Cooper Clinic™
Dermatology
A COOPER AEROBICS COMPANY

DERMATOLOGY MEDICAL HISTORY

Name _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ Zip Code _____

Email Address: _____

Date of Birth _____ Age _____ Sex __ M __ F

As a health care provider, race and ethnicity are required for lab testing and vaccinations. As a Cooper Clinic Dermatology patient, if you do not think you will have either of these services or you do not wish to answer the questions, you may select "Decline."

Race:
- ☐ American Indian or Alaska Native
- ☐ Asian
- ☐ Black or African American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ White
- ☐ Decline
- ☐ Unspecified

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline
- ☐ Unspecified

Do you have other family members who have been treated here? ___ Yes ___ No

How did you find out about our practice? _____

EMERGENCY CONTACT

Name _____ Phone Number _____

FINANCIAL RESPONSIBILITY

Patients are responsible for full payment the day of service. We accept MasterCard, Visa, Discover, American Express, a personal check, debit card or cash. Cooper Clinic **is not contracted** with any insurance companies and our physicians are opted out of Medicare. Your insurance policy is a contract between you and the insurance company. Because Cooper Clinic is preventive in nature, the costs of the procedure may not be covered by insurance. The business office will provide you with the necessary information to file or we can courtesy file for any out-of-network benefits.

CANCELLATION POLICY

When you schedule an appointment with our office, we reserve that time specifically for you. We require at least 24-hour cancellation notice. If we do not receive 24-hour cancellation notice, this will be considered a "No Show" appointment. You will be billed an office visit of $75.00.

LATE ARRIVAL POLICY

If you arrive more than 15 minutes after your scheduled appointment time, you will be required to reschedule your appointment.

AUTHORIZATION

I authorize release of medical records to determine liability for payments, treatment, or to obtain reimbursement.

_____ _____/_____/_____
Signature Date

PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE AS THIS WILL HELP US PROPERLY ADDRESS THE ISSUES IMPORTANT TO YOUR HEALTH:

Please list the purpose of your visit: _____

_____

1. Medical History

Are you currently pregnant? ☐ Yes ☐ No

Are you presently receiving medical treatment for any condition(s)? ☐ Yes ☐ No
(If *yes*, please list below)

Condition	How Long

2. Surgical History

Do you have a history of any surgeries? ☐ Yes ☐ No
(If *yes*, please list below)

Surgery	Date Performed

3. Medications

Do you take any medications on a regular basis? ☐ Yes ☐ No
(Prescription, non-prescription, supplements, etc.)
(If yes, please list below)

Medication (Including strength)	How many times a day	How long taken

4. Allergies

Are you allergic to any medications? (If yes, please list below) ☐ Yes ☐ No

Allergic to: _____

5. Family History

Has any blood relative ever had skin cancer? (If yes, please list below) ☐ Yes ☐ No

_____

6. Smoking

Have you ever smoked? ☐ Yes ☐ No

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Demographic Information Verification

I authorize Cooper Clinic to contact me at the address, phone and email shown below to send me medical information. I verify this is the correct information. Failure to indicate the correct information or an illegible address may result in confidential information going to the wrong person or place.

Full Legal Name: _____
First Middle Last

Nickname or name used: _____ Date of Birth:____/_____/_____

Address*: _____
**We cannot accept P.O. addresses outside of the continental United States.*

City:_____ State: _____ Zip: _____

Phone: _____ _____ _____
Mobile Home Work

Email: _____ Fax: _____

General Consent for Treatment/Consultation

I request and authorize Health Care Services by my physician and his/her designees as deemed advisable. This may include consultations, routine diagnostic, radiology and laboratory procedures, medication administration and retrieval of medication history.

Receipt of Notice of Privacy Practices

I have been given the opportunity to receive a copy of Cooper Clinic's Notice of Privacy Practices.

I understand that the demographic information on this form may be changed in writing at any time by contacting Cooper Clinic.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

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Authorization to Communicate Confidential Information to Specific Individuals

Full Legal Name: _____ Date of Birth: _____/_____/_____

I authorize **Cooper Clinic** to communicate my health information to the individuals listed below at my request. Information may be communicated by fax, mail, telephone and email to me and the individuals listed below (e.g., spouses, relatives, administrative assistants, etc.):

PLEASE PRINT

Individual's Name: _____ **Relationship to Patient:** _____

- ☐ All Information
- ☐ Medical Test Results
- ☐ Non-Medical Information
  - ☐ Appointment Information Only
  - ☐ Appointment & Billing Information

Individual's Name: _____ **Relationship to Patient:** _____

- ☐ All Information
- ☐ Medical Test Results
- ☐ Non-Medical Information
  - ☐ Appointment Information Only
  - ☐ Appointment & Billing Information

Individual's Name: _____ **Relationship to Patient:** _____

- ☐ All Information
- ☐ Medical Test Results
- ☐ Non-Medical Information
  - ☐ Appointment Information Only
  - ☐ Appointment & Billing Information

OR: ☐ Do not communicate with others.

I understand that this authorization may be revoked in writing at any time. I understand that any revocation will not apply to information that has already been released in response to this authorization.

I understand that authorizing the disclosure of this information is voluntary. I understand that Cooper Clinic will not condition payment or treatment based upon this authorization for release of information. I understand that any disclosure of information has the potential for unauthorized re-disclosure, and that the disclosed information may not be protected by federal confidentiality rules.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient

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AUTHORIZATION FOR ONLINE COMMUNICATION

Transactions that are permitted for online communication may include examples such as: prescription refill requests, appointment scheduling, follow-up medical advice, and medical information updates.

INSTRUCTIONS FOR USING ONLINE COMMUNICATION: (1) Please put the category of transaction in the subject line of the message for filtering: prescription, appointment, billing question, medical update, etc. (2) Please put your full name and date of birth in the body of the message. (3)

CONDITIONS FOR USING ONLINE COMMUNICATION: Online communication will be conducted if there was a previously established physician-patient relationship, one that included a face-to-face encounter with a Cooper Clinic physician or health care professional. Nutritional counseling provided to clients via email will be the exception to this condition. All online communication and corresponding responses will be retained and considered part of your medical record at Cooper Clinic.

RESPONSIBILITIES OF THE PATIENT: The information provided online will be concise. When email messages become too lengthy or the correspondence is prolonged, patient will be notified to discuss by phone or to schedule an office visit to come in to discuss in person. If the matter is of an urgent nature, it should be handled as a phone call or 911 should be called if it is a medical emergency.

If the guidelines of this authorization are not adhered to, Cooper Clinic has the right to terminate this authorization.

CONFIDENTIALITY: Any health care professional(s) that may work to coordinate your care (technologists, appointment assistants, dietitians, etc.) may view or access your emailed health information. Your email will not be forwarded to a third party without your authorization (unless involved with your treatment or payment). We will not use your email account for marketing. We will not share your email account with family members without your authorization. Cooper Clinic has safeguards in place such as passwords and automatic logouts, however the **emails are not encrypted or secured**.

CONSENT: I hereby consent to voluntarily engage in online communication with my physician, registered/licensed healthcare provider or healthcare personnel. I have read this consent form or it has been read to me, and I understand the protocol and risks involved. I have had the opportunity to ask questions, which have been answered to my satisfaction. I understand my responsibilities as described above.

_____ _____/_____/_____
Signature of Patient or Legal Representative Date

_____
Email Address

CC Form 3029D (Revised 04/16/2021-la)