ST. CLAIR
DERMATOLOGY

30060 23 Mile Rd. Chesterfield, MI 48047
Phone #586-207-2244 / Fax #586-307-4877
www.stclairdermatology.com
German Treyger, DO FAAD

Patient Information: **Initials: _____**

Full Name: _____ Date of Birth: _____

Phone Number: _____ Email: _____

Address: _____

Primary Care Doctor: _____

Phone Number: _____ Address/Location: _____

I authorize St. Clair Dermatology to disclose my Protected Health Information (PHI) to the recipient(s) specified below:

Contact #1

Name: _____ Relationship: _____

Phone Number: _____ Organization/Entity: _____

Address: _____

Contact #2

Name: _____ Relationship: _____

Phone Number: _____ Organization/Entity: _____

Address: _____

This authorization is valid for one year and will be updated one year from the date signed.

I understand that:

1. Voluntary Consent: My consent to release my PHI is entirely voluntary and I have a right to decline or withdraw my consent at any time, except to the extent that action has been taken based on this consent.
2. No Effect on Treatment: Refusal to sign this form will not affect my ability to receive treatment, payment, or eligibility for benefits.
3. Re-disclosure: Once my PHI is disclosed to the recipient, it may be re-disclosed by the recipient, and my PHI may no longer be protected by federal privacy regulations.
4. Revocation: I may revoke this authorization at any time by providing a written request to St. Clair Dermatology. However, this revocation will not apply to actions taken in reliance on this authorization before its revocation.
5. Access to Information: I have the right to request a copy of this authorization at any time.

By signing below, I indicate that I have read and understood the terms of this Release of Protected Health Information form and provide my voluntary consent for the purposes outlined herein.

Patient/Legal Representative Signature: _____ Date: _____

Printed Name of Parent/Legal Representative: _____

St. Clair Dermatology – HIPAA Privacy Notice

Your Privacy is Important to Us

At St. Clair Dermatology, we are committed to safeguarding the privacy of your protected health information (PHI) as mandated by the Health Insurance Portability and Accountability Act (HPIAA). This notice describes how medical information about you may be used and disclosed, and how you can access this information.

What is Protected Health Information (PHI)?

PHI includes any information about your health status, provision of healthcare, or payment for healthcare that can be linked to you. This includes medical records, treatment plans, insurance claims, and other individually identifiable health information.

How Your PHI May Be Used and Disclosed:

Treatment: We may use and disclose your PHI to provide, coordinate, or manage your healthcare and related services. For example, sharing information with specialists or labs.

Payment: We may use and disclose your PHI for billing purposes, including working with your insurance company to obtain payment for your treatment.

Healthcare Operations: We may use and disclose your PHI for activities such as quality improvement, staff training, and legal compliance.

Your Rights Regarding Your PHI:

Access: You have the right to see, receive a copy of, and request changes to your medical records.

Restrictions: You can request that we communicate with you about your health in a certain way or at a specific location to maintain privacy.

Confidential Communications: You can request that we communicate with you about your health in a certain way or at a specific location to maintain privacy.

Amendment: If you believe your PHI is incorrect or incomplete, you have the right to request changes.

Accounting of Disclosures: You can request a list of certain disclosures of your PHI that we have made.

Our Responsibilities:

We are required by law to maintain the privacy and security of your PHI.

We will provide you with a copy of this Privacy Notice and abide by its terms.

We will not use or disclose your PHI without your consent or authorization, except as described in this notice.

Complaints:

If you believe your privacy rights have been violated, you can file a complaint with us by contacting our Privacy Officer. You can also file a complaint with the U.S. Department of Health and Human Services.

St. Clair Dermatology – Cancellation and No-Show Policy

As part of our commitment to providing you with the highest quality medical care and ensuring efficient appointment scheduling, we have implemented a Cancellation and No-Show Policy. This policy is designed to optimize appointment availability for all patients while minimizing any inconvenience caused by last-minute cancellations or missed appointments.

Our Cancellation and No-Show Policy:

Cancellation Notice: If you need to cancel or reschedule your appointment, we kindly request that you provide at least a 24 hour notice. This allows us to offer the appointment slot to another patient in need of medical attention.

Late Cancellations and No-Shows: Cancellations made with less than 24 hours' notice or missed appointments (no-shows) are subject to a charge, which is not covered by insurance.

Repeated Occurrences: For patients who repeatedly miss appointments or provide late cancellations, we may need to reconsider our ability to continue providing care. It's important that we have a collaborative relationship based on mutual respect for each other's time and commitment.

How to Cancel or Reschedule:

To cancel or reschedule your appointment, please call our office at 586-207-2244 or contact us through our website at www.stclairdermatology.com. We understand that unforeseen circumstances can arise, and we appreciate your cooperation in keeping us informed as soon as possible.

We value your partnership in maintaining the efficiency and effectiveness of our medical practices. By adhering to this policy, you help us ensure that all patients receive timely and comprehensive care.

If you have any questions or concerns about our Cancellation and No-Show Policy, please do not hesitate to reach out to our office staff. We are here to assist you in any way we can.

Thank you for entrusting us with your Dermatology needs. We look forward to continuing to provide you with exceptional medical care.

I acknowledge and understand that St. Clair Dermatology has a policy regarding missed appointments and cancellations. This policy states that patients who fail to show up for their scheduled appointments or do not provide sufficient notice of cancellation may be subject to a No-Show/Cancellation Fee.

For all Surgical and Cosmetic appointments, a $200 fee would apply.

For all other appointments, a $75 fee would apply.

I understand that the No-Show/Cancellation Fee cannot be billed to my insurance and I will be responsible to pay this fee to any future appointments.

St. Clair Dermatology – Photo Consent/Release Form

I, hereby authorize, St. Clair Dermatology, permission to use my likeness, images, and personal experiences for the purpose of sharing information and educational content on their official website and social medial platforms. I understand that this consent allows St. Clair Dermatology to publish, distribute, and otherwise use photographs, videos, and written content that feature me, for the purposes stated below:

Purpose of Use:

Educational Posts: My images or stories may be shared to educate the public about medical conditions, treatment options and general healthcare information.

Promotional Material: My images may be used in marketing materials to showcase the quality of care provided at St. Clair Dermatology.

Awareness Campaigns: My experiences may be shared to support health awareness campaigns or initiatives organized by St. Clair Dermatology.

I acknowledge and agree to the following:

Voluntary Participation: I understand that my participation in social medial content sharing is entirely voluntary, and I have the right to decline or withdraw consent at any time.

No Financial Compensation: I do not expect any form of financial compensation or reimbursement for the use of my images or content.

Confidentiality: St. Clair Dermatology will take reasonable measures to ensure that any shared information or images maintain my privacy and confidentiality.

Rights and Ownership: St. Clair Dermatology retains ownership of the shared content and reserves the right to edit, modify or delete any content as deemed necessary.

Duration: This consent is valid indefinitely, unless revoked by me in writing.

I hereby release and discharge St. Clair Dermatology, its representatives, and employees from any and all claims, liabilities, demands, actions, causes of action, costs, and expenses arising out of the use of my images, content, or likeness in connection with the activities described above.

I have read and understood the terms of this Social Media Consent Form and willingly provide my consent for the purposes outlined herein.

I hereby authorize Dr. German Treyger, DO FAAD and St. Clair Dermatology to take photographs and/or images when medically or aesthetically necessary. I understand that the images will be a part of my medical record and may be used for purposes of medical teaching, training, or for Marketing and Social Media.

I understand that I will not be compensated from any party.

I further acknowledge that my participation is voluntary, and I agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I hereby release St. Clair Dermatology and any third parties involved in the creation of or any publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to St. Clair Dermatology, or by completion of a new form.

_____ _____

Patient/Agent/Guardian Signature Date

St. Clair Dermatology - Intake and History Form

Name: _____ Date: _____

Street Address: _____ City / State: _____

Zip Code: _____ Date of Birth: _____ Gender: _____

Phone Number (day): _____ Phone Number (day): _____

Email Address: _____

Emergency Contact: _____

Preferred Language: _____ Race: _____ Ethnic Group: _____

Preferred Pharmacy

Name: _____ Phone: _____ City or Zip Code: _____

Past Medical History – Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other:

_____

_____

_____

_____

Past Surgical History – Have you had any surgeries on the following organs?

- ☐ Appendix (appendectomy)
- ☐ Bladder (cystectomy)
- ☐ Breast: Breast Biopsy
- ☐ Breast: Lumpectomy (Right, Left, Bilateral)
- ☐ Breast: Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney: Kidney Biopsy
- ☐ Kidney: Kidney Stone Removal
- ☐ Kidney: Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Liver Transplant
- ☐ Liver: Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy): Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Skin Biopsy
- ☐ Skin: Squamous Cell Carcinoma
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ Other:

_____

_____

Skin Disease History – Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin cancer
- ☐ NONE
- ☐ Other:

_____

_____

Do you wear Sunscreen? ◯ Yes ◯ No

If yes, what SPF? _____

Do you tan in a tanning salon? ◯ Yes ◯ No

Do you have a family history of melanoma? ◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other:

_____

_____

Current Medications – List all current medications (please include dosing and frequency):

_____ _____

_____ _____

_____ _____

Allergies – List all allergies and reactions if known:

_____ _____

_____ _____

_____ _____

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker

Start Smoking (mm/dd/yy): _____

Quit Smoking (mm/dd/yy): _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status

- ☐ Drives in the Daytime
- ☐ Drives at Night

How often do you exercise?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other:

_____

What is your Caffeine Usage?

- ☐ Once a day
- ☐ Several times a day
- ☐ A few times week
- ☐ A few times a month
- ☐ None
- ☐ Other:

_____

Occupation and Workplace:

_____

Family History – Please include only first-degree relatives:

_____

_____

Review of Systems – Please indicate all that apply to you today:

- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss
- ☐ Thyroid problems
- ☐ Sore throat
- ☐ Blurry vision
- ☐ Abdominal pain
- ☐ Bloody stool
- ☐ Bloody urine
- ☐ Joint aches
- ☐ Problems with bleeding
- ☐ Problems with healing
- ☐ Problems with scarring (hypertrophic or keloid)
- ☐ Rash
- ☐ Immunosuppression
- ☐ Hay fever
- ☐ Chest pain
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Headaches
- ☐ Seizures
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Anxiety
- ☐ Depression

- ☐ Allergy to adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotic ointments
- ☐ Artificial heart valve
- ☐ Artificial joints within past two years
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Premedication prior to procedures
- ☐ Rapid heartbeat with epinephrine
- ☐ Pregnancy or planning pregnancy
- ☐ Ebola Risk: Fever >= 100.4 degrees (F) / 38.0degrees (C)
- ☐ Ebola Risk: Resided or traveled to country with widespread Ebola transmission in the last 21 days
- ☐ Ebola Risk: Contact with Ebola patient without proper protective equipment in the last 21 days
- ☐ Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage
- ☐ COVID Vaccine

If 66+ years old: Have you received a Pneumonia Vaccine on or after your 60th birthday? ◯ Yes ◯ No

Do you have a healthcare proxy in the event you are unable to make your own medical decisions? ◯ Yes ◯ No

Do you a have a living will? ◯ Yes ◯ No

Which statement(s) best reflects your wishes on advanced care recommendations?

- ☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.
- ☐ Do Not Resuscitate: if my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it is necessary to save my life.
- ☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

Height: _____

Weight: _____