Amanda Auerbach, M.D.
Christine M.Hayes, M.D.
Helen A.Raynham, M.D., Ph.D.
DERMATOLOGIC SURGEONS

Suzanne K. Freitag, M.D.
OCULOPLASTIC SURGEON

www.dermcare.us

Michael S. Krathen, M.D.
Steven I. Kornbleuth, M.D.
Ma Katrina Dy, M.D.
GENERAL DERMATOLOGISTS

Loreen A. Ali, M.D.
PLASTIC & RECONSTRUCTIVE SURGEON

**Welcome or Welcome Back to our Practice!**

Dear Patient:

Dermcare Physicians and Surgeons is dedicated to providing our patients with the best care available. For your convenience, we have scheduled you for a telephone consultation which will alleviate you having to schedule an in office visit prior to your surgery. Enclosed please find important information that you should review prior to your schedule telephone call.

It will be necessary to provide a photograph of the site of surgery. We have included a tip sheet to help you take your photograph which should be emailed to: photo@dermcare.us

Please arrive 10 minutes prior to your appointment with your completed paperwork.

The packet includes:
Patient Registration & Privacy Form
Patient Gateway Sign up sheet
Tips on how to take a photograph of the site of surgery
The questions you need to be prepared to answer during your call

For more information about our practice, please visit us at www.dermcare.us. Our Website provides detailed information about our physicians and our services.

If your address, phone number or insurance information has changed, please be sure to alert the front office staff.

If for any reason, you are unable to be available for your scheduled telephone consultation appointment, it is imperative that you call us 24 hours in advance to cancel or reschedule so that we can offer your slot to another patient.

If you would like to correspond with our office via email regarding your care and treatment, please sign up to our new Patient Gateway, **www.patientgateway.org**.

We look forward to seeing you!

*The Physicians and Staff of Dermcare Physicians and Surgeons*

*22 Mill Street, Suite 304*
*Arlington, MA 02476*
*P 781.641.4900 F 781.641.4904*

*27 Village Square*
*Chelmsford, MA 01824*
*P 978.244.0060 F 978.244.2522*

*154 East Central Street, 3rd floor*
*Natick, MA 01760*
*P 781.431.0060 F 781.431.0062*

*9 Hope Avenue, Suite 151*
*Waltham, MA 02453*
*P 781.810.9998 F 781.431.0062*

dermcare™ PHYSICIANS & SURGEONS

# GENERAL PATIENT INFORMATION

Patient Name______________________ Preferred name:______________________

Date of Birth__________ SSN__________ Marital Status S M W D

Address ______________________ City__________ State______ Zip______

Check preferred contact method. ❑ Home Phone __________ ❑ Cell Phone __________

Email Address: ______________________ (Email address to be used to communicate health events, practice news, cosmetic specials and events only generated by the practice administrator. Email addresses are kept securely within our practice management system only. )

Primary Care Physician ______________________ Town__________ Phone__________

Specialist physician who referred you __________ Town__________ Phone__________

Your Cardiologist (if seeing one) __________ Town__________ Phone__________

Race: ❑ White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American Language Spoken: __________

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Declined to state ❑ Native Hawaiian or Other Pacific Islander ❑ Declined to state

Employment Status: ❑ Full-time ❑ Part-time ❑ Retired ❑ Student Occupation __________

## MEDICAL EMERGENCY CONTACT INFORMATION

Contact Name______________________ Relationship______________________

Home Phone ______________________ Cell Phone ______________________

## AUTHORIZATION TO BILL INSURANCE

I hereby authorize and request my insurance company to pay Dermcare directly the amount due on my claim for services provided to my dependent or me. I also agree that should the amount be insufficient to cover the entire medical and/or surgical expense, I will be responsible for the payment of the difference and if the service provided is considered a non-covered service; I will be responsible for payment of that service.

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Center for Medicare and Medicaid Services or its intermediaries any information needed for this or related claim. I permit a copy of the authorization to be used in place of the original and request payment or medical services to be made to the party who accepts assignment. I certify that this information is true and correct to the best of my knowledge.

Responsible for the Balance – Although you may have health coverage through another person, all billing/payment information will always be sent directly to you and will be your responsibility. ❑ I have reviewed a copy of the office financial policy which is available at www.dermcare.us.

Patient Signature__________ Print Name__________ Date__________

Guardian Signature__________ Print Name__________ Date__________

## HIPAA PRIVACY INFORMATION - Acknowledgement of Receipt of Notice of Privacy Practices

Privacy notice of the privacy practices at Dermcare available at www.dermcare.us and posted in the office.

I ________ (patient initials) understand that if I email photos or protected health information to this office, Dermcare is only responsible for the content once received in this office and it will become part of your permanent electronic medical record. I also understand that when I leave the practice with my own personal health information such as my visit summary, pre/post operative instructions, etc, it is my responsibility to keep this information private and in safe-keeping.

- We will leave appointment reminders on the preferred contact phone number that you provided at the time of the appointment.

May we leave other medical information on/with?

Home Answering Machine ❑ Yes ❑ No

Cell Phone Voicemail ❑ Yes ❑ No

Automated Appointment/Reminder Calls ❑ Yes ❑ No ❑ Opt out

Patient Signature__________ Date__________

Print Name__________

Guardian Signature__________ Date__________

Print Name__________

Relationship to patient:__________

Form date: 08/02/17

- Authorization to discuss my appointments and Health information with:

Name:__________

Relationship__________

Name:__________

Relationship__________

Name:__________

Relationship__________

❑ I decline to give anyone permission to have access to my medical information

________ (Patient initials) ________ (Guardian initials)

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# Partners Health Care Patient Gateway

www.patientgateway.partners.org

Would you like to sign up for our patient gateway? Yes ____ No ______

Email address ____________________________________________

What does our patient portal do for you???

- You can reach your doctor's office – online
- Stop using the phone for your routine requests
- Request appointments, medicine or referrals
- View lab results
- Ask questions to the doctor, nurse or front desk staff
- Set appointment reminders
- Upload photos to your chart for phone consultation or wound care concerns

**You can access Patient Gateway 24/7 from the convenience of your PC, laptop, cell phone or tablet at your convenience. The MOBILE APP is now available!**

*22 Mill Street, Suite 304*
*Arlington, MA 02476*
*P 781.641.4900 F 781.641.4904*

*27 Village Square*
*Chelmsford, MA 01824*
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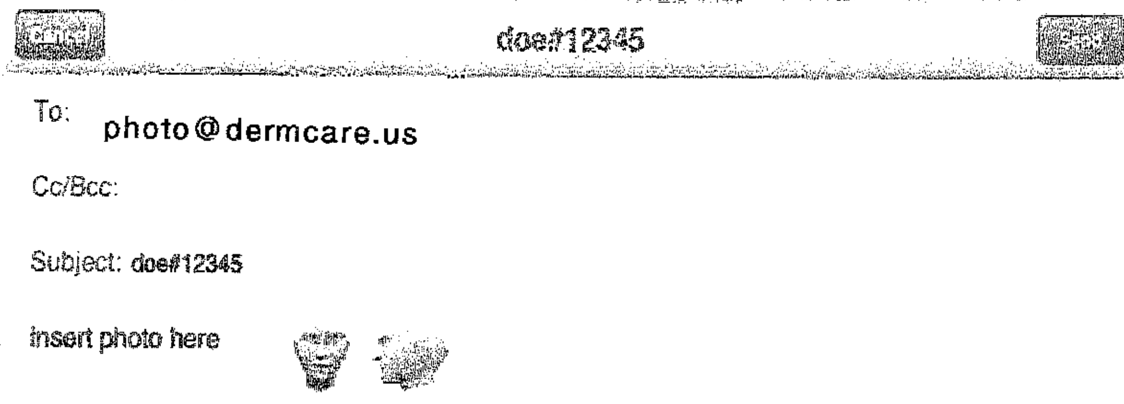
*Waltham, MA 02453*
*P 781.810.9998 F 781.431.0062*

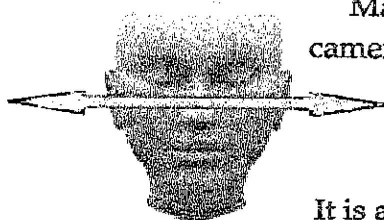
__Please email photo to:__ photo@dermcare.us

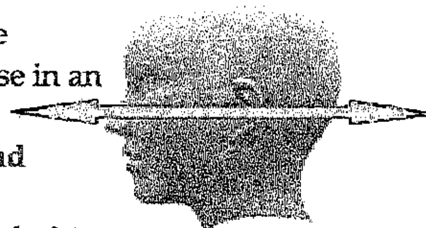
In the SUBJECT line, please include ONLY the first 3 letters of your LAST name and your patient ID #. Your unique patient ID number will be included in the phone consultation packet that we will send to you either by email or regular mail.

Below is an example email sent to us from Mrs. Jane Doe:




## *How do I take the Consult Photo?*



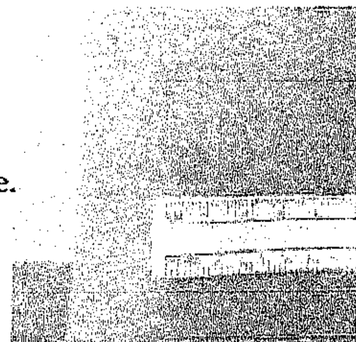


__*HEAD PHOTOS*:__

Make sure your head is straight and facing the camera directly. Ears should be lined up with nose in an imaginary straight line.

**It is important to take both a front view and a side view photo.**

It is also __very important__ to have a **close up** of the lesion next to the ruler found on the right side of this page.



__*OTHER BODY PART PHOTOS:*__

**The size of your lesion is very important to us,** as it will help us determine what treatment is best for you.

Please send us a __close up__ of your lesion, lined up next to the ruler found on the right side of this page.

***Be careful not to cover the lesion with the ruler.***

Please make sure to take a __distant shot__ of the same lesion, as it will help us identify the anatomical location on the day of surgery.

## Patient Telephone Consultation Questions

## Please be prepared to discuss the following information during your telephone consultation

- Site/s to be treated 1)
  2)
  3)
  4)
- Are you able to identify the site/s?
- Did you email photo of biopsy site/s to the office?
- We will review your medication list (prescriptions, over the counter medications, vitamins, and supplements, please include dosages of each)
- We will review your medical history (previous and current health conditions)
- Any new medical conditions that we may need to be aware of since the last time you were seen in our office? If yes, what?
- Do you have any allergies to medications or food?
- What is your current smoking status? Have you ever smoked?
- Do you have a pacemaker/defibrillator?
- Do you take any antibiotics prior to dental work? If yes, why?
- Do you have any family history of skin cancer?

Form date: 10/10/13