Patient Registration

In addition to the forms below, we ask that you bring your Identification Card, all Health Insurance Cards, and Prescription Plan Cards to every visit with Martin Dermatology, PLC.

Patient Demographics

First Name | Middle Initial | Last Name

Preferred Name

Date of Birth | Gender | Marital Status

Street Address

City | State | Zip

Mobile Phone | Home Phone | Email

Patient Permissions

Permission to leave medical information in message: ☐ Yes ☐ No

Permission to speak with someone about your protected medical information: ☐ Yes ☐ No

Name of person with whom we can share your protected medical information | Relationship

Call in Case of Emergency | Relationship | Phone

Provider Information

Name of Primary Care Physician, NP, or PA

Preferred Pharmacy | Address | Phone

Medication/Drug Allergies (or write No Known Drug Allergies)

Medications

Medical History

Past Skin History

- ☐ Basal Cell Cancer
- ☐ Squamous Cell Cancer
- ☐ Melanoma
- ☐ Family History of Melanoma
- ☐ Merkel Cell Cancer
- ☐ Actinic Keratosis
- ☐ Atypical Moles
- ☐ Blistering Burns
- ☐ Dandruff
- ☐ Eczema
- ☐ Psoriasis
- ☐ Other (Specify Below)

Details or if Other, please specify:

Past Medical History

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Bone Marrow Transplant
- ☐ Cancer - Breast Cancer
- ☐ Cancer - Colon
- ☐ Cancer - Leukemia
- ☐ Cancer - Lung
- ☐ Cancer - Lymphoma
- ☐ Cancer - Prostate
- ☐ Cancer - Other
- ☐ Chronic Kidney Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Heart Attack
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDs
- ☐ Irregular Heartbeat
- ☐ Seasonal Allergies
- ☐ Thyroid Disease
- ☐ Other (Specify Below)

Details or if Other, please specify:

Medical Alerts

- ☐ Artificial Heart Valve
- ☐ Blood Thinner Use
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ Joint Replacement
- ☐ History of Passing Out
- ☐ Immunosuppressed
- ☐ Organ Transplant
- ☐ Breast Feeding
- ☐ Pregnant
- ☐ Planning Pregnancy
- ☐ Other (Specify Below)

Details or if Other, please specify:

Smoking Status

- ☐ Current Use
- ☐ Former Use
- ☐ Never Used

Alcohol Use

- ☐ Current Use
- ☐ Former Use
- ☐ Never Used

ACKNOWLEDGEMENT FOR ELECTRONIC COMPLETION: *If you choose to complete this form electronically, you agree that your printed name is the legal equivalent of your manual signature on this document. You may also print, or request a printed copy of, this form for manual signature*.

Patient Name **Date**

Signature of Patient (or Representative/Guardian) **Date**

Printed Name and Relationship to Patient (Leave Blank if Signed by Patient) **Date**

Insurance and Financial Information

Please bring your Identification Card, all Health Insurance Cards, and Prescription Plan Cards to every visit with Martin Dermatology, PLC.

We will scan these cards into our electronic medical record and will confirm they remain valid at each visit.

Patient Name		Date of Birth
Responsible Party (If other than patient)	Relationship to Patient	Date of Birth
Billing Address (If other than patient)		Phone

Subscriber/Patient Authorization
I hereby authorize Martin Dermatology, PLC to apply for benefits on my behalf for covered services rendered. I request payment from my insurance company be made directly to Martin Dermatology, PLC.

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Signature of the Subscriber	**Date**

Consents and Medical Release Form

During your visit, Dr. Martin may need to perform cryosurgery, skin scrapings, a skin biopsy, or an excision to treat or evaluate your skin condition. We will obtain your medication and medical history to ensure safety and may ask to take relevant photographs.

Please review and sign the consent form below. This document serves as a standing consent for this and any future visits. Verbal consent will always be obtained prior to any procedure.

Consent Regarding Procedures

- Skin scrapings, biopsies, and excisions are surgical procedures used to obtain a sample of tissue for microscopic examination to aid diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be indicated by the results of these procedures.
- Cryosurgery is the use of liquid nitrogen to create a destructive freeze-thaw cycle for skin lesions suspected to be responsive to this approach. Examples of lesions treated in this manner include actinic keratoses, seborrheic keratoses, skin tags, and warts. If a treated lesion does not resolve as discussed, Dr. Martin requests that you contact our office for re-evaluation.
- Risks related to the procedures above may include, but are not limited to, bleeding, pain, irritation, infection, slow healing, permanent change in skin color and texture, and scarring.
- When a sample is collected for processing and evaluation, a pathologist or laboratory will examine the obtained sample. Any charges related to these services will be billed directly from the pathologist or laboratory, and are separate from billing related to services provided by Martin Dermatology, PLC.

Consent Regarding Protected Medical Information

- By signing this consent, you give Martin Dermatology permission to use your personal and health information to schedule and manage appointments, deliver healthcare services, manage external referrals, and communicate with you regarding your care. This includes collection and sharing of medication history from your pharmacy and other healthcare providers.
- We may share your personal information with third-party service providers, such as labs, pharmacies, or insurance providers, to provide you with medical services. We may share information with trusted business associates who assist us in operating the Website or providing services, subject to confidentiality agreements and compliance with applicable laws. We may disclose your information if required by law, such as in response to a subpoena or to comply with HIPAA regulations.

Consent Regarding Photography

- You authorize Martin Dermatology, PLC to take medically relevant photographs for documentation and educational purposes. With your signature below, you also agree not to photograph or record any part of your visits with Martin Dermatology, PLC.

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Patient Name	**Date**
Signature of Patient (or Representative/Guardian)	**Date**
Printed Name and Relationship to Patient (Leave Blank if Signed by Patient)	**Date**

Notice of Privacy Practices for Protected Health Information (PHI)

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

Effective date: January 2025

The Practice of **Martin Dermatology** is required by applicable federal and state laws to maintain the privacy of your health information. Protected health information (PHI) is the information we create and maintain in the course of providing our services to you. Such information may include documentation of your symptoms, examination and test results, diagnoses and treatment protocols. It also may include billing documents for those services. We are permitted by federal privacy law (the Health Insurance Portability & Accountability Act of 1996 (HIPAA)), to use and disclose your PHI, without your written authorization, for purposes of treatment, payment, and health care operations.

Examples of Using Your Health Information for Treatment Purposes:

- Our nurse obtains treatment information about you and records it in your medical record.
- During the course of your treatment, the physician determines he will need to consult with a specialist. He will share the information with the specialist and obtain his/her input.
- We may contact you by phone, at your home, if we need to speak to you about a medical condition or to remind you of medical appointments.

Example of Using Your Health Information for Payment Purposes:

- We submit requests for payment to your health insurance company. We will respond to health insurance company requests for information from about the medical care we provided to you.

Example of a Using Your Information for Health Care Operations:

- We may use or disclose your PHI in order to conduct certain business and operational activities, such as quality assessments, employee reviews, or student training. We may share information about you with our Business Associates, third parties who perform these functions on our behalf, as necessary to obtain their services.

Your Health Information Rights

The health and billing records we maintain are the physical property of the Practice. The information in them, however, belongs to you. You have a right to:

- Obtain a paper copy of our current Notice of Privacy Practices for PHI ("the Notice");
- Receive Notification of a breach of your unsecured PHI;
- Request restrictions on certain uses and disclosures of your health information. We are not required to grant most requests, but we will comply with any request with which we agree. We will, however, agree to your request to refrain from sending your PHI to your health plan for payment or operations purposes if at the time an item or service is provided to you, you pay in full and out-of-pocket;
- Request that you be allowed to inspect and copy the information about you that we maintain in the Practice's designated record set. You may exercise this right by delivering your request, in writing, to our Practice;
- Appeal a denial of access to your PHI, except in certain circumstances;
- Request that your health care record be amended to correct incomplete or incorrect information by delivering a written request to our Practice. We may deny your request if you ask us to amend information that (a) was not created by us (unless the person or entity that created the information is no longer available to make the amendment), (b) is not part of the health information kept by the Practice, (c) is not part of the information that you would be permitted to inspect and copy, or (d) is accurate and complete. If your request is denied, you will be informed of the reason for the denial and will have an opportunity to submit a statement of disagreement to be placed in your record;
- Request that communication of your health information be made by alternative means or at alternative locations by delivering a written request to our Practice;
- If we engage in fundraising activities and contact you to raise funds for our Practice, you will have the right to opt-out of any future fundraising communications;
- Obtain a list of instances in which we have shared your health information with outside parties, as required by the HIPAA Rules.
- Revoke any of your prior authorizations to use or disclose information by delivering a written revocation to our Practice (except to the extent action has already been taken based on a prior authorization).

Our Responsibilities

The Practice is required to:

- Maintain the privacy of your health information as required by law;
- Notify you following a breach of your unsecured PHI;
- Provide you with a notice ('Notice') describing our duties and privacy practices with respect to the information we collect and maintain about you and abide by the terms of the Notice;
- Notify you if we cannot accommodate a requested restriction or request; and,
- Accommodate your reasonable requests regarding methods for communicating with you about your health information and comply with your written request to refrain from disclosing your PHI to your health plan if you pay for an item or service we provide you in full and out-of-pocket at the time of service.

We reserve the right to amend, change, or eliminate provisions of our privacy practices and to enact new provisions regarding the PHI we maintain about you. If our information practices change, we will amend our Notice. You are entitled to receive a copy of the revised Notice upon request by phone or by visiting our website or Practice.

Other Uses and Disclosures of your PHI

Communication with Family

- Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or payment for care, if you do not object or in an emergency. We may also do this after your death, unless you tell us before you die that you do not wish us to communicate with certain individuals.

Notification

- Unless you object, we may use or disclose your PHI to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care about your location, your general condition, or your death.

Research

- We may disclose information to researchers if an institutional review board has reviewed the research proposal and established protocols to ensure the privacy of your PHI. We may also disclose your information if the researchers require only a limited portion of your information.

Disaster Relief

- We may use and disclose your PHI to assist in disaster relief efforts.

Organ Procurement Organizations

- Consistent with applicable law, we may disclose your PHI to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation/transplant.

Food and Drug Administration (FDA)

- We may disclose to the FDA your PHI relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.

Workers' Compensation

- If you are seeking compensation from Workers Compensation, we may disclose your PHI to the extent necessary to comply with laws relating to Workers Compensation.

Public Health

- We may disclose your PHI to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; or to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.

As Required by Law

- We may disclose your PHI as required by law, or to appropriate public authorities as allowed by law to report abuse or neglect.

Employers

- We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of the release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of information to your employer.

Law Enforcement

- We may disclose your PHI to law enforcement officials (a) in response to a court order, court subpoena, warrant or similar judicial process; (b) to identify or locate a suspect, fugitive, material witness, or missing person; (c) if you are a victim of a crime and we are unable to obtain your agreement; (d) about criminal conduct on our premises; and (e) in other limited emergency circumstances where we need to report a crime.

Health Oversight

- Federal law allows us to release your PHI to appropriate health oversight agencies or for health oversight activities such as state and federal auditors.

Judicial/Administrative Proceedings

- We may disclose your PHI in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.

For Specialized Governmental Functions or Serious Threat

- We may disclose your PHI for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, to public assistance program personnel, or to avert a serious threat to health or safety. We may disclose your PHI consistent with applicable law to prevent or diminish a serious, imminent threat to the health or safety of a person or the public.

Correctional Institutions

- If you are an inmate of a correctional institution, we may disclose to the institution or its agents the PHI necessary for your health and the health and safety of other individuals.

Coroners, Medical Examiners, and Funeral Directors

- We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about our Patients to funeral directors as necessary for them to carry out their duties.

Website

- You may access a copy of this Notice electronically on our website.

Other uses and disclosures of your PHI not described in this Notice will only be made with your authorization, unless otherwise permitted or required by law. Most uses and disclosure of psychotherapy notes, uses and disclosures of your PHI for marketing purposes, and disclosures of your

PHI that constitute a sale of PHI will require your authorization. You may revoke any authorization at any time by submitting a written revocation request to the Practice (as previously provided in this Notice under "Your Health Information Rights.")

To Request Information, Exercise a Patient Right, or File a Complaint

If you have questions, would like additional information, want to exercise a Patient Right described above, or believe your (or someone else's) privacy rights have been violated, you may contact the Practice's Privacy Officer at 804-917-3376, or in writing to us at:

Adam Martin, MD
Martin Dermatology, PLC
7229 Forest Avenue, Suite 108
Richmond, VA 23226

Please note that all complaints must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of Health and Human Services (HHS), Office for Civil Rights (OCR). Your complaint must be filed in writing, either on paper or electronically, by mail, fax, or e-mail. The address for the Colorado regional office is: Office for Civil Rights, U.S. Department of Health and Human Services, 999 18th Street, Suite 417, Denver, CO 80202; or call (800) 368-1019. More information regarding the steps to file a complaint can be found at: www.hhs.gov/ocr/privacy/hipaa/complaints.

- We cannot, and will not, require you to waive the right to file a complaint with the Secretary of HHS as a condition of receiving treatment from the Practice.

- We cannot, and will not, retaliate against you for filing a complaint with the Secretary of HHS.

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I have been provided with a copy of the Practice's Notice of Privacy Practices.

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Signature of Patient (or Representative/Guardian)	**Date**
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For Practice Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

*If Patient Representative is signing, legal documentation must be included designating authority to sign or receive information. This form must be maintained for 6 years.

Martin Dermatology, PLC Credit Card on File and AutoPay Policy

Purpose	Our practice is trying to simplify balance collection and move away from the high costs associated with printing and mailing individual financial statements through the mail.
Request	We request you keep a credit card on file through ModMed Pay, an encrypted platform alongside your medical record. The credit card must be in the name of the patient or the patient's authorized representative. The physical card must be presented in person and cannot be taken by any other means.
Security	Martin Dermatology prioritizes the security of your private information. Your credit card information is encrypted and stored securely alongside the same system that stores your medical records.
Use of Credit Card	When your insurer's billing information is received by Martin Dermatology, PLC or our billing company, ClarityRCM, any adjustments and payments will be made. At that time, patients will be notified by email of any due balance, and an alternative method of payment may be made within 30 days. After 30 days, if no alternative payment method is established, the credit card on file with be charged for any patient balance.
Responsibility	Patients are responsible for keeping credit card information up to date. If the credit card on file is lost or replaced, please notify our office as soon as possible.
Consent	By signing this policy, I agree to keep a credit card on file with Martin Dermatology. I consent to the credit card on file to be used to pay for any unpaid balances 30 days after insurance claim adjudication

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