

DERMATOLOGY INC. OF VIRGINIA BEACH

George C. Harr, M.D. Jennifer L. Pike, M.D. Kristyn D. Beck, M.D.
1200 First Colonial Road, Suite 200
Virginia Beach, Virginia 23454
Phone: 757-481-4422 Fax: 757-481-9182

Date: \_\_\_\_\_ Chart: \_\_\_\_\_

Patient Name: \_\_\_\_\_
(PLEASE PUT NAME AS IT APPEARS ON YOUR INSURANCE CARD)

Address: \_\_\_\_\_
(Street) (Apt.) (City) (State) (Zip)

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Marital Status: M W D S

Home Phone: \_\_\_\_\_ Work/Cell #: \_\_\_\_\_ Social Security #: \_\_\_\_\_
(Please circle primary contact number)

Gender: M / F E-mail Address: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Everyone Please Fill Out The Next Section:
If Patient is a Child, Information Pertains to the Parents – If Patient is an Adult, Information Pertains to You.

Person responsible for payment: \_\_\_\_\_

Address if Different than Above: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

Work Phone \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_
(If Different from Above)

Name of Spouse: \_\_\_\_\_ Occupation: \_\_\_\_\_

Spouse's Employer and Address: \_\_\_\_\_

Spouse Social Security #: \_\_\_\_\_ Spouse Date of Birth: \_\_\_\_\_

Primary Insurance Company \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

\*\*\*PLEASE PRESENT ALL
INSURANCE CARDS
ID# \_\_\_\_\_

\*\*\*ARE YOU ELIGIBLE FOR TRICARE FOR LIFE
Y OR N . IF YES, HAVE YOU ACCEPTED THIS
AS YOUR SECONDARY INSURANCE PLAN.

I authorize you to release my medical information (i.e.: Biopsy results), to the following:
\_\_\_\_\_
\_\_\_\_\_

May we leave information on your cell phone? Y / N

PLEASE COMPLETE BACK OF FORM

2019

# DERMATOLOGY INC. OF VIRGINIA BEACH

Name: \_\_\_\_\_

Reason for Visit: \_\_\_\_\_ Duration: \_\_\_\_\_  
(Please be Specific)

Patient Referred By: \_\_\_\_\_ Family Physician: \_\_\_\_\_

## PLEASE CHECK ...THE PROBLEMS THAT APPLY TO YOU:

Do you have to be premedicated prior to dental procedures? \_\_\_\_\_  
Do you have a pacemaker or a defibrillator? \_\_\_\_\_  
Do you have any artificial joint replacement? \_\_\_\_\_

FEMALES: Are you pregnant? \_\_\_\_\_

### PERSONAL HISTORY:

Occupation: \_\_\_\_\_  
\_\_\_\_\_ Smoke Amount \_\_\_\_\_  
\_\_\_\_\_ Blood Transfusion Year \_\_\_\_\_  
\_\_\_\_\_ Tested for AIDS Year and Results \_\_\_\_\_

### MEDICATIONS NOW TAKING (Include over the Counter medications and aspirin)

Type:	Dose:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

### I have ALLERGIES to the following MEDICATIONS:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Have you been diagnosed with:

\_\_\_\_\_ Malignant Melanoma  
\_\_\_\_\_ Other Skin Cancer

### PAST HISTORY:

#### \_\_\_\_\_ MEDICAL PROBLEMS:

_____ Diabetes	
_____ Cancer	Types: _____
_____ Anemia	
_____ Arthritis	
_____ Stomach/Bowel Problems	Types: _____
_____ High Blood Pressure	
_____ Heart Trouble	
_____ Thyroid Problems	
_____ Urinary Problems	
_____ Hepatitis	
_____ Liver Problems	
_____ Neurologic Disorders	Types: _____
_____ Asthma/Lung Disorder	
_____ Lupus or other collagen vascular disease	
_____ High Cholesterol	
_____ Psychological Disorders	
_____ Kidney Disease	

### PREVIOUS SURGERY (List all surgery)

Type:	Date:
_____	_____
_____	_____
_____	_____

### Has anyone in your family been diagnosed with:

\_\_\_\_\_ Malignant Melanoma  
\_\_\_\_\_ Other Skin Cancer

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE... I authorize the release of any medical or other Information necessary to process claims. I also request payment of government benefits either to myself or the party who accepts assignment.

INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the physical or supplier for services rendered.

### AGREEMENT TO BE FINANCIALLY RESPONSIBLE:

I/We, \_\_\_\_\_ (guarantor) agree to be financially responsible for the cost of all medical services rendered to the patient by Dermatology Inc. of Virginia Beach. If payment for these services is not made when requested, I agree to pay, in addition to the physician's fee, all costs of collected the amount due. If this account is turned over to an attorney for collection, the undersigned agrees to pay interest on the unpaid balance at the rate of 1.5% per month (18% per annum) from the date that said monies became due and attorney's fee of thirty-three and one-third percent (33.3%) of the principal amount due and owing when turned over to said attorney for collection. I understand that my insurance will be filed for me a courtesy and that I will be responsible for payment of any amount not paid by the insurance company because of all applicable deductibles, including surgery deductibles, co-insurance, lapse of coverage or cancellation of coverage. If you have insurance coverage with a company with whom we do not participate, you will be asked to pay for the cost of the office visit on the day of service. We will file your insurance claim for you so that you can receive your reimbursement.

\_\_\_\_\_  
(Signature)

\_\_\_\_\_  
(Date)

# DERMATOLOGY INC. OF VIRGINIA BEACH

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Dermatology Inc. Of Virginia Beach (Dermatology Inc.) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent and I have been provided with a copy for my personal records. Dermatology Inc. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology's Privacy Officer at 1200 First Colonial Road, Suite 200, Virginia Beach, VA 23454.

With my consent, Dermatology Inc. may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology Inc. may mail to my house or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right request that Dermatology Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restriction, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dermatology's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology Inc. may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

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## NOTICE OF CONSENT TO HIV BLOOD TESTING

A law was enacted in Virginia in 1989 which authorized health care providers to test their patients for HIV antibodies when the health care provider is ACCIDENTALLY EXPOSED to blood or body fluids in a manner which may transmit the human immunodeficiency virus (HIV). However, you would be informed before any of your blood would be tested for HIV antibodies. The testing would be explained and you would be given the opportunity to ask any questions you might have.

In addition, the event one of our health care providers is exposed to potentially infectious body fluids, permission is hereby granted to test my blood for Hepatitis B and C.

THE EXPENSE IS COVERED BY DERMATOLOGY INC. OF VIRGINIA BEACH. YOU WOULD BE INFORMED PRIOR TO ANY BLOOD TESTING BY THE DOCTOR FOR THE HIV HEPATITIS B AND C ANTIBODIES.

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Patient's Name

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Date