Rhode Island
Dermatology Institute

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

REGISTRATION INFORMATION

Name: _____ Date: _____/_____/_____

DOB: _____/_____/_____ Age: _____ Last 4 of SSN #: _____ Gender: M___F___Other_____

Postal Address: _____

Primary #: (____) _____-_____ Home ( ) Cell ( ) Work ( )

Secondary #: (____) _____-_____ Home ( ) Cell ( ) Work ( ) Marital Status: S__ M__D__W__

EMERGENCY CONTACT

Who would you like us to contact in case of an emergency?

Name:_____ Relationship: _____

Primary #: (____) _____-_____ Home ( ) Cell ( ) Work ( )

Secondary #: (____) _____-_____ Home ( ) Cell ( ) Work ( )

PRIMARY CARE, REFERRAL & OTHER INFO

Primary Care Physician: _____ Phone: (___) ____-_____

Referring Physician: _____ Phone: (___) ____-_____

Were you a patient of Dr. Chang's at a previous practice? Yes/No

Are other family members a patient of Dr. Chang's? _____

PREFERRED PHARMACY INFORMATION

Pharmacy Name: _____Phone: (_____) _____-_____

Pharmacy Address: _____

***If you require refills, please have your pharmacy fax requests to us directly before you call the office. This will help us get refills to you quicker.

PERMISSION FOR CONFIDENTIAL COMMUNICATION

I give permission to be contacted regarding my medical care by the following (check ALL that apply):

☐ I authorize to be notified by PHONE: (_____) _____-_____

- *Initial here if okay to leave message with personal health information* _____

☐ I authorize to be notified by EMAIL (ie. Email, text message, etc): _____

- *Initial here if okay to include personal health information* _____

☐ I authorize to be notified by TEXT MESSAGE: (_____) _____-_____

- *Initial here if okay to include personal health information* _____

Rhode Island
Dermatology Institute

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

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: _____

All communications with Rhode Island Dermatology Institute may become part of your medical record and some communication may contain private protected health information (PHI). Electronic communications may not always be safe nor secure. Although Rhode Island Dermatology Institute will make all reasonable efforts to keep electronic communications confidential and secure, communications with anyone at Rhode Island Dermatology Institute using e-mail, facsimile, instant messaging, or any other electronic communication, are not guaranteed to be secure or confidential methods of communications. By providing us with your preferred method of communication, you are authorizing Rhode Island Dermatology Institute to communicate with you by that method. For your own protection, Rhode Island Dermatology Institute prefers not to share PHI via email or text message. However, should your preferred method be electronic, such as e-mail or text message, you understand that there is always a possibility that a third party may gain access to your information. By signing this form, you express understanding of the terms above and are consenting to allow our office to communicate with you or other authorized persons by the means designated in this section. Additionally, I understand and acknowledge that Authorized persons or entities that receive PHI may not be a health care provider, health plan, or other entity covered by the federal privacy regulations, and that PHI may be redisclosed and no longer protected by these regulations. This consent will remain in effect unless otherwise changed by you.

X _____

Patient/Personal Representative Signature Print Name Date

Rhode Island
Dermatology Institute

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

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	Condition	Personal	Family
Acne	☐	☐	Hay Fever/Allergies	☐	☐
Anxiety	☐	☐	High blood pressure	☐	☐
Arthritis	☐	☐	High cholesterol	☐	☐
Artificial joints	☐	☐	HIV/AIDS	☐	☐
Asthma	☐	☐	Keloids	☐	☐
Atopic dermatitis	☐	☐	Liver disease	☐	☐
Autoimmune	☐	☐	Lung disease	☐	☐
Explain: _____			Multiple sclerosis	☐	☐
Bleeding disorder	☐	☐	Psoriasis	☐	☐
Clotting disorder	☐	☐	Radiation treatment	☐	☐
Cancer	☐	☐	Rosacea	☐	☐
Explain: _____			Thyroid disorder	☐	☐
Crohn's/Colitis	☐	☐	Transplant	☐	☐
Celiac Disease	☐	☐	*Other including Surgeries* _____		
Diabetes	☐	☐			

SKIN CANCER HISTORY

Condition	Yes	No
Have you seen a dermatologist before?	☐	☐
Have you had an atypical mole removed before?	☐	☐
Have you ever had a skin cancer?	☐	☐

Type (basal cell, squamous cell, melanoma, etc), location on skin and date of diagnosis:

_____

_____

_____

Have you ever had a melanoma?	☐	☐
Have you had actinic keratoses/pre-cancers?	☐	☐
Do you have a first degree relative with melanoma?	☐	☐
Do you have a history of blistering sunburns?	☐	☐
Do you have a history of tanning bed use?	☐	☐
Do you use sunscreen? If yes, SPF_____	☐	☐

OTHER MEDICAL HISTORY

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

Rhode Island
Dermatology Institute

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

Name: _____Age: _____DOB: _____/_____/_____ Date: _____

MEDICATIONS: Include supplements, IUD, patches, etc

_____
_____
_____
_____
_____
_____

ALLERGIES TO MEDICATION: List type of reaction

_____
_____
_____
_____
_____
_____

OTHER ALLERGIES (Please check all that apply.):

Allergen	Yes	No
Latex	☐	☐
Neomycin/Neosporin	☐	☐
Adhesive	☐	☐

Allergen	Yes	No
Nickel	☐	☐
Lidocaine	☐	☐

Other _____

SOCIAL HISTORY

Occupation:_____
Hobbies:_____
Recreational drug use? Yes No
If yes, provide details: _____
Drink alcohol? Yes No
How many drinks per week? _____
Smoke tobacco? Yes No
How many packs per day? _____

FAMILY PLANNING (females only):

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

Other important medical information:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Rhode Island
Dermatology Institute

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

Medicare Opt Out Agreement

This agreement ("Agreement") is entered into by and between Rhode Island Dermatology, Inc., a Rhode Island professional corporation, owned and operated by Caroline A. Chang, MD, (the "Physician"), whose principal medical office is located at 5586 Post Road, Suite 6, East Greenwich, RI 02818 and _____, a beneficiary enrolled in Medicare Part B ("Beneficiary"), who resides at _____.

Introduction

The Balanced Budget Act of 1997 allows physicians to "opt out" of Medicare and enter into private contracts with patients who are Medicare beneficiaries. In order to opt out, physicians are required to file an affidavit with each Medicare carrier that has jurisdiction over claims that they have filed (or that would have jurisdiction over claims had the physicians not opted out of Medicare). In essence, the physician must agree not to submit any Medicare claims nor receive any payment from Medicare for items or services provided to any Medicare beneficiary for two years. This Agreement between Beneficiary and Physician is intended to be the contract physicians are required to have with Medicare beneficiaries when physicians opt-out of Medicare. This Agreement is limited to the financial agreement between Physician and Beneficiary and is not intended to obligate either party to a specific course or duration of treatment.

Physician Responsibilities

(1) Physician agrees to provide Beneficiary such treatment as may be mutually agreed upon and at mutually agreed upon fees.

(2) Physician agrees not to submit any claims under the Medicare program for any items or services, even if such items or services are otherwise covered by Medicare.

(3) Physician agrees not to execute this contract at a time when Beneficiary is facing an emergency or urgent healthcare situation.

(4) Physician agrees to provide Beneficiary with a signed copy of this document before items or services are furnished to Beneficiary under its terms. Physician also agrees to retain a copy of this document for the duration of the opt-out period.

(5) Physician agrees to submit copies of this contract to the Centers for Medicare and Medicaid Services (CMS) upon the request of CMS.

Beneficiary Responsibilities

(1) Beneficiary agrees to pay for all items or services furnished by Physician and understands that no reimbursement will be provided under the Medicare program for such items or services.

(2) Beneficiary understands that no limits under the Medicare program apply to amounts that may be charged by Physician for such items or services.

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

(3) Beneficiary agrees not to submit a claim to Medicare and not to ask Physician to submit a claim to Medicare.

(4) Beneficiary understands that Medicare payment will not be made for any items or services furnished by Physician that otherwise would have been covered by Medicare if there were no private contract and a proper Medicare claim had been submitted.

(5) Beneficiary understands that Beneficiary has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and that Beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered items and services furnished by other physicians or practitioners who have not opted out of Medicare.

(6) Beneficiary understands that Medigap plans (under section 1882 of the Social Security Act) do not, and other supplemental insurance plans may elect not to, make payments for such items and services not paid for by Medicare.

(7) Beneficiary understands that CMS has the right to obtain copies of this contract upon request.

Medicare Exclusion Status of Physician

Beneficiary understands that Physician has not been excluded from participation under the Medicare program under section 1128, 1156, 1892, or any other sections of the Social Security Act.

Duration of the Contract

This contract becomes effective on _____, 20___, and will continue in effect for one calendar year. Either party may terminate treatment with reasonable notice to the other party. Notwithstanding this right to terminate treatment, both Physician and Beneficiary agree that the obligation not to pursue Medicare reimbursement for items and services provided under this contract will survive this contract.

Successors and Assigns

The parties agree that this agreement will be fully binding on their heirs, successors, and assigns. Physician and Beneficiary intend to be legally bound by signing this agreement on the date set forth below.

Executed on ___/____/___ by:

Rhode Island Dermatology Institute By: _____
Caroline A. Chang, MD

_____ _____
Name of Beneficiary (printed) Signature of Beneficiary

Rhode Island
Dermatology Institute

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

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 Caroline A. Chang, MD. I 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 understand that Dr. Chang may, or will have a need to, take, use, and disclose photographs and video of me, in electronic or digital form or otherwise (hereinafter, "media") that constitutes Protected Health Information and represent stages of my treatment by Dr. Chang.

General Consent and Authorization:

I hereby consent to and authorize Dr. Chang to take, use and disclose such media to patients, prospective patients, and such other individuals as may be necessary for marketing and educational purposes, without further limitation and for such period of time as my be determined in the discretion by Dr. Chang, including after the completion of my treatment. 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. Chang.

_____ _____
Print Name DOB

_____ _____
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

Rhode Island
Dermatology Institute

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

PRIVACY NOTICE

Although Rhode Island Dermatology Institute is not subject to the Health Insurance Portability and Accountability Act (HIPAA), we nevertheless choose to provide privacy rights similar to those you expect from your other medical providers and remain subject to all applicable Rhode Island laws as well. 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	Your Choices	Our Uses and Disclosures
You have the right to: ✓ Get a copy of your paper 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	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 ✓ Market our services and sell your information ✓ Raise funds	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, and other government requests ✓ Respond to lawsuits and legal actions

BY SIGNING THIS FORM, I ACKNOWLEDGE THAT I UNDERSTAND AND AGREE TO THE PRACTICE'S USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION AND THAT I MUST PROVIDE WRITTEN AUTHORIZATION FOR RELEASE OF MY PHI AS SET FORTH WITHIN THIS NOTICE. ADDITIONALLY, I UNDERSTAND AND ACKNOWLEDGE THAT AUTHORIZED PERSONS OR ENTITIES THAT RECEIVE PHI INFORMATION MAY NOT BE A HEALTH CARE PROVIDER, HEALTH PLAN, OR OTHER ENTITY COVERED BY THE FEDERAL PRIVACY REGULATIONS, AND THAT THE INFORMATION DESCRIBED ABOVE MAY BE RE-DISCLOSED AND NO LONGER PROTECTED BY THESE REGULATIONS

_____ _____
Print Name DOB

_____ _____
Signature Date

_____ _____
Parent/Guardian OR Personal representative Signature Date

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

YOUR RIGHTS

When it comes to your health information, you have certain rights. You have a right to:

Get a 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. 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.
- 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.

5586 Post Road #6, East Greenwich, RI 02818
(p) 401-398-2500 (f) 401-398-2599
riderminstitute@gmail.com
http://riderminstitute.com

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

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OUR USES AND DISCLOSURES

How do we typically use or share your health information?

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.

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

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 of it.
- 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. Let us know in writing if you change your mind.

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.
Effective date: August 15, 2018
For more information, contact Dr. Caroline Chang at riderminstitute@gmail.com or 401-398-2500.