FIVENSON DERMATOLOGY

David Fivenson, MD, Dermatology, PLLC
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WELCOME TO FIVENSON DERMATOLOGY!!

Your appointment is scheduled for: _____ @ _____ a.m. p.m.

Enclosed you will find a patient demographic and a health history questionnaire. Please complete this form and bring to your visit along with:

- Your insurance card(s) and photo identification (proof of COVID-19 Vaccination or negative test within last 72h---if an exemption to this policy is needed or a video appointment is desired, please call asap.
- Cash, check, Visa, MasterCard or Discover, for co-payments, deductible portions or payment in full for services not covered by your insurance company. ALL COPAYS ARE DUE AT TIME OF SERVICE
- Medical records from any outside facility or referring physicians such as lab results, skin biopsies, doctor's notes, etc. that pertain to your current medical problem should be sent ahead of your consultation. A complete medication list including all over-the-counter items, creams and supplements is also very important. We encourage you to put everything you take or use in a bag and bring it with you.
- Any referral, if required by your insurance. If not provided, you might be responsible for the cost of your visit.

We will not be able to bill your insurance without verification of active insurance coverage. Also enclosed is a map and directions to our office. ***Please arrive 15-20 minutes early*** so that we may open a patient chart for you. This will allow you time to sign all consent forms including those for treatment, HIPAA review, portal, email/phone contacts for communication of test results, billing, electronic lab and medication interfaces (from the central pharmacy website known as Surescripts). A detailed description of these forms will be available to review in the office waiting room.

We encourage you to sign up for a portal account. On the portal you can review and electronically authorize documents prior to your appointment. To do so, go to our website: fivensondermatology.com and use the link on the home page for our **PATIENT PORTAL**. All that is required to sign up and register for the portal is your name, date of birth and email address. Click on your appointment to enter your medical history information. This will help us keep your appointment on time, save repeated questions and avoid errors. The portal is also a great way to manage other routine tasks such as paying your bill, request appointments; request medication refills and get lab results. On the portal you can also fill out your medical history, surgery history, medications, allergies, as well as review copies of the office policies. This is also a great way to get questions answered or forward labs, pictures, other requests.

We participate with most major insurance companies including Medicare, Blue Cross Blue Shield PPO, POS, Blue Care Network (with referral), Cigna PPO, HAP PPO/POS, Aetna PPO, Priority Health, Medicaid (Straight), United Healthcare PPO, AARP, Humana PPO and Tricare. It is important to check with your insurance company to verify coverage before your appointment.

We look forward to meeting you and making your visit as pleasant as possible. Please telephone our office if you have any questions prior to your visit with us.

NOTICE OF PRIVACY PRACTICES & PATIENT RIGHTS

As of April 14, 2003 HIPAA requires that healthcare practices take certain steps, and provides steep penalties for those who do not comply. Under HIPAA, Patients are now given new fundamental rights, including:

- The right to inspect and/or obtain copies of your medical records.
- The right to request amendments to your records (if you feel your records are incorrect you may submit to the Office a written request for changes to your records).
- The right to request restrictions on the disclosure of your protected health information.
- The right to ask our practice to communicate with you in a certain manner. For example, certain contact number only, email, mail, etc.
- The right to ask our practice for a log of who has accessed your protected health information.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY & PATIENT RIGHTS

I would like a copy of the Notice of Privacy Practice form. ☐

Declined copy of Notice of Privacy Practice form. ☐

_____ _____

Patient Signature ***Date***

AUTHORIZATION FOR THE USE, RELEASE OF DISCLOSURE OF YOUR HEALTH INFORMATION

By signing this document, I hereby authorize the use, release, or disclosure of my Protected Health Information (PHI) to the following person(s) (i.e. family members and/or health care providers). I understand that this authorization is voluntary at my request.

Name	Relationship	Telephone Number	This authorization shall expire on:
_____	_____	_____	_____
_____	_____	_____	_____

_____ _____

PATIENT SIGNATURE DATE

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OFFICE POLICIES AND PROCEDURES

OFFICE HOURS

-Monday – Thursday from 8:00am to 5:00pm, with appointments scheduled from 8:15 – 11:30 and 1:30 – 4:15.
-When our office is closed, the answering service will give instructions on leaving a message or who to call with questions.
-We will try to be available to help you with any questions that might arise related to your skin conditions, and will try to have a 'live' person answer every phone call. Our **Patient Portal** is a very efficient and secure way to communicate with us. We encourage this method for the most efficient way to have your questions answered (if a personal call is not needed).

Appointments

NO-SHOW/CANCELLATION POLICY

-It is our policy to encourage patients to arrive and receive care at their scheduled arrival time, or to give appropriate notice of cancellation to allow other patients to receive timely care.
-If you are unable to make your scheduled arrival time, we request that you notify us as soon as possible, but no later than 24 hours prior to your scheduled arrival time.
-By not providing 24 hours notice of a cancellation of your appointment, you may be assessed a $50.00 fee for a missed office visit.

Our office will call you if there was a "no show" appointment to try and help with rescheduling. If three (3) or more appointments are missed, our office reserves the right to terminate our relationship with you.
It is not our intent to assess an additional financial burden, but it is costly if you miss your appointment and do not give us time to schedule another patient in your time slot.
-Minor children (age 17 and younger) must be accompanied by their parent or legal guardian for new patient visits.

PRESCRIPTION REFILLS

We require 48 hours' notice for all prescription renewals. Using the having your pharmacy send an electronic refill request are the most efficient methods to request prescription renewals.
For prescriptions requiring a prior authorization, be sure to allow time for insurance verification/authorizations of up to two (2) weeks.
-We will fill prescriptions for topical medications (at our discretion) up to one (1) year after the last office visit and internal medications (at our discretion) up to six (6) months after the last office visit. Beyond these times, an office (in person or video) visit may be required.
-To refill a prescription, we will need the following information for each prescription you are requesting:

- Your full (legal) name and date of birth
- The medication name, dose previously prescribed the medication vehicle (i.e. cream, lotion, solution, gel or ointment and the size or number of tablets preciously prescribed.
- Pharmacy name, location and phone number – be specific.
- Daytime phone number and an alternative number where you can be reached, the pharmacy name and phone number, your type of insurance.

-Please feel free to leave this information on our answering service, email or PATIENT PORTAL.

LAB WORK

-Our preferred site to send biopsy specimens and blood work is St. Joseph Mercy Hospital in Ann Arbor, however, we have electronic connections to many other labs for your convenience.
-Please let us know if your insurance requires use of a specific laboratory for lab/pathology services.
-Our **Patient Portal** and "Results Call" system will provide you timely, secure access to test results via your choice of email, text or phone call.

BILLING

-Payment is due at the time of service, unless Fivenson Dermatology participates with your insurance. All co-pays are due at the time of service. We accept cash, check, Master Card, Visa and Discover.

-Patient statements will be mailed monthly by our billing service and prompt payment of remaining balances is appreciated.

Our **Patient Portal** credit card payment is an easy way to manage these balances.

-We strongly encourage you to enter your credit card information on the **Patient Portal** as a pre-approved payment method.

-There will be a $50 service charge for any check returned to us from the bank.

-Balances of greater than 60 days past due will be subject to a 2% monthly fee.

PRIVACY STATEMENT

We respect that your personal information is private and will only exchange such information with those parties whom we have your permission to and only as part of your health care in Dr. Fivenson's practice. Confidential health care information is only released with your permission other health care providers. Your health care information may also be shared with your insurance company to allow us to collect for Dr. Fivenson's services. Details of our HIPAA Policy are available for your review.

PLEASE SIGN BELOW

1. I give my consent for treatment: Signed _____ Date _____

   Print Name _____

2. I understand the policies and have been advised of and offered to review the practice HIPAA Privacy policies on site.

   _____(Initial)

3. I have read the above and consent to phone messages, email, text message or telephone "Results Call" notification of laboratory results. (Circle all that you agree to.)

   _____(Initial)

4. I hereby give my consent to Dr. Fivenson to access and download my medication history electronically into my chart.

   _____(Initial)

5. I hereby give my consent to Fivenson Dermatology to send orders and receive results of any lab work electronically through electronic interface or HL7.

   _____(Initial)

PATIENT PORTAL – Please register for this after making your appointment- Please answer all questions as accurately as possible and bring this form with you on the day of your appointment. Some can be done through the Portal but not all.

Name: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: Home (____) _____ Work (____) _____ Cell (____) _____

Birth date: ____/____/____ Race _____ Okay to text? [ ] Yes [ ] No

Birth Gender: _____ Gender Identity: Male ____ Female ____ Choose not to disclose ____
Preferred Pronouns, Gender Identity: he/him ____ she/her____ they/them____ Choose not to disclose ____
Sexual Orientation: LGBTQ _____ Straight/Heterosexual _____ Non-binary _____ Choose not to disclose _____
Email Address: _____

PREFERRED CONTACT PHONE NUMBER: _____

Do you have an Advanced Care Directive Plan? (ie., Durable Power of Attorney, Patient Advocate)
Yes____ No_____ Not Sure _____

WHY ARE YOU HERE/WHAT IS YOUR MAIN PROBLEM: _____

WHERE IS THE PROBLEM(S) ON YOUR SKIN: _____

HOW LONG HAVE YOU SUFFERED FROM THIS/THESE PROBLEMS: _____

Medication History – *List all medications that you currently take. Include drugs like creams, Motrin, Tylenol, Vitamins, Herbals, etc. Please bring all your medications to your visit-bring it all in a bag or a complete list..*

Drug	Dose	How often?	Reason for taking?	Start date?	Stop date?	Still using?

Primary Care Physician: _____ Telephone: _____

Referring Physician: _____ Telephone: _____
Pharmacy of Choice: _____ Telephone: _____
Specialty Pharmacy of Choice: _____

Our electronic medical records system includes E-Prescribing software and we will try to use this for all of your prescriptions.

Allergies Please list Medications/Substances that you are allergic to and the reaction you have/had. ☐ **NONE**

Medication/Substance	**Reaction/Date**
_____	_____
_____	_____
_____	_____

List Your Surgeries ☐*NONE*

	Date	Surgeon
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Highest level of education achieved: _____

Do you smoke/chew tobacco? Yes ☐ No ☐

If yes, how many packs/week? _____How long? _____ How long since quit? ____

Do you use any other nicotine devices like e-cigarettes? Yes ☐ No ☐ Cigars? Yes ☐ No ☐ Nicotine gum? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐

Do you use marijuana? Yes ☐ No ☐ If yes, how much? _____

Do you work? Yes ☐ No ☐

Are you interested in help with alcohol, tobacco or drug abuse? Yes ____ No _____

Do you use illegal drugs? Yes ☐ No ☐

Have you ever had an STD? Yes ☐ No ☐

Do you use tanning beds? Yes ☐ No ☐

Do you wear sunscreen? Occassionally___ Regularly____ What SPF?____

How many sunburns have you had? ____

FAMILY HISTORY

Family History	YES	NO	RELATIONSHIP- Please indicate maternal (M) or paternal (P) for relatives
Arthritis			
Cancer – Breast			
Cancer – Colon			
Cancer – Lung			
Cancer – Skin			
Diabetes			
Heart disease			
Hypertension			
Leukemia/lymphoma			
Lupus			
Psoriasis			
Melanoma			
Atopic Dermatitis/Eczema			

*PLEASE CHECK CURRENT CONDITIONS FOR WHICH YOU SEE A DOCTOR REGULARY (**IN BOLD TEXT**). Current Symptoms/Complaints are in plain text.*

GENERAL
- ☐ appetite change
- ☐ chills
- ☐ dizziness
- ☐ nausea/vomiting
- ☐ fatigue
- ☐ fever
- ☐ night sweats
- ☐ weight change
  loss/gain #_____lbs

_____

EYES
- ☐ **cataracts**
- ☐ **glaucoma**
- ☐ **macular degeneration**
- [ ] **retinal disease**
- ☐ dry eyes
- ☐ discharge
- ☐ blurry vision
- ☐ itching
- ☐ red eyes

CARDIO-VASCULAR
- ☐ **hi cholesterol**
- ☐ **hi triglycerides**
- ☐ **hypertension**
- ☐ **heart attack**
- ☐ **arrhythmia**
- ☐ **heart valve problem**
- ☐ **coronary artery disease**
- ☐ **lymphedema**
- ☐ **phlebitis**
- ☐ **raynaud's**
- ☐ **stroke**
- ☐ **varicose veins**
- ☐ **heart murmur**
- ☐ leg pain with walking
- ☐ leg swelling
- ☐ palpitations
- ☐ short of breath w/exertion
- ☐ chest pain
- ☐ irregular heartbeat

_____

SKIN
- ☐ **keloids**
- ☐ **lupus**
- ☐ **melanoma**
- ☐ **molluscum**
- ☐ **pemphigus**
- ☐ **psoriasis**
- ☐ **sun allergy**
- ☐ **vitiligo**
- ☐ **warts**
- ☐ **acne**
- ☐ **eczema**
- ☐ **folliculitis**
- ☐ **herpes**
- ☐ **history of skin cancer**
  where: _____
  when:_____
  who treated _____
- ☐ blisters
- ☐ rash
- ☐ itching

ENT
- ☐ **deafness**
- ☐ **thrush**
- ☐ bleeding gums
- ☐ sinus problems
- ☐ dry mouth
- ☐ growths in mouth
- ☐ mouth ulcers
- ☐ nose bleeds
- ☐ difficulty swallowing
- ☐ burning mouth
- ☐ ear pain
- ☐ hay fever
- ☐ scaly ears
- ☐ ear drainage

LUNGS
- ☐ **TB**
- ☐ **asthma**
- ☐ **emphysema/COPD**
- ☐ **sarcoidosis**
- ☐ **pulmonary embolism**
- ☐ cough
- ☐ wheezing
- ☐ short of breath
- [ ] difficulty breathing

GI
- ☐ **reflux/GERD**
- ☐ **hemorrhoids**
- ☐ **hiatal hernia**
- ☐ **hepatitis**
- ☐ **inflammatory bowel disease**
- [ ] **Crohn's**
- [ ] **Ulcerative colitis**
- ☐ **irritable bowel disease**
- ☐ black stools
- ☐ bloody stools
- ☐ constipation
- ☐ diarrhea
- ☐ stomach pain
- ☐ vomiting

GU
- ☐ **renal failure/dialysis**
- ☐ **urinary tract infection**
- ☐ **kidney stones**
- ☐ discharge
- ☐ urine odor
- ☐ frequency
- ☐ incontinence
- ☐ painful urination
- [ ] growths
- [ ] genital ulcers/rash

MUSCULO-SKELETAL
- ☐ **arthritis**
- ☐ back pain
- ☐ joint pains
- ☐ joint swelling
- ☐ weakness
- [ ] muscle pain

HEMATOLOGY
- ☐ **anemia**
- ☐ **bleeding disorder**
- ☐ **sickle cell**
- ☐ **leukemia**
- ☐ **lymphoma**
- ☐ easy bruising
- ☐ swollen lymph nodes
- ☐ bleeding problems

ENDOCRINE
- ☐ **diabetes**
- ☐ **thyroid disorders hyper / hypo**
- ☐ **menstrual problems**
- ☐ abnormal hair growth/loss

OTHERS
- ☐ history of **cancer-lung, breast, prostate, colon, other**_____
- ☐ **drug abuse**
- ☐ other diagnoses-
- ☐ x-ray therapy
- ☐ chemotherapy
- ☐ unusual childhood illnesses

Skin Continued--
- ☐ growths
- [ ] Hives
- [ ] Wounds/Ulcers
- [ ] Excessive sweating
- ☐ nail changes
- ☐ pigment loss
- ☐ unusual moles
- ☐ acne
- ☐ burning
- ☐ tenderness
- ☐ other skin symptoms_____

NEUROLOGIC
- ☐ **migraines**
- ☐ **seizure disorder**
- ☐ **multiple sclerosis**
- ☐ **stroke**
- ☐ **dementia**
- ☐ headaches
- ☐ numbness/tingling

PSYCHIATRIC
- ☐ **anxiety disorder**
- ☐ **depression**
- ☐ panic attacks
- ☐ trouble sleeping
- ☐ hallucinations
- ☐ stress

ALLERGY/IMMUNOLOGY
- ☐ **HIV/AIDS**
- ☐ **gout**
- ☐ **seasonal allergies**
- ☐ **lupus**
- ☐ **rheumatoid arthritis**
- ☐ **scleroderma**
- ☐ **vasculitis**
- ☐ runny nose
- ☐ sinus pressure
- ☐ frequent sneezing
- ☐ **drug allergies-** *please list reactions on bottom of page*
- ☐ food allergy

PAIN
- ☐ Where? _____
- ☐ Sharp, dull, burning, aching, stabbing, throbbing

☐ *CHECK HERE IF NONE OF THE ABOVE APPLY*

Other medical conditions:_____

_____

From Jackson Area:
I 94 EAST to EXIT 169 (Zeeb Road), turn right onto Zeeb. Turn left onto Jackson Road, turn right onto Wagner. Take to Liberty Road (4 way stop). Turn left on Liberty. Office is on left side. Approximately ¼ mile.

From Brighton Area:
US 23 SOUTH to M14 WEST. EXIT AT Exit #2 (Miller/Maple). Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile.

From Downtown and East Detroit
94 to 96 WEST to M14 WEST. EXIT AT Exit #2 (Miller/Maple). Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile.

From Detroit (West of Downtown): 94 WEST to 23 NORTH to M14 WEST . Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile.

From Toledo: 23 NORTH to M14 WEST. EXIT AT Exit #2 (Miller/Maple) Take 2nd right on round-a-bout to Miller Rd. Turn right on Miller Rd. Take Miller Rd. to Wagner Rd (1st stop sign) and turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile.

From Downtown Ann Arbor: MILLER WEST to Wagner, turn left. Take Wagner Rd. to Liberty Rd. and turn left. Office on left side approximately ¼ mile.