Patient Medical History

Patient Name:______________________________ Date:__________
Home Phone:______________________________ Date of Birth:__________
Cell Phone:______________________________ Age:__________
Work Phone:______________________________
Preferred Pharmacy:______________________ Pharmacy Phone:__________
Pharmacy Address:______________________________
Primary Care Physician:______________________ Phone:__________
Primary Care Physician Address:______________________________
Current Medications, Vitamins, Supplements:______________________________
____
Medical Allergies:______________________________
Reason for Today's Visit:______________________________

Past Skin History

1. History of Skin Cancer (which type): ______________________
2. Family History of Skin Cancer (which type):______________________
3. Prior History of Tanning Bed Use:______________________
4. History of Blistering Sunburns:______________________
5. History of X-Ray Treatment:______________________
6. History of Transplant:______________________
7. Were you ever a Lifeguard/worked outside?______________________
8. Have you ever seen a Dermatologist before and was anything removed?__________
____
9. History of Eczema as a Child:______________________
10. History of Cold Sores/Herpes:______________________
11. History of Warts:______________________
12. Do you use Sunscreen regularly?______________________
13. Are you allergic to Latex?______________________
14. Have you had any problems with Anesthetic at the Dentist office?__________

Medical History (Current/Past Problems)

			If yes, please explain:
Skin Cancer	Yes	No	
Cancer & Type (Other than Skin Cancer)	Yes	No	
Eyes	Yes	No	
Ear, Nose, Throat, Mouth	Yes	No	
Heart	Yes	No	
Stomach/Bowel	Yes	No	
Kidneys	Yes	No	
Arthritis, Muscle, Joints	Yes	No	
Skin	Yes	No	

Headaches, Seizures	Yes	No	
Psychological Disorders	Yes	No	
Thyroid/Diabetes	Yes	No	
Blood/Bleeding Disorder	Yes	No	
Allergy/Immunologic	Yes	No	
High Cholesterol	Yes	No	
Asthma/Hayfever	Yes	No	
Hepatitis	Yes	No	
HIV/AIDS	Yes	No	
Are you pregnant?	Yes	No	
Planning to become pregnant?	Yes	No	
Nursing or Breastfeeding?	Yes	No	

Family History

Mother: Living/Deceased Age:________ Cause of Death:________________

Father: Living/Deceased Age:________ Cause of Death:________________

Number of Children:________ Age(s):____________

Allergies/Hayfever	Mother	Father	Child	Other (Whom)
Arthritis	Mother	Father	Child	Other (Whom)
Cancer & Type (Other than Skin Cancer)	Mother	Father	Child	Other (Whom)
Diabetes	Mother	Father	Child	Other (Whom)
Eczema	Mother	Father	Child	Other (Whom)
Heart Disease	Mother	Father	Child	Other (Whom)
High Blood Pressure	Mother	Father	Child	Other (Whom)
Lung Disease	Mother	Father	Child	Other (Whom)
Psoriasis	Mother	Father	Child	Other (Whom)
Skin Cancer- Melanoma	Mother	Father	Child	Other (Whom)
Skin Cancer- Basal Cell Carcinoma	Mother	Father	Child	Other (Whom)
Skin Cancer- Squamous Cell Carcinoma	Mother	Father	Child	Other (Whom)
Tuberculosis	Mother	Father	Child	Other (Whom)
Hepatitis	Mother	Father	Child	Other (Whom)
HIV/AIDS	Mother	Father	Child	Other (Whom)

Social History

Occupation:____

History of cigarette smoking: Now:________ In the past:________ How much?________

Do you drink alcohol? Yes/No Frequency:____________________

Do you live alone? Yes/No

Hobbies/Leisure Activities:________________________________

Reviewed:______________________________ Date:____________ Update:____________

William Sawchuk, M.D.

Insurance Information

A) We accept

1) Medicare part B.
2) BCBS PPO

- **Medicare:** Your card must say Medicare part B:Medical. We accept plans that have both part A and B, as well as plans with part B only.
    - **Medicare Advantage plans:** We accept all Medicare Advantage Plans.
- **BCBS PPO:** We accept all BCBS PPO plans. Most cards will state whether or not you have a PPO plan. If you are uncertain as to whether or not your plan is a PPO, please contact your insurance company.
    - **Carefirst BCBS:** We are preferred providers. This means the insurance company will cover 100% of the visit as long as your deductible is met.
    - **Anthem BCBS:** we are participants. This means the insurance company will usually cover 80% of the visit as long as deductible is met.

B) We File Out Of Courtesy With:

1) Geha
2) Tricare

- Geha and Tricare: We file out of courtesy with these insurance companies. It is up to each individual plan how much of the visit will be covered. Any portion not covered will be the patient's responsibility.

C) Under no circumstances do we accept medicaid insurance.

I have read and understand the insurance information stated above and acknowledge that i will be legally responsible for any payments due for services rendered.

______________________________ ____________________

Patient's Signature Date

NOTICE OF PRIVACY PRACTICES

WILLIAM SAWCHUK, MD

8320 Old Courthouse Rd, Suite 303
Vienna, VA 22182
Phone: (703) 532-7211 Fax: (703) 534-2874

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.

This notice takes effect on **SEPTEMBER 23, 2013** and remains in effect until we replace it.

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. We need to maintain a record of your services at our office in order to provide you with quality care and to comply with certain legal requirements.

LAW REQUIRES US TO:

1. Keep your medical information private.
2. Give you this notice describing our legal duties, privacy policies, and your rights regarding your medical information.
3. Follow the terms of the current notice.

WE HAVE THE RIGHT TO:

1. Change our privacy practices and the terms of this notice at any time, provided that the changes are permitted by law.

USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

We will not use or disclose your medical information for any purpose not listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by writing to us at the address provided at the top of this notice.

FOR TREATMENT: We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or other people who are taking care of you. We may also share medical information about you with your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes. A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include your medical information.

FOR DATA BREACH NOTIFICATION PURPOSES: We may use your medical information to provide legally required notices of unauthorized acquisition, access, or disclosure of your health information due to a breach.

FOR HEALTHCARE OPERATIONS: We may use and disclose your medical information for our healthcare operations. This might include measuring and improving quality, evaluating the performance of employees conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

HEALTH OVERSIGHT ACTIVITIES: We may disclose medical information to an agency providing health oversight for oversight activities authorized by law: including audits; civil, administrative, or criminal investigations; proceedings; inspections; licensure; disciplinary actions; or other authorized activities.

LAW ENFORCEMENT: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as the reporting of certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of a law enforcement official, reports regarding suspected victims of crimes at the request of a law enforcement official, reporting death, crimes on our premises, and crimes in emergencies.

APPOINTMENT REMINDERS: We may use and disclose medical information for purposes of sending you appointment postcards or otherwise reminding you of your appointments.

MEDICAL PHOTOGRAPHY: Due to the nature of dermatological practice we may require medical photographs to aid in your treatment. These photographs will be combined with your medical records and are subject to the same constraints as your other medical information. They will not be used for marketing, shared with the public, or disclosed to any third party not directly involved in the coordination of your medical care.

WITH MY CONSENT... William Sawchuk, MD, may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out treatment, payment, and healthcare operations. This includes any call pertaining to my clinical care, including laboratory results, among others.

WITH MY CONSENT... William Sawchuk, MD, may mail to my home or other designated location any items that assist the practice in carrying out treatment, payment, or healthcare operations, as long as they are marked Personal and Confidential. These items include appointment reminder cards and patient statements. You have the right to request restrictions on how the practice uses and discloses your medical information. The practice is not required to agree to your requested restrictions, but if it does, it is bound by this agreement.

YOU HAVE A RIGHT TO...

1. Look at or get copies of certain parts of your medical information. You may request that we provide copies in a format other than photocopies. You must make your requests for medical records in writing. You may make a request by using the form our office provides to request access. You may also request access by sending a letter to our practice. If you request copies, we will charge you **$0.50** for each page, as well as charge for the postage if you want the copies mailed to you.
2. Request that we communicate with you about your medical information by different means or to different locations. This request must be made in writing.

If you have questions about this notice or if you think that your privacy rights have been violated, please contact us.

By signing this form, I am consenting to the use and disclosure of my personal health information by William Sawchuk, MD in order to carry out treatment, payment, and healthcare operations. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, William Sawchuk, MD, may decline to provide treatment to me.

I have received this Notice of Privacy Practices and I have been provided an opportunity to review it.

______________________________	______________
Signature of Patient/Legal Guardian	**Date**
______________________________	______________
Printed Name of Patient	**Patient's DOB**

____

Printed Name of Legal Guardian (if applicable)

WILLIAM SAWCHUK, M.D.
8320 Old Courthouse Rd., Suite 303
Vienna, VA 22182
Telephone: (703) 532-7211
Fax: (703) 534-2874

NAME	☐ F ☐ M	BIRTHDATE	PAGE

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone ____________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Work Telephone ____________________
- ☐ O.K. to leave message with detailed information
- ☐ Leave message with call-back number only

☐ Written Communication
- ☐ O.K. to mail to my home address
- ☐ O.K. to mail to my work/office address
- ☐ O.K. to fax to this number ____________

☐ Other ____________________
____

____________________ Patient Signature ____________________ Date

PATIENT MESSAGE AUTHORIZATION

Dear Patient,

As a part of the HIPAA regulations, we are required by law to have documentation of any designated relative or friend that you authorize our office to communicate with concerning your PHI (protected health information). Please be advised that it is your responsibility to keep the practice informed of any changes to this information.

Thank you for your cooperation as we continue to respect your Privacy Rights.

Name	Address	Telephone #	Relationship
1.			
2.			

☐ I DO NOT WISH TO HAVE MY PHI DISCLOSED TO ANYONE OTHER THAN MYSELF.

PRINT NAME ____________________

SIGNATURE ____________________ DATE ____________

Patient Name: ______________________________
DOB: ____/____/____

Encounter Date: ____/____/____

Medication Record

It is important to our physicians that each of our patients update medications at each visit in order to prevent drug interactions, ensure patient safety and deliver quality care. We kindly ask all patients to list all medications. Always include over-the-counter, herbals and vitamins/mineral/dietary supplements. Please also list your drug allergies on the line below.

The clinical assistant will use the shaded area to review your medications with you for the next seven visits.

Drug Allergies: ______________________________

				Shaded Area for Office Use Only						
			Appointment Date:							
Medications (Prescription, Over-the-Counters, Herbals, Vitamin/Mineral/Dietary Supplements)	Dose	Frequency (Ex. 2x/Day)	Route (Ex. Injection, By Mouth, Patch, etc.)	Is the patient currently taking these medications?						
				(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)	(Y/N)

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NO SHOW POLICY

Dear Sir or Madam:

We realize that your time is valuable and hope that you realize the time of our doctors and our staff is valuable as well. If you are unable to keep your scheduled appointment with Dr. William Sawchuk, we request that you provide us notification at least two full business days (no less than 48 hours) in advance, so that we may provide an opportunity for another patient to seek our dermatological services. If you do not notify us of your intent to cancel a scheduled appointment at least 48 hours prior, then you will be responsible for an out-of-pocket cancellation fee of **$100 for Surgical Appointments and $50 for all other appointment types.**

For example, if your appointment falls on a Monday at 10 am, we must have your notification of intent to cancel this appointment no later than 10 am on the Thursday prior to the appointment. If your appointment falls on a Tuesday at 2 pm, we must have notification of intent to cancel by no later than 2 pm on the Friday prior to the appointment. If Monday is a holiday then notification of cancellation for a Tuesday appointment must be made by 2 pm the prior Thursday.

These fees must be paid in full within ten business days upon receipt of our bill.

We realize that extenuating circumstances do occur and the final decision to assess for this fee is left to the discretion of the doctor.

Sincerely,
William Sawchuk, M.D.

I have read the above policy and agree to its terms and acknowledge that I will be legally responsible for the prompt payment of the assessed fee.

______________________________________ _______________

Patient's Signature Date