martha e. stewart, md, llc
dermatology

martha e. stewart, md
olivia a. gioe, md
harley davis, md

board certified dermatologists

REGISTRATION FORM (please print)

PATIENT

First Name: ______________________Middle: ______________ Last: __________________ Date of Birth: __________

Referred By: ____________________________________ Primary Care Physician (PCP): ___________________________

Email: ____ Name for email: ________________________

Would you like to receive emails about our monthly cosmetic promotions and flash sales? YES or NO

**** To sign up for our monthly email specials visit** us on our website at **www.drmarthastewart.com**

Would you like to learn more about the skin care products and cosmetic procedures that we offer? YES or NO

If **YES,** we offer a complimentary skin care consultation with our aesthetician. Please schedule at the front desk if you are interested.

If you have Medicare:

Have you seen your PCP in the last 6 months? _____ **YES** _____ **NO**

PERMISSION TO DISCUSS INFORMATION

Do you give our office permission to discuss your medical information (i.e. all health information, appointments, your medical condition, treatment, test results, prescriptions) with a family member?

(Please initial one) **YES** ____________ **NO** ____________

❒ If **YES**, please provide the following information:

Name: ____ Relationship:___________________ Phone#:________________

By providing my signature below, I acknowledge that all information I have submitted on this form is correct.

____

Signed By: Patient or Legal Guardian, if a minor Date

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OFFICE POLICIES

BILLING AND INSURANCE: It is your responsibility to know and understand your insurance plan's policies. There are a number of different insurance plans and each one has its own unique reimbursement policies. It is your responsibility to notify us of any special requirements within your plan. We accept most insurance plans and will file all claims, including secondary insurance, to the plans with which we participate.

All co-payments and deductibles are collected at the time of service. If you have not met your deductible, we require that you pay a percentage of the contracted fee amount at the time of service. You will receive a bill for the remaining balance. It is important to understand that most insurance companies consider all procedures (i.e. freezing warts, biopsies, etc.) applicable to your surgery deductible (if you have one). If your insurance company denies your bill, you will be held financially responsible. If you have no insurance or if you are having a cosmetic procedure done, the fees will be collected in full at the time of service. If your insurance changes, it is your responsibility to notify our office at least 24- hours before your appointment to make sure we are a provider. Failure to do so may result in needing to reschedule your appointment and a $35 cancellation fee.

You may receive a separate bill for any laboratory tests or pathology services that Dr. Stewart, Dr. Gioe or Dr. Davis may order.

PAYMENT: We accept the following forms of payment: personal check, cash, MasterCard, Visa, American Express, and Discover.

RETURNED CHECK FEE/COLLECTIONS: There will be a $35.00 charge for all returned checks. If it is necessary to collect unpaid fees for services rendered, you will be responsible for the charges assessed by the collection service, legal counsel, or court.

UNACCOMPANIED MINORS: At all initial visits, minors must be accompanied by a parent or legal guardian. Thereafter, if a minor is attending an appointment without a parent, payment is still expected at the time of service. Please provide written consent for all unattended minors - Parental Permission Form for Minors.

LATE POLICY: Our physicians and staff strive to be on time. In order to help our office run smoothly, we ask that you do the following: If you are running more than 15 minutes late, please call to let us know as we may need to reschedule your appointment.

MISSED APPOINTMENTS: If you need to cancel or reschedule an appointment, we kindly request that you give our office 24-hour notice. If we do not receive 24-hour notice, there will be a cancellation fee billed to the patient or responsible party. This fee will be waived with the first occurrence. Thereafter, the cancellation fees are as follows: $35 for a regular appointment and $75 for all surgery, filler, Botox, or advanced service appointments. Please note: Patients who continually miss their appointments without giving proper notice to our office staff will be discharged from the practice after the third violation.

GIFT CERTIFICATES

- Gift Certificates MUST be present at the time of service.
- Gift Certificates are nonrefundable and nontransferable.
- Gift Certificates can only be used for cosmetic services/procedures.
- Martha E. Stewart, MD, LLC is not responsible for lost or stolen Gift Certificates.
- Gift Certificates are valid for one year from the date of purchase.

HAVE A QUESTION? We request that any medical correspondence, including prescription refill requests, be through our **patient portal**. The portal keeps your personal health information secure and private. You can easily access your portal at the top of our website under "**Patient Portal**." Use your login information that you received at your visit. If you do not have this information please contact our office at 985-727-7701 and one of our staff members can assist you with your login. If you are a new patient you will be given access and login information at your office visit.

I have read and understand the financial policy of the practice and I agree bound by its terms.

____

Signature of Patient or Responsible Party

____

Print Name Date

ACKNOWLEDGEMENT OF RECEIPT OF NONDISCRIMINATION POLICIES AND NOTICE OF PRIVACY PRACTICES
By providing my name below, I hereby acknowledge that I have reviewed the Nondiscrimination Policies and Notice of Privacy Practices, describing the privacy practices and safeguards as well as my rights with respect to my protected health information maintained and used by Martha E. Stewart, M.D., L.L.C.
By providing my name below, I hereby declare that I have honestly and completely answered the questions that were asked in this form to the best of my knowledge. I understand that it is my responsibility to notify Dr. Martha E. Stewart, Dr. Olivia A. Gioe, Dr. Harley Davis and/or the staff of Martha E. Stewart, MD, L.L.C of any changes in insurance coverage, personal information, my medical condition, or medication during the course of my treatments or follow up visits.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize Martha E. Stewart, M.D., L.L.C., or any holder of medical information about me to release to the Health Care Financing Administration and its agents (Medicare) or Insurance Companies or Third Parties, any information needed to determine these benefits or the benefits payable for related services.

ASSIGNMENT OF BENEFITS
I request that authorized Medicare or Insurance payments of medical benefits be made to Martha E. Stewart, M.D., L.L.C.

GUARANTOR RESPONSIBILITY
I understand that I am ultimately responsible for payment of any and all charges for medical services rendered by Martha E. Stewart, M.D., L.L.C, and if this assignment is rejected, modified, or not paid within a reasonable time after it has been filed, it will be my responsibility to pay any unpaid charges in full. If it is necessary to collect unpaid fees for services rendered, I agree to pay the charge assessed by the collection service, legal counsel or court.
This authorization and assignment may be revoked by me at any time by a written notice.
I agree that a photocopy of this form may be used in lieu of the original.

By providing my signature below, I acknowledge that all information I have submitted on this form is correct.

____

Signed By: Patient or Legal Guardian, if a minor Date

____

Nondiscrimination Notice
Martha E. Stewart, M.D., L.L.C.

Martha E. Stewart, M.D., L.L.C. complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity). Martha E. Stewart, M.D., L.L.C. does not exclude people or treat them differently because of race, color, national origin, age, disability, religion, or sex (including pregnancy, sexual orientation, and gender identity).

Martha E. Stewart, M.D., L.L.C.

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services contact our office manager, Kim Guidroz, at 985-727-7701.

If you believe that Martha E. Stewart, M.D., L.L.C. has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with Kim Guidroz, Office Manager, 4060 Lonesome Road, Mandeville, LA 70448, Phone: 985-727-7701, Fax: 985-727-7375, Email: **kim4mstewartderm@bellsouth.net**.

You can also file a grievance with the U.S. Department of Health and Human Services, Office of Civil Rights, electronically through the Office of Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,** or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Notice of Privacy Practices

Martha E. Stewart, M.D., L.L.C.

This notice describes how information about you may be used and disclosed and how you can get access to this information. Please review it carefully. At the office of Martha E. Stewart, M.D., L.L.C, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective April 14th, 2003 and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit a hospital, physician, or other healthcare provider, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

· Basis for planning your care and treatment
· Means of communication among the many health professionals who contribute to your care
· Legal document describing the care you received
· Means by which you or a third-party payer can verify that services billed were actually provided
· A tool in educating health professionals
· A source of data for medical research
· A source of information for public health officials charged with improving the health of the nation
· A source of data for facility planning and marketing
· A tool by which we can assess and work to improve the care we render and outcomes we achieve

Understanding what is in your record and how your health information is used helps you to:

· Ensure its accuracy
· Better understand who, what, when, where, and why others may access your health information
· Make more informed decisions when authorizing disclosure to others

Examples of Disclosures we May Make

We will use your health information for **Treatment, Payment** and **Health Operations**. For example: Information obtained by a nurse, physician, or other member of your healthcare team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your healthcare team. Members of your healthcare team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment. Communication of your health record between your physician and various hospital healthcare providers is also routine, to ensure continuity of care between providers. We will use your health information for payment. For example: A bill may be sent to you or a third-party (insurance) payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used. We will use your health information for regular health operations. For example: Members of the medical staff, the risk manager, or members of the quality improvement team may use information in your health record to
assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Other Permitted or Required Uses and Disclosures

Business associates: There are some services provided in our organization through contracts with business associates. Some examples of business associates we may use are: physician services in the emergency department and radiology, certain laboratory tests, physician billing companies, and copy services we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, of your location, and general condition.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care. We may also notify you of upcoming appointments via mail or by leaving an answering machine message.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Correctional institution: Should you be an inmate of a correctional institution, we may disclose to the institution or agents thereof health information necessary for your health and the health and safety of other individuals.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena. Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Government Agencies: We may be required by applicable law to disclose health information to federal and state regulatory agencies during review processes by those agencies.

Our Responsibilities

Our office is required to:

· Maintain the privacy of your health information
· Provide you with a notice as to our legal duties and privacy practices
· Abide by the terms of this notice
· Notify you if we are unable to agree to a requested restriction
· Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will provide you with a copy of the revised notice at your next visit, or upon request. We will not use or disclose your health information without your authorization, except as described in this notice.

Your Health Information Rights

Although your health record is the physical property of the healthcare practitioner or facility that compiled it, the information belongs to you. You have the right to:

· Request a restriction on certain uses/disclosures of your information as provided by 45 CFR 164.522
· Obtain a paper copy of the notice of information practices upon request
· Inspect and obtain a copy of your health record as provided for in 45 CFR 164.524
· Request amendments to your health record as provided in 45 CFR 164.528
· Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528
· Request communications of your health information by alternative means or at alternative locations
· Revoke your authorization for future use or disclosure of your health information

For More Information or to Report a Problem

If you have questions and would like additional information, you may contact our privacy officer at our practice at 985-727-7701. If you believe your privacy rights have been violated, you can file a complaint with our privacy