UPS
UNION PHYSICIAN SERVICES
UPS Dermatology

420 James St. Suite D
Dover, Ohio 44622
Phone: (330) 365-9825

Dear Patient,

We are delighted to welcome you as a patient to UPS Dermatology!
Thank you for choosing our practice as your dermatologist. We will strive to meet your Dermatology needs.

We have enclosed a New Patient packet for you. Please fill it out completely, and bring with you to your first appointment. Along with the packet. bring your most recent insurance cards, driver's license, and current office Co-Pay (which is due at time of visit).

Please arrive 15 minutes early to your appointment. We ask this to ensure that we get you in a room and ready to see the doctor in a timely manner. Please be advised that there is a *No Show fee of $25 for any missed appointment that is not canceled prior to the appointment time*. We ask that you give a 24 hour notice for any cancellations.

If you have any questions leading up to your appointment, or if you need to reschedule, please feel free to contact us at 330-365-9825.

We look forward to meeting you at your upcoming appointment.

Sincerely,
UPS Dermatology Staff

UNION PHYSICIAN SERVICES

UPS Dermatology

Lindsey Moore, MD

420 James Street, Suite D,
Dover OH 44622
Phone 330.365.9825
Fax 330.364.3282

PATIENT INFORMATION

Last Name: First Name: MI:	Marital Status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced	Spouse's Name: Spouse's Date of Birth:
Home Address: City: State: Zip:		Home Phone:
Date of Birth:	Age:	Sex: ☐ Male ☐ Female
Social Security #:	Home Email Address	Cell Phone:
Employer:	Employer Phone:	Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other
Race: ☐ African American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other		
Family Physician:	Referring Physician Phone:	Primary Language if other than English

PRIMARY INSURANCE

Insurance Company:	Policy #:	Group #:
Policyholder's Name:	Social Security #:	Date of Birth:
Address if Different from Patient:	City, State, Zip	Phone:

SECONDARY INSURANCE

Is patient covered by additional insurance: ☐ Yes ☐ No

Insurance Company:	Policy #:	Group #:
Policyholder's Name:	Social Security #:	Date of Birth:
Address if Different from Patient:	City, State, Zip	Phone:

INJURY INFORMATION

Affected/injured Body Part:	Side of Body: ☐ Right ☐ Left	
Work Related Accident: ☐ Yes ☐ No	Automobile Accident: ☐ Yes ☐ No	Date of Injury: Time of Day ☐ AM or ☐ PM
Describe how the Injury occurred:		

EMERGENCY CONTACT

Name of person to contact in case of emergency:	Phone:	Relationship:

RELEASE OF INFORMATION

Name(s) to whom we may release info:	Phone:	Relationship:
Name(s) to whom we may release info:	Phone:	Relationship:

ASSIGNMENT AND RELEASE OF BENEFITS

I authorize the release of any medical other information necessary to process any claims for medical services provided to me by my physician under Union Physician Services, LLC. I hereby authorize payment of medical benefits from my insurance company directly to my physician under Union Physician Services, LLC.

Print Name _____ Signature _____ Date _____

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Patient: _____ **DOB:** _____ **Account #:** _____

Height: _____ Weight: _____ ☐ Male ☐ Female

Referring Doctor: _____ Family Doctor: _____

Patient Medical History:

- ☐ Heart Disease
- ☐ Heart Attack
- ☐ Arrhythmia
- ☐ Congestive Heart Failure
- ☐ High Blood Pressure
- ☐ Stroke
- ☐ Diabetes
- ☐ Cancer/Type: _____
- ☐ Lung Disease
- ☐ Asthma
- ☐ COPD
- ☐ Sleep Apnea
- ☐ Kidney Disease
- ☐ Kidney Failure
- ☐ Bladder Infection
- ☐ Liver Disease
- ☐ Hepatitis
- ☐ Cirrhosis/Liver
- ☐ Phlebitis
- ☐ Anemia
- ☐ Blood Clots
- ☐ Bleeding
- ☐ AIDS
- ☐ Thyroid Disease
- ☐ Seizures
- ☐ Osteoporosis
- ☐ Gout
- ☐ Stomach Ulcers
- ☐ Arthritis
- ☐ Rheumatoid Arthritis

☐ Skin Cancer/Type: _____ Treatment Date: _____
☐ Serious Injury: _____
☐ Other: _____

Surgical History. Please mark if you have any of the following:

- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Heart Valve Replacement
- ☐ Joint Replacement

Problems with Anesthesia? ☐ Yes ☐ No Describe: _____

Family History of Skin Cancer:

- ☐ Father/Type of Cancer: _____
- ☐ Mother/Type of Cancer: _____
- ☐ Brother/Type of Cancer: _____
- ☐ Sister/Type of Cancer: _____
- ☐ Son/Type of Cancer: _____
- ☐ Daughter/Type of Cancer: _____
- ☐ Other: _____

Patient Social History:

☐ Married ☐ Single ☐ Widowed ☐ Divorced
Do you live alone? ☐ Yes ☐ No If no, who do you live with: _____
_____ # of Children Do you exercise regularly? ☐ Yes ☐ No Describe: _____
Are you planning a pregnancy ☐ Yes ☐ No
Contraception Method: _____

Social History:

Tobacco use:

- ☐ Current smoker _____PPD _____# Cigars
- ☐ Former smoker _____Date Stopped
- ☐ Smokeless tobacco
- ☐ Never smoked

Alcohol Consumption: ☐ yes ☐ no

Recreational drug use: ☐ yes ☐ no
Type _____

Medications:

Allergies to Medications: ☐ None ☐ Yes, list: _____
Latex Allergy/Sensitivity? ☐ No ☐ Yes
Metal Allergy? ☐ No ☐ Yes

Pharmacy: _____

Medication	Dosage	How many times taken daily

Patient /Guardian Signature: _____ Date: _____

Physician Reviewed: Initials: _____

UPS
UNION PHYSICIAN SERVICES

Financial Policy

I am pleased to provide your family's health care needs. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy which you need to read and sign.

All patients or their legal representative shall complete an Information and Insurance form before seeing the doctor.

- *Full payment is due at the time of service.*
- *Co-payments are due at the time of service.*
- *Known coinsurance amounts are due at the time of service.*
- *We accept cash, checks, and credit cards. Returned checks will be subject to a $25.00 fee.*
- *Auto accident claims are your responsibility, payment is due at the time of service.*

REGARDING INSURANCE:

Presenting correct insurance information at the time of service is the patients/guarantor's responsibility. Failure to produce verification of guarantor insurance information will result in a patient status of "self pay" and payment will be due at the time of service.

Your insurance coverage is a contract between you and your insurance company. The Physician office is not a party to that contract. Not all service provided to you by the Physician office may be considered covered by your insurance company. It is your responsibility to know what service is covered under your policy and to check with your insurance company to verify whether the service to be provided is covered. As a standard procedure, the Physician office will bill your insurance company for the service rendered. The Physician office will attempt to identify and inform the patient when it becomes aware of non-covered services.

_____ Initials — I agree that, should the service not be covered or paid by my insurance company, I will be responsible for payment of the amount billed by the Physician office for the service rendered.

USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

MINOR PATIENTS:

The adult accompanying a minor is responsible for full payment at the time of service.

MISSED APPOINTMENTS:

As a courtesy to our other patients please contact the office with a 24 hour notice if you need to cancel an appointment. ***A fee of $25.00 will be entered to your account for each occurrence of "No Call - No Show."*** *If you fail to keep an appointment three times without calling to cancel, you shall be terminated as a patient.*

We understand that temporary financial problems may arise and affect timely payment on your account. Please contact our office promptly for assistance in the management of your account.

HIPAA PRIVACY DISCLOSURE AND USE ACKNOWLEDGEMENT

I acknowledge that I have received a copy or have reviewed the posted HIPAA Privacy Disclosure statement and use of medical information for services rendered to me by physicians under Union Physician Services, LLC.

_____ PRINT NAME

_____ SIGNATURE OF ADULT PATIENT/PARENT OR GUARDIAN

_____ DATE

UNION HOSPITAL

NOTICE OF PRIVACY PRACTICES

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.

The terms of this Notice of Privacy Practices apply to The Union Hospital Association operating as a clinically integrated health care arrangement composed of The Union Hospital Association, The Union Hospital Association Home Health Agency, The Union Hospital Association Medical Staff, and other professionals seeing or treating patients at The Union Hospital Association. The members of this clinically integrated health care arrangement work and practice at The Union Hospital Association in Dover, Ohio, All of the entities and persons listed will share personal health information of our patients as necessary to carry out treatment, payment, and health care operations as permitted by law.

We are required by law to maintain the privacy of our patients' personal health information and to provide patients with notice of our legal duties and privacy practices with respect to your personal health information and to notify you in the unlikely event of a breach or unauthorized disclosure of your personal health information. We are required to abide by the terms ofthis Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all personal health information maintained by us. You may receive a copy of any revised notices in the Development and Community Relations Department or a copy may be obtained by mailing a request to The Union Hospital Association, Attn: Director, Development and Community Relations, 659 Boulevard, Dover, Ohio, 44622.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

Your Authorization. Except as outlined below, we will not use or disclose your personal health information for any purpose unless you have signed a form authorizing the use or disclosure. You have the right to revoke that authorization in writing unless we have taken any action in reliance on the authorization. There are certain uses and disclosures of your personal health information for which we will always obtain a prior authorization and these include:

- **Marketing communications,** unless the communication is made directly to you in person, is simply a promotional gift of nominal value, is a prescription refill reminder, general health or wellness information, or a communication about health related products or services that we offer or that are directly related to your treatment.
- **Most sales** of your health information unless for treatment or payment purposes or as required by law.
- **Psychotherapy notes** unless otherwise permitted or required by law.

Uses and Disclosures for Treatment. We will make uses and disclosures of your personal health information as necessary for your treatment. For instance, doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to plan a course of treatment for you that may include procedures, medications, tests, etc. We may also release your personal health information to another health care facility or professional who is not affiliated with our organization but who is or will be providing treatment to you. For instance, if, after you leave the hospital, you are going to receive home health care, we may release your personal health information to that home health care agency so that a plan of care can be prepared for you.

Uses and Disclosures for Payment. We will make uses and disclosures of your personal health information as necessary for the payment purposes of those health professionals and facilities that have treated you or provided services to you. For instance, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you or we may use your information to prepare a bill to send to you or to the person responsible for your payment.

Uses and Disclosures for Health Care Operations. We will use and disclose your personal health information as necessary, and as permitted by law, for our health care operations, which include clinical improvement, professional utilization and peer review, business management, accreditation and licensing, conducting training programs in which students, trainees, or practitioners in areas of health care learn under supervision to improve their skills as health care providers, etc. For instance, we may use and disclose your personal health information for purposes of improving the clinical treatment and care of our patients. We may also disclose your personal health information to another health care facility, health care professional, or health plan for such things as quality assurance and case management, but only if that facility, professional, or plan also has or had a patient relationship with you.

Our Facility Directory. We maintain a facility directory listing the patient name and location. Unless you choose to have your information excluded ("opt-out") from this directory, the information will be disclosed to anyone who requests it by asking for you by name, This information, including your religious affiliation, may also be provided to members of the clergy, You have the right during registration to have your information excluded from this directory,

Family and Friends Involved In Your Care. With your approval, we may from time to time disclose your personal health information to designated family, friends, and others who are involved in your care or in payment of your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation and we determine that a limited disclosure may be in your best interest, we may share limited personal health information with such individuals without your approval. We may also disclose limited personal health information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you.

Business Associates, Certain aspects and components of our services are performed through contracts with outside persons or organizations, such as auditing, accreditation, legal services, etc. At times it may be necessary for us to provide certain of your personal health information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately safeguard the privacy of your information.

Fundraising. We may contact you to donate to a fundraising effort for or on our behalf, You have the right to "opt-out" of receiving fundraising materials/communications and may do so by sending your name and address to The Union Hospital Association, Attn: Director, Development and Community Relations, 659 Boulevard, Dover, Ohio, 44622 together with a statement that you do not wish to receive fundraising materials or communications from us.

Appointments and Services. We may contact you to provide appointment reminders or test results. You have the right to request and we will accommodate reasonable requests by you to receive communications regarding your personal health information from us by alternative means or at alternative locations. For instance, if you wish appointment reminders to not be left on voice mail or sent to a particular address, we will accommodate reasonable requests. You may request such confidential communication in writing and may send your request to The Union Hospital Association, Attn: Manager, Patient Registration and Scheduling, 659 Boulevard, Dover, Ohio, 44622.

Health Products and Services. We may from time to time use your personal health information to communicate with you about health products and services necessary for your treatment, to advise you of new products and services we offer, and to provide general health and wellness information.

Research. In limited circumstances, we may use and disclose your personal health information for research purposes. For example, a research organization may wish to compare outcomes of all patients that received a particular drug and will need to review a series of medical records, In all cases where your specific authorization has not been obtained, your privacy will be protected by strict confidentiality requirements applied by an Institutional Review Board or privacy board which oversees the research or by representations of the researchers that limit their use and disclosure of patient information.

UNION HOSPITAL

NOTICE OF PRIVACY PRACTICES

Other Uses and Disclosures. We are permitted or required by law to make certain other uses and disclosures of your personal health information without your consent or authorization:

- for any purpose required by law,
- for public health activities, such as required reporting of disease, injury, and birth and death, and for required public health investigations;
- as required by law if we suspect child abuse or neglect; we may also release your personal health information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- release immunization records to a student's school but only if parents or guardians (or the student if not a minor) agree either orally or in writing;
- to the Food and Drug Administration if necessary to report adverse events, product defects, or to participate in product recalls;
- to your employer when we have provided health care to you at the request of your employer; in most cases you will receive notice that information is disclosed to your employer;
- if required by law to a government oversight agency conducting audits, investigations, or civil or criminal proceedings;
- if required to do so by a court or administrative ordered subpoena or discovery request; in most cases you will have notice of such release;
- to law enforcement officials as required by law to report wounds and injuries and crimes;
- to coroners and/or funeral directors consistent with law;
- if necessary to arrange an organ or tissue donation from you or a transplant for you;
- for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- in limited instances if we suspect a serious threat to health or safety;
- if you are a member of the military as required by armed forces services; we may also release your personal health information if necessary for national security or intelligence activities;
- to workers' compensation agencies if necessary for your workers' compensation benefit determination;
- genetic information to the Ohio Health Care Data Center; and
- to the state-mandated cancer or tumor registry.

Ohio law requires that we obtain a consent from you in many instances before disclosing the performance or results of an HIV test or diagnoses of AIDS or an AIDS-related condition; before disclosing information about drug or alcohol treatment you may have received in a drug or alcohol treatment program; or before disclosing information about mental health services you may have received. For full information on when such consents may be necessary, you can contact the Health Information Management Department.

RIGHTS THAT YOU HAVE

Access to Your Personal Health Information. You have the right to copy and/or inspect much of the personal health information that we retain on your behalf. All requests for access must be made in writing and signed by you or your representative. We may charge you an amount up to the maximum as permissible under Ohio Law if you request a copy of the information. We may also charge for postage if you request a mailed copy and will charge for preparing a summary of the requested information if you request such summary. You may obtain an access request form from the Health Information Management Department. You have the right to obtain an electronic copy of your health information that exists in an electronic format and you may direct that the copy be transmitted directly to an entity or person designated by you, provided that such designation is clear, conspicuous, and specific with complete name and mailing address or other identifying information, We will charge you a fee for our labor and supplies in preparing your copy of the electronic health information.

Amendments to Your Personal Health Information. You have the right to request in writing that personal health information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary. You may obtain an amendment request form from the Health Information Management Department.

Accounting for Disclosures of Your Personal Health Information. You have the right to receive an accounting of certain disclosures made by us of your personal health information for six years prior to the date of your request. Requests must be made in writing and signed by you or your representative. Accounting request forms are available from the Health Information Management Department. The first accounting in any 12-month period is free; you may be charged a fee for each subsequent accounting you request within the same 12-month period.

Restrictions on Use and Disclosure of Your Personal Health Information. You have the right to request restrictions on certain of our uses and disclosures of your personal health information for treatment, payment, or health care operations. A restriction request form can be obtained from the Health Information Management Department. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate and we retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction to sending such termination notice to The Union Hospital Association, Attn: Director, Information Management, 659 Boulevard, Dover, Ohio, 44622. We will honor any request to restrict disclosures to your health plan if the information to be disclosed pertains solely to a health care item or service for which The Union Hospital Association has been paid in full.

Breach Notification: In the unlikely event that there is a breach or unauthorized release of your personal health information, you will receive notice and information on steps you may take to protect yourself from harm.

Complaints. If you believe your privacy rights have been violated, you can file a complaint with our Director, Risk Management. We request that the complaint be prepared, in writing, and sent to The Union Hospital Association, Attn: Director, Risk Management, 659 Boulevard, Dover, Ohio, 44622. You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington D.C. in writing within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

Acknowledgment of Receipt of Notice. You will be asked to sign an acknowledgment form that you received this Notice of Privacy Practices.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact The Union Hospital Association's Privacy Officer at 330.343.3311 .

As a patient you retain the right to obtain a paper copy of this Notice of Privacy Practices, even if you have requested such copy by e-mail or other electronic means. You may contact Central Registration at 330-364-0814.

EFFECTIVE DATE

This Important Privacy Notice is effective April 14, 2003.

REVISION DATE

This Important Privacy Notice was revised March 19, 2007 and February 03, 2014.