Soderma Dermatology
General, Surgical & Cosmetic

Welcome to Soderma, General, Surgical & Cosmetic Dermatology. We are a comprehensive dermatology practice, providing a full range of medical, surgical and cosmetic dermatologic services for all skin types. Whether it is treating skin cancer, clearing acne, removing fine lines and wrinkles, or refining uneven skin complexions, our board certified dermatologists, **Dr. Cylburn E. Soden, Sr**. and **Dr. Cylburn E. Soden, Jr.** work individually with each patient to design a personalized treatment plan to help you look and feel your best. At Soderma our entire staff is passionate about providing excellent, compassionate care to all our patients. Soderma looks forward to helping you define, renew and cherish your health and beauty.

For added ease we have made available via www.sodermaskin.com (also by mail by request) our new patient registration forms. This can sometimes be a lengthy process when seeing a new health care provider and we recognize that pertinent information is not always at your fingertips when away from home. So please take some time to review, complete and return the following forms to Soderma Dermatology prior to your appointment via fax or mail. You may also bring your forms into the office directly.

Fax To: Soderma Dermatology (301) 776-0456	**Mail To:** (Proper time allotted for timely receipt) Soderma Dermatology c/o New Patient Registration 13920 Baltimore Avenue Laurel, MD 20707

To better assist you and provide you with an accurate and timely registration process, please review the New Patient Registration Forms checklist below. If you have any questions regarding completing or submitting the following forms please contact us at (301) 776-1094. We all look forward to meeting you and servicing your skin care needs.

SODERMA DERMATOLOGY
PHYSICIANS & STAFF

PATIENT REGISTRATION FORMS CHECKLIST

- ☐ REGISTRATION FORM (1 PAGE)
- ☐ MEDICAL HISTORY FORM (2 PAGES)
- ☐ FINANCIAL RESPONSIBITY FORM (1 PAGE)
- ☐ PRIMARY CARE PHYSICIAN REFERRAL *(Attach if applicable)

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REGISTRATION FORM

DATE _____

NAME_____ DOB _____ F ___/M ____

MARITAL STATUS: Married ____ Divorced ____ Single ____ Widowed ____ Other ____

Race: _____ Preferred Language: _____

DRIVER'S LIC. # _____STATE _____ EMAIL _____

ADDRESS_____

CITY/STATE/ZIP_____

Billing Addresses (If different from above address)

_____

HOME # ( ) _____ MOBILE# ( ) _____

WORK # ( ) _____ OCCUPATION _____

EMERGENCY CONTACT NAME/ PH# _____

REFERRING PHYSICIAN NAME/PH# _____

PHARMACY NAME/PH #/FAX#_____

INSURANCE INFORMATION

PRIMARY INSURANCE CO_____

ID NUMBER_____ GROUP NUMBER_____

SUBSCRIBER'S NAME_____ DOB_____

SUBSCRIBER'S EMPLOYER_____WORK#_____

SUBSCRIBER'S SOC.SEC. #_____ RELATIONSHIP_____

HMO _____ PPO_____ REFERRAL: YES ____/ NO_____ SPECIALIST CO-PAY **$**_____

SECONDARY INSURANCE CO_____

ID NUMBER_____ GROUP NUMBER_____

SUBSCRIBER'S NAME_____ DOB_____

SUBSCRIBER'S EMPLOYER_____ __WORK#_____

SUBSCRIBER'S SOC.SEC. #_____ RELATIONSHIP_____

HMO _____ PPO_____ REFERRAL: YES ____/ NO_____ SPECIALIST CO-PAY **$**_____

I AUTHORIZE AND REQUIRE MY INSURANCE COMPANY TO DISPERSE DIRECTLY TO CYLBURN E. SODEN M.D. P.A. MY INSURANCE BENEFITS. I ALSO AUTHORIZE RELEASE OF MEDICAL INFORMATION THAT MAY BE NECESSARY FOR MEDICAL CARE FOR PROCESSING MY FINANCIAL BENEFITS. I CERTIFY THAT THE INFORMATION I HAVE GIVEN IS CORRECT AND I UNDERSTAND THAT I AM FIANANCIALLY RESPONSIBLE FOR ANY BALANCE NOT COVERED BY MY INSURANCE COMPANY.

_____ _____

SIGNATURE **PRINT NAME**

SODERMA DERMATOLOGY 13920 BALTIMORE AVE., LAUREL, MD 20707
CYLBURN E. SODEN MD
PH: (301) 776-1094 FAX: (301) 776-0456
WWW.SODERMASKIN.COM

Soderma Dermatology
General, Surgical & Cosmetic

Today's Date: _____

Patient Name: _____ DOB _____

Briefly describe the reason for your visit today:

_____

_____

_____

Select any of the following medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ BPH
- ☐ Bone Marrow Transplant
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Other_____

Have you had any surgeries on the following organs?

- ☐ Appendix
- ☐ Bladder
- ☐ Breast
- ☐ Colon
- ☐ Heart: Bypass
- ☐ Heart: Stent
- ☐ Heart: Valve Replacement
- ☐ Heart Transplant
- ☐ Joint Replacement: Knee
- ☐ Joint Replacement: Hip
- ☐ Joint Replacement: Shoulder
- ☐ Kidney
- ☐ Ovaries
- ☐ Prostate
- ☐ Skin: Biopsy
- ☐ Skin: Basal Cell
- ☐ Skin: Squamous Cell
- ☐ Skin: Melanoma
- ☐ Spleen
- ☐ Testicles
- ☐ Uterus

Other_____

Do you currently have any of the following?

- ☐ Pacemaker
- ☐ Defribillator
- ☐ Artificial Joints within past 2 years
- ☐ Premediciation prior to procedures
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotics
- ☐ Blood thinners
- ☐ Allergy to lidocaine
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning pregnancy
- ☐ Problems with scarring
- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Immunosuppression

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Have you had any of the following skin conditions?

□ Acne	□ Eczema	□ Precancerous Moles
□ Actinic Keratoses	□ Flaking or Itchy Scalp	□ Psoriasis
□ Basal Cell Carcinoma	□ Hay Fever/Allergies	□ Squamous Cell Carcinoma
□ Blistering Sunburns	□ Melanoma	
□ Dry Skin	□ Poison Ivy	

Other_____

Do you wear sunscreen? □ Yes □ No

If yes, what SPF? _____

Do you tan in a tanning salon? □ Yes □ No

Do you have any family history of melanoma? □ Yes □ No

If yes, which relatives?

□ Mother	□ Daughter	□ Grandmother
□ Father	□ Son	□ Grandfather
□ Sister	□ Uncle	□ Grandson
□ Brother	□ Aunt	□ Granddaughter
□ Nephew	□ Niece	

Other_____

Please list all current medications you are taking: (please be as detailed as possible)

- **_____ dose _____ frequency _____**
- **_____ dose _____ frequency _____**
- **_____ dose _____ frequency _____**
- **_____ dose _____ frequency _____**
- **_____ dose _____ frequency _____**
- **_____ dose _____ frequency _____**
- ***if necessary attach a separate medication list***

Please list any medication allergies: _____

Do you consume or use any of the following? How Often? (Please be as detailed as possible)

□ Tobacco _____/day, week	□ Drug Use _____/day, week
□ Alcohol _____/day, week	□ IV Drug Use _____/day, week

_____ _____

Signature **Print Name**

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FINANCIAL RESPONSIBILITY POLICY

Thank you for choosing Dr. Cylburn E. Soden for your medical needs. In order for us to provide you with the best possible service we need you to understand your financial responsibility. Please read this document thoroughly.

Co-pays, deductibles, and co-insurances are collected at the time of check-in.

Self-pay patients should be prepared to pay at the time of each visit.

For your convenience, we accept cash, checks and most major credit cards (visa, master card, Discover, and American express). We also accept Care Credit.

Returned checks will have an additional fee of $25 added to the check amount. There will be a one-time service charge of $25 for all outstanding accounts that are not paid within 30 days. Outstanding balances older than 90 days maybe subject to collection. Patients with balances have the option to leave their credit card on file for auto-pay.

Appointment cancellations:
We ask that patients give us a 24 hour notice to cancel an appointment and a 48 hour notice for any surgical or cosmetic procedure. Failure to cancel appointment in a timely manner will result in a $50 “No show” charge for regular appointments and $100 fee for surgical/cosmetic procedures. Patients who leave their credit card on file will be automatically charged for these fees.

Cancellations can be made through our reminder service by text message or email. Appointments may also be cancelled by leaving a voicemail. These services are checked throughout the day or the next business day.

For insured patients, please fill in the blanks below:

My insurance company, _____ / ID# _____ may not cover certain services. I understand that any unpaid charges are my responsibility. I will pay all applicable co-pays, deductibles and outstanding patient balances as they become due. This also applies to secondary insurance policies which may not cover my visit(s).

If you have any questions about your financial responsibility please do not hesitate to ask.

_____	_____	_____
Print name	Signature	Date

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CYLBURN E. SODEN MD
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WWW.SODERMASKIN.COM

CYLBURN E. SODEN, SR., M.D. CYLBURN E. SODEN, JR., M.D M.A.
13920 BALTIMORE AVENUE. LAUREL, MD 20707
PHONE: (301)776-1094 FAX: (301)776-0456

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 READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, and the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this would include referring you to a retina specialist.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also disclose your PHI for law enforcement and other legitimate reasons although we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alterative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if you're unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of September 23, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer for more information, in person or in writing.

This consent was signed by: _____

Print name-Patient or Representative

_____

Signature-Patient or Representative

Relationship to the patient (if other than patient): _____

_____

Date

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