GOLDEN RULE
— skin clinic, p.c. —

Patient Intake Form

Demographic:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Date of Birth: _____ Gender: M or F or Other

Cell Phone: _____ Home Phone: _____

Work Phone: _____

Emergency Contact: _____

Relationship: _____ Phone: _____

Primary Care Doctor or Provider: _____

Pharmacy Preference: _____

Personal/Family Medical History:

Have you experienced:	In yourself?		In your family? (who)
Skin Cancer (type)_____	N	Y	_____
Other Cancer (type)_____	N	Y	_____
Eczema/Psoriasis (circle one)	N	Y	_____
Asthma	N	Y	_____
Difficulties with bleeding	N	Y	_____
Difficulties with clotting	N	Y	_____
Difficulties with scarring/keloid	N	Y	_____
HIV/AIDs/Hepatitis C (circle)	N	Y	_____

Female patients please inform provider if you are pregnant or plan to become pregnant during your treatment.

Personal Medical History Continued:

GOLDEN RULE
— skin clinic, p.c. —

Please list medication allergies: _____

Please list all other conditions for which you are currently receiving treatment:

_____

_____

_____

Joint Replacement Y N Blood Thinners Y N

Valve Replacement Y N Immune-Suppressing Medication Y N

Please list all medications you are currently taking:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Contact Information:

--If we need to get in touch with you regarding your care, what is the best way to reach you? (Please circle one) Home Cell Work

--If you are not at home, do we have permission to leave a message with personal information? (Please circle one) Yes No

--Who may we discuss your care or results with if you are not available?

Name: _____ Relationship: _____

--Please sign and fill in date this form was completed:

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY/NOTICE OF PRIVACY PRACTICES

Please initial next to each paragraph as well as sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies.

GOLDEN RULE
— skin clinic, p.c. —

_____**RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)** I have been given the opportunity to read a copy of the Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records. This is also posted on Golden Rule Skin Clinic's website at goldenruleskinclinic.com.

_____**CONTACT PERMISSION** In the event that Golden Rule Skin Clinic needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

□ Leave a message on an answering machine or voice mail. Phone # _____

□ Speak with spouse/significant other. Name: _____

□ Speak with other family members. Name: _____

_____**CONSENT TO TELEPHONE/EMAIL COMMUNICATION** I understand that any phone or email communication will be part of my medical record. I also understand that all email communication is not secure, not to be used for any emergent matters, and response will be given back within three to five business days. Phone contact remains the most effective, efficient communication technique. Non-urgent messages may be left after hours on our phone line. The messages will be checked once daily during non-business hours (i.e. Friday-Sunday).

_____**CONSENT FOR PAYMENT** In exchange for services, I agree to pay Golden Rule Skin Clinic, P.C. according to the pricing schedule available on the website and for any additional costs explained and agreed upon during the office visit before the completion of any additional treatments.
Payments are due, in full, at the time the service is rendered by the Clinic. Payments may be made by Cash, Check, Debit, Credit Card, HAS, or other Health Savings Account.

_____**CONSENT TO TREATMENT** I consent to the performance of those examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I authorize Golden Rule Skin Clinic to take photographs/videos of myself; I understand that the photograph/video will only be used in my medical record and will not be released without my prior authorization. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

Signature _____ **Date Signed**_____

Patient Printed Name/Legal Guardian _____
If Legal Guardian, please indicate relationship to the patient (circle): Parent or Legal Guardian

---

Office Use Only We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to the following:

☐ Individual waived signature ☐ An emergency situation prevented us from obtaining acknowledgement
☐ Communication barriers prohibited obtaining the acknowledgement ☐ Other: _____

_____ _____
Practice Representative Date