RENEW
DERMATOLOGY & LASER CENTER

Dr. Elizabeth Stratte
Board Certified Dermatologist

Welcome to our practice! We would like to thank you for choosing our office and putting your trust in us.

Dr. Elizabeth Stratte is a Board Certified Dermatologist, practicing pediatric and cosmetic dermatology. Dr. Stratte limits her pediatric dermatology practice patients up to the age of 18, as well as acne and rosacea in adults. We also offer laser and cosmetic services through our Renew Dermatology & Laser Center.

The following is to acquaint you with our policies regarding your visit so that we can provide you with the best medical care.

Our medical office hours are limited, so we ask you to keep your scheduled appointment. We also ask that you call at least 24 hours prior to your scheduled appointment if you need to reschedule or cancel. A fee of $25.00 will be assessed at your next visit if you fail to comply. **All children under the age of 18 must be accompanied by a parent at their initial examination, no exceptions unless prior approval by Dr. Stratte has been arranged.**

Please complete the attached medical history and patient billing forms and bring them with you to your appointment. It is very important to list all medications, cleansers, creams, lotions, ointments, moisturizers, and cosmetics you have apply to your skin and **bring them to your appointment with Dr. Stratte.** If your appointment is to evaluate acne, you will be asked to remove your makeup so Dr. Stratte can evaluate the skin on your first visit.

Our office is contracted with Blue Cross and Blue Shield only. Your obligations will differ depending on what services you require. Should you have any questions regarding your coverage, we urge you to contact your insurance carrier. **All copays are due at the time of service.** All other insurance plans, as a courtesy, will be billed for your reimbursement.

If you have any questions, please ask our friendly and knowledgeable staff or visit our website at www.strattedermatology.com.

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Welcome to Renew Dermatology & Laser Center

Thank you for choosing our office. In order to serve you properly, we will need the following information. All information will be kept strictly confidential. (PLEASE PRINT)

Date_____ PatientDOB_____ Patient Name:_____
Patient Social Security #_____-_____-_____ Sex ____Male____Female
Home Phone:_____ Cell Phone:_____ Marital Status_____
Address_____ City_____ State____ Zip_____
Employer/Occupation_____ Work Address_____ Work Phone_____

If Patient is a child, please fill in parent information:
Father's name_____Address_____DOB_____
Mother's name_____Address_____DOB_____
Guardian name_____Address_____DOB_____

Do you have medical insurance? ___Yes ___No If no, how do you intend to pay? ___Check___CC___Cash
Visa/MC/Discover card #_____
Insurance Company name & address_____
Subscriber name_____Policy #_____Group#_____
Is this through your employer? ____ Yes_____No

(If patient is and adult)Name of spouse_____Spouse DOB_____
Spouse's employer name & address_____Phone_____
Is there a secondary insurance___Yes___No Secondary Insurance name_____
Policy #_____Group #_____Subscriber name_____

Person financially responsible for this account___Self___other(please specify)_____
If patient is a child, who may authorize treatment for this child? (specify relationship)_____

Nearest relative not residing with you_____Relationship_____Phone_____

If you have a telephone answering machine, may we leave a message?_____Yes_____No

Whom shall we thank for referring you to our practice?_____
Other family members patients_____
Pharmacy of choice (please list name and street location)_____

I authorize this office to release to the named insurance company the information necessary to expedite insurance payment. I understand that I am responsible for all charges, regardless of insurance coverage. I understand office visits, and procedures considered cosmetic will not be billed to my insurance company.

Patient, Parent or Guardian signature_____

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Name_____Date_____
Age_____ Primary Care Physician_____

1. Reason for patient visit_____
2. Does the patient have any food or drug allergies?___Yes___No
   Please list allergies and describe reaction below:
   _____
   _____
3. Does the patient have any medical conditions or problems?___Yes___No
   If yes, please list below:
   1.
   2.
   3.
4. Does the patient have any birthmarks? ___Yes ___No
5. List all medications the patient is currently taking. Please include all over-the-counter medications and supplements.
   1.
   2.
   3.
6. Does the patient have a history of: (circle all that apply)

Stroke, seizure, persistent headache or dizziness, asthma, breathing difficulty, shortness of breath, emphysema, bronchitis, hay fever, heart disease, chest pain, palpitations, rheumatic fever, heart murmur, abdominal pain, constipation, nausea, vomiting, diarrhea, jaundice, hepatitis, urinary frequency, pain with urination, blood in urine, bed wetting, joint pain, muscle aches, broken bones, swollen glands, abnormal teeth, abnormal nails, fever, chills, night sweats, weight loss, diabetes, or bleeding tendency?

Female patients:

Age of first menstrual period_____ Are periods regular?_____Yes _____No

7. Does any blood relative have asthma, hay fever, eczema, cancer, diabetes or bleeding tendencies? (circle all that apply)
8. Has the patient had skin cancer? ____Yes ____No
9. Does anyone else in the family have a rash, skin disease or skin cancer? ____Yes ____No
   If yes, please describe:
   1.
   2.
   3.
10. List below all creams, lotions, solutions, and ointment applied to skin: (Please Bring all products to your initial appointment)
    1.
    2.
    3.
11. What specifically would you like to discuss with Dr. Stratte? _____
12. What would you like to achieve cosmetically? (If cosmetic consult)_____
13. What specific areas of the body are you concerned with?_____

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HIPPA Notice of Privacy Practices

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

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required or required by law. It also describes your rights to access and control your PHI. "PHI" is information about you, including demographic information, that may identify you, that relates to your past, present or future physical or mental health or condition and related health care services.

1. **Uses & disclosures of protected health information:**
Your PHI may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and for treatment purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Payments: Your PHI will be used as needed to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as needed, your PHI in order to support the business activities of your physicians practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and conducting or arranging for other business activities. For example, we may disclose your PHI to a medical students that see patients at our office. In addition, we may use a sign-in sheet at the front desk where you will be asked to sign your name and asked to specify your physician. We will also call you by name in the waiting room when your physician is ready to see you. We may also use your PHI as necessary to contact you about your appointments.

We may use or disclose your PHI in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Diseases; Oversight: Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement: Coroners, Funeral Directors and Organ Donation; Research; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures: Under the law, we must make disclosures to you when when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance requirements of section 164.500.

Other permitted and required uses and disclosures will be made ONLY WITH YOUR CONSENT, authorization or opportunity to object, unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

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Your Rights: The following is a statement of your rights with respect to your Protected Health Information(PHI)

You have the right to inspect and copy your PHI. Under Federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in a civil, criminal or administrative action or proceeding, and PHI that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your PHI. This means you can ask us not to use or disclose any part of your PHI for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your PHI not be disclosed to any family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and whom you want the restriction to apply.

Your physician is not required to agree to restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. You then have the right to use another healthcare professional.

You have the right to request and receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request even if you have agreed to accept this notice alternatively, i.e. electronically.

You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI.

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdrawal as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaints. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on/before April 14, 2003.

We are required by law to maintain the privacy and provide individuals with this notice of our legal duties and privacy practices with respect to PHI. If you have any objections to this form, please ask to speak with out HIPPA Compliance Officer in person or by phone at (530) 243-6085

Signature below is acknowledgment that you received this Notice of Privacy Practices.

Print Name_____Signature_____Date_____