ I.D.#: _____

Address: _____ Group Number: _____

Policy Holder: _____ Effective Date: _____

Policy Holder's Social Security Number: _____-_____-_____

Person responsible for bill (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____-____-_____

Relationship to Patient: (please check): ( ) Spouse ( ) Parent ( ) Other _____

Date of Birth: ___-___-_____

Address: _____Phone Number: _____

Employer Name: _____ Employer Phone Number: (____) _____-_____

Employer Address:

_____

_____

I give permission for the following persons to have access to:

___ ALL information in my Medical Records (PHI) and receive results and messages regarding my care

___ Specific protected health information listed here: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Skin Bar MD and Vibrant Dermatology. I acknowledge that I am financially responsible for payment whether or not covered by insurance.

Signature: _____ Date: _____

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Your Information. Your Rights. Our Responsibilities.

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.**

Your Rights **You have the right to:**

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care

Our Uses and Disclosures We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, or other government requests
- Respond to lawsuits and legal actions

Your Rights When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information on page 1.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

Your Choices For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory

If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

Our Uses and Disclosures We typically use or share your health information as follows:

Treat you

We can use your health information and share it with other professionals who are treating you.

Example: A doctor treating you for an injury asks another doctor about your overall health condition.

Run our organization

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Example: We use health information about you to manage your treatment and services.

Bill for your services

We can use and share your health information to bill and get payment from health plans or other entities.

Example: We give information about you to your health insurance plan so it will pay for your services.

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html**.**

Help with public health and safety issues

We can share health information about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety

Do research

We can use or share your information for health research.

Comply with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

Respond to organ and tissue donation requests

We can share health information about you with organ procurement organizations.

Work with a medical examiner or funeral director

We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests

We can use or share health information about you:

- For workers' compensation claims
- For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions

We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time with written notice.

For more information see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html**.**

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

Date of Notice – March 1, 2019

For More Information Contact Our Office at 781 708-9299

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PARENTAL PREAUTHORIZATION FOR MEDICAL CARE TO MINORS

If the circumstance arises that a parent or guardian cannot physically be present for the evaluation and/or treatment of a minor, it is necessary to have a prior authorization for medical care delivered to minors without a parent/guardian present. Please review the following authorization for treatment and complete the information if you wish to authorize such treatment.

I request and authorize Skin Bar MD and Vibrant Dermatology and its personnel to deliver medical care to my child listed below:

_____ _____
Name Date of Birth

_____ _____
Signature of Parent/Legal Guardian Date

_____
Print Name and Relationship

If necessary, please contact the following regarding the health of my child:

Name of Parent/Legal Guardian Phone

_____ _____
_____ _____
_____ _____

Please note any special family relationships below:

588 Providence Hwy
Dedham, MA 02021

(p) 781-708-9299
(f) 855-699-6813

Patient Rights

At Vibrant Dermatology we are committed to maintaining the rights, dignity and well-being of our patients. We do not discriminate against any individual regardless of race, color, religious creed, gender, gender identity or expression, genetic information, sexual orientation, age, disability, veteran or active military status, marital status, national origin/ethnicity, citizenship, alienage.

Each patient has the right:

- To be treated in a caring, safe and compassionate way.
- To receive timely, complete and accurate information.
- To know the name and specialty of those providing care.
- To say yes or no to treatment as allowed by law.
- To ask questions about what is happening and why.
- To have things explained in their preferred language.
- To make an advance directive, such as a health care proxy, for those 18 years of age or older.
- To have privacy (within the capacity of the facility) when being examined or when talking to a health care provider.
- To choose who may be present to provide emotional support.
- To review and request medical records, as allowed by law.
- To get timely responses to questions or concerns.
- To know how health information is used and shared. Ask for the Vibrant Dermatology Privacy Notice if you want this in writing.

Each patient has the responsibility:

- To work together with health care providers on the plan of care.
- To let your health care provider know if you want family or others involved in care and decision making.
- To share information about health history, any changes in health, and current symptoms.
- To share information about current and past medications, including vitamins, herbs and/or alternative medicines or treatments.
- To talk about any allergies or reactions to medications.
- To talk about reactions to anesthesia, if surgery is needed.
- To tell health care providers if you don’t understand or think you will not be able to do what is being asked.
- To speak and act in a respectful manner.
- To maintain confidentiality of staff and other patients by not taking cell phone pictures or audio/video recordings.

- To remain on assigned unit, except for tests or procedures, in order to receive the best possible care.

If you have any questions about any of this information or would like a copy of the law called the Massachusetts Patient Bill of Rights, please let us know.

Payment Policies

Thank you for choosing Vibrant Dermatology. We are committed to providing you with exceptional care. As well, we are committed to making our financial policies as simple and efficient as possible. Below you will find the policies that relate to how we bill and how we collect for services provided at Vibrant Dermatology.

If you have an insurance plan that we accept:

- We will bill your insurance for the visit
- Your co-pay will be collected on the day of your visit
- If your insurance requires a referral, it is your responsibility to obtain that referral from your PCP. If a valid referral is not on file, you will be asked to sign a referral waiver. If the referral is not sent to us, you will be responsible for the cost of services rendered.
- Many insurance policies have an annual deductible, the amount you are required to pay out of pocket for medical expenses before your insurance company begins to pay.
- Deductibles will be charged to your credit card on file, once the insurance company has confirmed the patient pay portion of your bill

If you have an insurance plan that we do not accept:

- Payment is due at the time of visit; we accept cash, checks, and credit cards
- We are happy to provide you with a visit summary, which includes your diagnosis and visit codes. The summary may be submitted to your insurance company or Health Savings Account for reimbursement directly to you. In most cases, the insurance companies will pay a portion of your total bill
- Some of the services you receive here may not be covered by your insurance. If you and your provider agree that non-covered services are needed to provide you with the highest level of care or if you request a non-covered service, you will be asked to sign a statement indicating that you accept responsibility for payment in full. Aesthetic services are always payable at the time of service.

If you have no insurance or if you choose not to use your insurance for this visit:

- Payment is due at the time of visit; we accept cash, checks, and credit cards
- We offer same day, prompt payment discounts. Note that once a visit fee is discounted, you will not be eligible for reimbursement by your insurance company

Policy for booking medical appointments

At Vibrant Dermatology, we are trying to change the way patient visits take place. We won't rush through your appointment and will always focus on quality not quantity of visits. We don't overbook and the time we schedule for you is yours alone. At the time of scheduling, we do

require a valid credit card number to reserve your appointment time. If you need to cancel, kindly provide at least 24 hours notice. Any cancellations with less than 24 hours notice, will result in a charge of $35.

I have reviewed the Vibrant Dermatology Payment Policies and Understand my Financial Responsibilities.

_____
Print name

_____
Signature

_____
Date

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AUTHORIZATION FOR USE AND DISCOSURE OF PRIVATE HEALTH INFORMATION

Patient's Name:_____ Date of Birth: _____
Previous Name:_____ Social Security #:_____

I request and authorize to _____ to release healthcare information of the patient named above to:

Dr. Joyce Imahiyerobo-Ip
Skin Bar MD and Vibrant Dermatology
588 Providence Highway, Dedham MA 02026

Description of Private Health Information to be released

I authorize the above provider to release protected health information to Skin Bar MD and Vibrant Dermatology for the purpose of medical treatment. This may include information pertaining to mental health, alcohol or drug use, and HIV status. This authorization will expire in one year and may be rescinded at any time.

Specific information to be disclosed:

-Problem list or patient summary page
-Pathology reports
-Record of immunizations
-Medication list
-Health maintenance page or records of health maintenance testing
-Office notes from the past 2 years
-Diagnostic studies (lab, radiology, etc.) from the past 2 years
-Other _____

A copy of this authorization is available to me, or to my authorized representative, upon request and will serve as the original. I understand that if this information is to be received by individuals or organizations that are not health care providers, healthcare clearinghouses, or health plans covered by federal privacy regulations, my information described above may be re-disclosed by the recipient and no longer protected by federal privacy regulations. This authorization is subject to revocation at any time upon written notice to the person/company specified above except to the extent that the person/company has already taken action on the disclose provisions contained in this document.

_____ Date:_____
(Signature of Patient)

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Policy for booking medical appointments

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