

WELCOME TO THE DERMATOLOGY OFFICE OF  
MAGGIE SPARKS, MD

Below you will find the following new patient / updating forms:

**Patient Information Sheet-**

Please fill out this form as completely and accurately as possible.

**Financial Policy-**

Located on the back of the Patient Information Sheet, this form details our insurance and billing policies. Please read and sign where indicated. Our office participates with Medicare, United Healthcare, and Anthem Blue Cross & Blue Shield, and MedCost. While we do not partner with other insurance companies, we will gladly file with any insurance company, **EXCEPT MEDICAID**, as a courtesy to you. If you do not have insurance or have a nonparticipating insurance, we will collect payment in full for your visit at the time of service.

**Patient Contact Information**

Filling this form out gives or denies us permission to speak with persons, other than you, about your account and medical information.

**Medical History**

Please fill out both pages as completely and accurately as possible.

**HIPAA Form-**

This form makes you aware of your rights under federal HIPAA guidelines. Please read and sign where indicated. Print two copies; one is for you to keep and the other should be returned to our office.

**\*\*Please bring these completed forms, a picture ID, and your medical insurance cards with you when you come in for your first appointment. If you have Medicare, please bring any secondary policy cards, except Medicaid and Passport, with you as well.**

**REMINDERS**

**\*\*All co-payments, deductible, coinsurances, and outstanding balances are due at the time of service. If you have an insurance that we do not participate with, we will collect the full amount of charges for the day's services.**

**\*\*If you cannot keep your appointment, we ask that you try to notify our office at least 24 hours in advance.**

**\*\*If you have any questions about these forms, please call, toll-free, 866-200-9874.**



## FINANCIAL POLICY

### INSURANCE

As a courtesy to our patients, we will file all insurances with the exception of MEDICAID.

**Dr. Sparks does not participate with or file MEDICAID insurance.**

**Dr. Sparks participates with the following insurances:**

- \*Medicare
- \*United Healthcare
- \*Blue Cross Blue Shield
- \*MedCost

*Your copayment will be collected at the time of your visit.*

**If you are insured by a carrier other than those listed above, you should be aware that you will be seen at “out-of-network” benefits.**

- \* We will collect the full amount of the charges at the time of service
- \* Your insurance will be filed on your behalf
- \* When the insurance payment arrives, the payment will be posted, and if a credit balance occurs, you will be issued a refund check promptly for the amount of overpayment.
- \* As a patient being seen “out-of-network”, you may be responsible for a larger portion of your bill because often deductibles and larger co-payments apply.

**It is the responsibility of the patient to know the requirements of their medical insurance policies such as:**

- \* Deductible amounts
- \* Co-payment
- \* Coinsurance amounts
- \* Whether a referral is needed

If a referral is required by your policy, it is the responsibility of the patient (or responsible party) to obtain the referral before the patient arrives for their appointment with Dr. Sparks. Any charges that are denied by your insurance because a referral was not obtained, will become the responsibility of the patient to pay.

### BILLING

**As a courtesy to our patients, Dr. Sparks’ staff will file your insurance for you.**

Once your primary insurance pays, if you have a secondary policy, that insurance will be filed. When we have received payment from all insurances for your visit, you will be billed for any amounts that insurance deems “patient responsibility” (co-payments, deductibles, coinsurance, and noncovered charges).

Our billing office will send you 3 statements.

As soon as our office receives response/payment from your insurance(s), you will be sent your first billing statement for any balances owed by you. You should receive three statements from our office. All balances must be paid in full by the end of the third (3<sup>rd</sup>) billing cycle. Any balances that are left unpaid after the end of the third billing cycle will be automatically forwarded to a collection agency. The patient will be held responsible for the cost of collections and/or for attorney fees incurred in collecting balances owed. These fees will be in addition to the outstanding balance due on medical services.

**Should you have any questions regarding your account, please contact the billing office at our toll free number (866) 200-9874. We will return your call.**

**I understand and agree to comply with the above Financial Policy of Dr. Maggie Sparks. I understand that it is my responsibility to pay all charges not paid by my insurance(s) and for the costs of collecting these balances owed, including collection fees and attorney fees.**

\_\_\_\_\_  
PATIENT NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF RESPONSIBLE PARTY

**PATIENT CONTACT INFORMATION**

Margaret K Sparks, MD

PATIENT NAME \_\_\_\_\_ DATE \_\_\_\_\_

May we leave personal medical information on your answering machine at home or on your cell phone?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If "No" is checked above, how would you like us to contact you regarding appointment reminders, lab results, etc.?

\_\_\_\_\_

Do you give our office permission to discuss your medical information / lab results / account information with family members?

\_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please provide their name, phone # and relationship to you below:

1. Name \_\_\_\_\_ Phone # (day) \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # (evening) \_\_\_\_\_

2. Name \_\_\_\_\_ Phone # (day) \_\_\_\_\_

Relationship \_\_\_\_\_ Phone # (evening) \_\_\_\_\_

In case of emergency, whom should we notify?

Name \_\_\_\_\_

Phone # (day) \_\_\_\_\_

Relationship \_\_\_\_\_

Phone # (evening) \_\_\_\_\_

**MEDICAL HISTORY...NEW/UPDATE**  
*Please fill out both the front and back of this sheet.*

NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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

Are you allergic to any medications?  Yes  No If yes, list reaction (-- rash, hives, nausea, breathing problems, etc.)  
1. \_\_\_\_\_ 2. \_\_\_\_\_

Are you allergic to latex?  Yes  No

Do you have any other known allergies? (If yes, please list) \_\_\_\_\_  
\_\_\_\_\_

**MEDICATIONS CURRENTLY TAKING (include non-prescription) DOSE & HOW OFTEN:**

- |          |          |          |
|----------|----------|----------|
| 1. _____ | 2. _____ | 3. _____ |
| 4. _____ | 5. _____ | 6. _____ |
| 7. _____ | 8. _____ | 9. _____ |

**MAJOR ILLNESS (in yourself) PLEASE CIRCLE:**

Arthritis, Asthma, Abnormal Moles, Anemia, Cancer, Diabetes, Eczema, Hayfever, Hives, Heart Disease, High Blood Pressure, Headaches, High Cholesterol, Melanoma, Psoriasis, Skin Cancer, Stroke, Sinus, Thyroid Disease, Other \_\_\_\_\_

**SURGERIES:** 1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_  
4. \_\_\_\_\_ 5. \_\_\_\_\_ 6. \_\_\_\_\_

**FAMILY HISTORY: (parents, brothers, & sisters) PLEASE CIRCLE:**

Blood relation with Arthritis, Asthma, Abnormal Moles, Cancer, Diabetes, Eczema, Hayfever, Hives, Heart Disease, High Blood Pressure, Headaches, High Cholesterol, Melanoma, Psoriasis, Skin Cancer, Stroke, Sinus, Thyroid Disease, Other \_\_\_\_\_

**SKIN:** When you are exposed to sun do you:  Tan only  Tan & Burn  Burn

**PLEASE ANSWER THE FOLLOWING QUESTIONS:**

Do you use tobacco? <input type="checkbox"/> Yes <input type="checkbox"/> No	Cigarettes / Smokeless	How often? _____
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes _____	drinks per day
Do you use IV drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what? _____	How much? _____
Have you had or have you been exposed to HIV (AIDS)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Have you ever had dental anesthesia (Novacaine)? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any bad reaction?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you bleed easily? <input type="checkbox"/> Yes <input type="checkbox"/> No		
(Women) Are you pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	Due Date: _____	

**SOCIAL HISTORY:**

Married  Divorced  Significant Other  Widow(er)  Single  Student   
Special Diet \_\_\_\_\_ (Diabetic, Low Fat, Low Cholesterol, Low Salt, etc.)  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Completed By:  Patient  
 Medical Assistant \_\_\_\_\_  
INITIALS

\_\_\_\_\_  
Signed by Physician / Physician Assistant Date

\_\_\_\_\_  
Reviewed by Date



# HIPAA Notice of Privacy Practices

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Margaret Sparks, MD  
866-200-9874

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.**

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

## **1. Uses and Disclosures of Protected Health Information**

### **Uses and Disclosures of Protected Health Information**

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

**Treatment:** We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

**Payment:** Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

**Health Operations:** We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of an appointment, to advise you that we have received your lab results, and to obtain additional information (this may be done by phone, postcard, or regular mail).

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law, Public Health issues as required by law, Communicable Disease: Health Oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directors, and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers' Compensation: Inmates: Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

**Other Permitted and Required Uses and Disclosures Will Be Made Only with Your Consent, Authorization or Opportunity to Object unless required by law.**

**You make revoke this authorization,** at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

**Your Rights**

Following is a statement of your rights with respect to your protected health information.

**You have the right to inspect and copy your protected health information.** Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiles in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

**You have the right to request a restriction of your protected health information.** This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If a physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You have the right to use another Healthcare Professional.

**You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,** upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

**You may have the right to have your physician amend your protected health information.** If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

**You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.**

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

**Complaints**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. **We will not retaliate against you for filing a complaint.**

This notice was published and becomes effective on/or before **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at 866-200-9874.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

Signature: \_\_\_\_\_