MEDICAL ASSOCIATES OF RHODE ISLAND, INC.
Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ DOB: _____

ACKNOWLEDGMENT AND CONSENT

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

AND/OR: **I request the following Restriction(s) concerning the use of my personal medical information:**

_____

_____

AND: **LEAVING PPHI ON VOICE MAIL AND ELECTRONIC MAIL**

_____Yes, I give permission to leave my personal protected health information on my voice mail and / or send electronically.

E-Mail Address: _____

_____No, I do not give permission to leave my personal protected health information on my voice mail and / or send electronically.

AND: **EMERGENCY CONTACT**

In an emergency please contact: Name:_____Phone#: _____

Address:_____Relationship: _____

****

_____
Signature of Patient or Legal Representative

_____
Print Name of Patient or Legal Representative

_____ _____
Signature of MARI Provider/Staff **Date**

****

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____ _____By: Staff Name: _____

MEDICAL ASSOCIATES OF RHODE ISLAND, INC.

AUTHORIZATION TO DISCUSS/LEAVE MESSAGE REGARDING PERSONAL PROTECTED HEALTH INFORMATION

I, _____, DOB, _____ give

Dr.: _____ and his/her staff permission to discuss my personal protected health information with the following person(s):

Name: _____ Tel#: _____

Relationship to Patient: _____

****

Name: _____ Tel#: _____

Relationship to Patient: _____

_____ Yes, information regarding HIV, sexually transmitted disease or mental health issues may be discussed.

_____ No, information regarding HIV, sexually transmitted disease or mental health issues may NOT be discussed.

AND/OR

_____ Yes, I give permission to leave my personal protected health information such as lab or test results on my phone voice mail.

_____ No, I do not give permission to leave my personal protected health information such as lab or test results on my phone voice mail.

This authorization will remain in place from the date signed or until I submit notification in writing to revoke or change.

_____ _____
Signature of Patient Date

_____ _____
Signature of MARI Provider/Staff Date

MARI Dermatology

Name: _____ Date of Birth: ___/___/___ Today's Date___/___/___
Best Phone number: _____ Is it OK to leave a message with medical results? □YES □ NO
First and last name of your Primary Care Doctor: _____
Reason for today's visit: _____
Treatments tried so far: _____
Are you allergic to any medications? □YES □NO if yes, list below:
_____
Have you ever had dental anesthesia (Novocaine)? □YES □ NO Any bad reaction? □YES □ NO

List all prescription and otc medications you are currently taking:

1._____	5._____	9._____
2._____	6._____	10._____
3 _____	7._____	11._____
4._____	8._____	12._____

Please list additional medications on the back of this page

Please circle any of these medications you take, even occasionally, which can cause thinning of the blood:
Aspirin/ Ibuprofen/ Motrin/ Advil/ Excedrin / Naprosyn/ Naproxen/ Coumadin/ Warfarin/ Plavix/ Xarelto/ Vitamin E

Have you ever been diagnosed with:

	YES	NO
Seasonal Allergies/Hay fever	□	□
Asthma/Other breathing	□	□
High Blood Pressure	□	□
High Cholesterol	□	□
Chest Pain/Heart Attack	□	□
Heart Murmur/ Irregular Beat	□	□
Phlebitis/Inflamed vein	□	□
Blood clots	□	□
Pacemaker	□	□
Diabetes	□	□
Kidney Problems	□	□
Dialysis	□	□
Amputation	□	□
Thyroid disease	□	□
Bladder Problems	□	□
Gastrointestinal problems	□	□
Heartburn/GERD	□	□
Arthritis/Joint Deformity	□	□
Artificial Joint	□	□
Autoimmune Disease	□	□
Epilepsy or Seizures	□	□
Neurologic Problems	□	□
Fainting/Dizziness	□	□
Depression	□	□
Other psychiatric problems	□	□
Cancer	□	□

Type of Cancer /Treatment/ Dates
_____

Do you currently have these symptoms?

	YES	NO
Chills	□	□
Unintended weight loss	□	□
Fever	□	□
Fatigue	□	□
Itchy, Irritated, or Dry eyes	□	□
Dry mouth	□	□
Constipation	□	□
Diarrhea	□	□
Nausea/Vomiting	□	□
Swelling of feet or ankles	□	□
Excess or unusual hair growth	□	□
Excess or unusual hair loss	□	□
Nail changes	□	□
Rashes	□	□
Hives	□	□
Itching	□	□
Dry skin	□	□
Mouth Sores	□	□
Cold Sores/ Fever Blisters	□	□
Skin Growths/ Lesions	□	□
Irregular Periods (Women)	□	□
Joint Pain or stiffness	□	□
Numbness/Tingling	□	□
Chest Pain	□	□
Cough/Wheeze	□	□
Headaches	□	□
Anxiety/ Depression	□	□
Fainting/ Dizziness	□	□

List any other diseases or conditions: _____
List Surgical procedures you have ever had and date: _____

Skin:

MARI Dermatology

Have you ever had skin cancer? □ YES □ NO If yes, type_____
Has anyone in your immediate family had skin cancer? □ YES □ NO If yes, type_____
Do you have a history of any specific skin diseases? □ YES □NO If yes, _____
Do you have problems with wound healing? □YES □NO
Do you develop keloids (abnormal scars? □YES □ NO
Do you bleed easily? □YES □No
Do you develop skin rashes in reaction to: □ Medications □ Food □ Environmental Products
□ Bandages □ Neosporin □ Metals (Nickel, Gold etc.) □ Laytex □ Cosmetic □ Other_____

Social History:
Do you drink alcohol? □YES □NO If yes, _____drinks per day
Do you smoke? □YES □NO If yes, how much: _____
Have you ever used illicit drugs? □YES □ NO If yes, what & how often? _____
What is your occupation? _____ Hobbies? _____

Women:
Are you pregnant? □YES □NO Due Date ____/___/____
Are you breast-feeding? □YES □NO
Do you use birth control? □YES □NO Type/Name_____

Consent to photograph:
I authorize and consent to the taking of photographs of me while I am a patient at MARI, Inc. for use of treatment purposes. I hereby release MARI from all liability related to the taking of such photographs.
□ Yes, I give consent. □ No, I don't give consent.

This form was completed by:

□ Patient _____ ___/___/___
Signed by Patient Date

□ Other _____ ___/___/___
Signed by Parent/ Guardian/ Family Member Date

For Office Use Only:

_____

MARI Dermatology

☐ ______________________________ ____/____/____
Reviewed By Date

____/____/____ ______
Updated Initials
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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Please complete all steps to form. There may be a processing fee associated with this request.
EACH SECTION OF FORM MUST BE CHECKED TO BE COMPLETE (except for # 6)

Completed	Section	
☐	1	**PATIENT INFORMATION :** ***(PLEASE PRINT)*** Patient Name: _____ Date of Birth: _____ Address: _____ Street City State Zip Code Home Phone: _____ Cell/Daytime Phone: _____
☐	2	**AUTHORIZATION** I, _____ hereby authorize Physician Name: _____ Address: _____ _____ to release my protected health information to: Name: _____ Address: _____ _____ as set forth: □ Entire Record □ Only Dates of Treatment: _____ to _____ □ Only Medical Data/Information related to: □ Specific condition: _____ □ Specific service: _____ □ Specific medication: _____ □ Other: _____
☐	3	**SIGNATURE** I understand my records are protected under the federal and state privacy laws and cannot be disclosed without my written consent except as otherwise specifically provided by law. I also understand that this authorization is valid for one (1) year and may be revoked at any time in writing, except to the extent that action has already been taken prior to the revocation date. All revocations must be sent to Medical Associates of RI, Inc. to the attention of the Privacy Officer for approval. Additional authorization for re-disclosure beyond recipient is required. **Patient (or Parent/Guardian) Signature:** **_____Date_____** **Witness Signature:** **_____**

☐	**4**	**SENSITIVE INFORMATION** I understand that if my medical record contains protected health information in regards to drug and/or alcohol abuse**(including 42CFR Part 2 information)** psychiatric, sexually transmitted disease, social service, hepatitis b testing/ treatment, and/or sensitive information: □ I am agreeing to its release: _____ □ I **DO NOT** want the following sensitive information released: _____ _____ _____ **Patient (or Parent/Guardian) Signature:** _____
☐	**5**	**RELEASE OF HIV INFORMATION** In addition to the above signatures, if you **DO WANT** your HIV (AIDS) testing/treatment records released you must sign and date on The line below: **Patient (or Parent/Guardian) Signature:** **_____Date_____**
☐	**6**	**Consent to Photograph** I authorize and consent to the making of photographs of me while I am a patient at Medical Associates of RI, Inc. for the use of treatment purposes. I hereby release MARI from all liability related to the making of such photographs. **Patient (or Parent/Guardian)Signature:** **_____ Date: _____**

Revised 08/17