HIPPA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how many we may use and disclose Protected health information about you. The Notice contains a Patient Rights section Describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on you prior Consent. The Practice provides this form to comply with the Health Insurance Portability an Accountability Act of 1996 (HIPPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: ____

Printed Name- Patient or Representative

____________________________/_______/_____

Signature Date

Relationship to Patient
(if other than patient): ____

Witness: ____

Printed Name- Practice Representative

______________________________/______/____

Signature Date

A Message to our patients about Arbitration:

Dear Patient:

The attached contract is an Arbitration Agreement. By signing it, you are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than in court. Lawsuits are something that no one anticipates and everyone hopes to avoid. We believe that resolving disputes by arbitration is one of the fairest systems for both patients and physicians.

By signing this agreement you are changing only the place where your claim will be presented. You may still be represented by an attorney, who may call witnesses and present evidence. Each party selects an Arbitrator, and those arbitrators then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patient and physician. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings.

Our goal, of course, is to provide medical care in such a way as to avoid any such dispute. We know that most problems begin with communication; therefore, if you have any questions about your care, please feel free to ask us.

We appreciate the opportunity to serve you.

Dr. Michael T. Lin
MD Solutions Medical Corporation

Michael T. Lin, MD

Dermatology and Laser Surgery
www.DrMichaelLin.com

Name: ____ **Date:** ____________________

(CC) Reason for Visit: _________________________________
Skin Area Involved: ___________________________________
How long (Time): _____________________________________
Associated Symptoms: 1)_____________________________ -> Severity: 1 2 3 4 5 6 7 8 9 10
(Pain, Itch?) 2)_____________________________ -> Severity: 1 2 3 4 5 6 7 8 9 10
3)_____________________________ -> Severity: 1 2 3 4 5 6 7 8 9 10
Previous Treatments: 1)_____________________________ -> Effectiveness: None Poor Fair Good
2)_____________________________ -> Effectiveness: None Poor Fair Good
Other: ____

Review of Systems:

General Health Status (Circle One):
Poor Fair Good Very Good Excellent

	YES	NO
Acne Problems		
Breathing Difficulties		
Cardiovascular Problems or Chest Symptoms		
Currently Pregnant (Male leave Blank)		
Discoloration		
Dry Skin		
Pacemaker		
Recent Illness		

Past Medical History:

	YES	NO
Diabetes		
Eczema		
Hepatitis C		
HIV/AIDS		
Psoriasis		
Skin Cancer		
Stomach Ulcers		
Tuberculosis		

Describe Conditions *Checked Yes Above* and/or Other Medical Problems (If applicable):

____
____

Past Surgical History (Please Describe) (What year?):

____
____

Family History of Skin Cancer and/or Skin Disease (Please Describe):

____
____

Social History

Do you Use:				
	Alcohol:	Yes	No	Social Mild Moderate Heavy
	Tobacco:	Yes	No	Packs Smoked Per Week: __________
	Illegal Drugs:	Yes	No	Overexposed to the Sun: Yes No

Allergies (Including Allergies to Medications) (Symptoms of allergy?):

____
____

Medications being taken:

____
____

Patient Signature: ____ **Date:** ________________

Assistant Signature: Date: