DAWES FRETZIN DERMATOLOGY

We are honored that you have chosen us for your skin care needs, and we promise to provide you with the best care available. This page introduces you to some of our office policies and likely answers many questions you may have.

Our physicians are all Board Certified by the American Board of Dermatology. They are experts in a broad array of dermatologic problems including medical and surgical management of diseases of the skin, hair, nails, as well as cosmetic services designed to enhance the appearance of your skin. In addition to our physicians our talented staff includes four experienced Physician Assistants and our knowledgeable estheticians. In September 2021 we welcomed our newest physician and Mohs surgeon, Michael Dent, to our practice. For a list of our providers and their specialties visit our website at dawesfretzin.com.

SERVICES

Dawes Fretzin Dermatology proudly offers a variety of dermatologic treatments, including medical and surgical management of diseases of the skin, hair, and nails, as well as cosmetic services to enhance the appearance of your skin. Our Skin Care and Aesthetics Center include, but are not limited to:

- Laser treatments for skin tightening, facial blood vessels, age spots, tattoos, and hair removal
- Botox Cosmetic©, and nearly all the available filler products for facial rejuvenation.
- Platelet Rich Plasma (PRP) is available for hair restoration.
- Chemical peels, Ultrasonic facials, HydraFacial, and Micro-needling

Our Skin Care and Aesthetics Center also has the latest in skin care product lines available for facial skin rejuvenation. Same day appointments for our Esthetician may be available.

For more information visit our aesthetics website at dawesfretzinaesthetics.com

APPOINTMENTS

We strive to give all patients the earliest available appointment. We request 24 hours notice for cancellations, as this will enable us to fill the appointment with another patient. Without proper notice there is a $50 fee for missed general dermatology appointments, a $100 fee for any missed surgical, cosmetic, Aesthetics or Blu Light appointments, and a $150 fee for missed Mohs procedure appointments.

We also reserve the right to dismiss you from the practice for repeated missed appointments.

WHAT TO BRING

- A complete list of the medications (prescription and non-prescription) you are currently taking
- Your most recent insurance card(s)
- A photo ID
- A referral from your primary care physician, **if necessary/required** by your insurance plan

PAYMENT FOR SERVICES

By contract, we are required to collect copays **at the time of service**. We accept cash, check and Visa/MasterCard/Discover. We will bill your insurance company and we do accept assignment from them. Any remaining balance will be billed to you. If you do not have insurance, or do not have your card with you for your visit, full payment will be necessary at the time of service. Accounts referred to an attorney for collection will incur an additional charge.

PRESCRIPTION REFILLS

Please call our office during regular business hours to request prescription refills. We try to accommodate these requests on the same day, though it is not always possible. Return calls will only occur if there is a problem or question regarding your request; you should call your pharmacy to see if the refill has been called in. Yearly visits are necessary to maintain a status as an active patient and to qualify for prescription refills.

TELEPHONE CALLS

We understand how frustrating it is to be stuck in a phone messaging system when you call an office. Below you will find a few extensions that you may dial as soon as the message system is engaged. If you leave a message on the scheduling line, you will receive a call back within 24 hours.

Our phones are on from 7:30 to 4:30.

2	Scheduling/Referrals/Front Desk
3	Nursing (prescription refills, medical questions)
4	Billing Department
5	Psoriasis Center
6	Skin Care and Aesthetics Center

If you have an urgent medical need outside of office hours, dialing our office number will tell you how to reach the doctor on call. Routine prescription refills and lab/pathology results are not available after business hours.

OUR OFFICE LOCATIONS

Indianapolis (Castleton)
7910 N Shadeland Ave
Indianapolis, IN 46250
(317) 516-5000

Kokomo
2220 W Alto Rd
Kokomo, IN 46902
(317) 516-5000

West Carmel/Zionsville
10801 North Michigan Road
Zionsville, IN 46077
(317) 516-5000

Anderson
1601 Medical Arts Blvd
Suite 303
Anderson, IN 46011
(317) 516-5000

Indianapolis (East)
1250 N Post Rd
Suite B
Indianapolis, IN 46219
(317) 516-5000

DAWES FRETZIN DERMATOLOGY

FINANCIAL RESPONSIBILITY STATEMENT:
If no insurance is to be filed by Dawes Fretzin Dermatology Group, full payment is due at time of service. Should valid insurance be provided to the office after the date of service and denied for timely filing, patient will be responsible for the full balance due. Co-payments, co-insurance, deductibles and non-covered services are due at time of service as well. A $150.00 fee will be assessed for missed Mohs surgery appointments without 24-hour notice. A $100.00 fee will be assessed for missed surgical, cosmetic, esthetics and Blu Light appointments without 24-hour notice. A $50.00 fee will be assessed for all other missed appointments without 24-hour notice and for returned checks. Patient Initials: _____

The undersigned acknowledges that in the event this account is turned over to collection, I will be responsible for the costs of collection, which includes, but is not limited to, reasonable collection agency fees equal to 33% of the delinquent balance, reasonable attorney's fees, court costs, witness costs and prejudgment interest at 8% per annum. Each party further agrees that the Marion County Circuit, Superior, or Small Claims Court shall be the proper court of jurisdiction and venue. Further, each party waives trial by jury.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE INFORMATION:
I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

CONSENT FOR MEDICAL TREATMENT OF A MINOR:
I (we) the undersigned parent, parents, or legal guardian of a minor do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of a duly licensed physician, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to this patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

CONSENT TO TREAT:
I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my physician for my health, and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICEMAIL:
I give consent and authorization for the Medical or Billing Staff of my Physician's office to leave Protected Health Information about me or for me on my answering machine or voicemail via the telephone number I have listed. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

I acknowledge a receipt of a copy of Notice of Privacy Practices

Date _____ Account# (office use) _____

Patient Name (print)_____

Patient or Parent/Guardian Signature: _____

***If Patient is a minor please complete the following**

Parent/Guardian Printed Name: _____

Parent/Guardian Date of Birth_____

Relationship to Patient_____

***I hereby give my consent for the above-named patient to be seen without a Parent/Guardian present.** _____ (please initial)

Notice to Patients

Although we are affiliated with Community Hospital Network we do not use, and will not be transitioning to, the EPIC EMR system they use. You will be required to fill out demographic and medical history documentation for Dawes Fretzin Dermatology. We apologize if this causes any inconvenience.

PATIENT REGISTRATION FORM

First Name:	Nickname:	MI:	Last Name:
Address:		City/State/Zip:	
Date of Birth:	Gender: Male Female Other:		Social Security Number:
Home Phone:	Work Phone:	Cell Phone:	E-Mail:
Marital Status: Single Married Divorced Widowed			Spouse Name:
Pharmacy Name & Location:			Phone Number:
Emergency Contact Name & Relationship:			Phone Number:
Preferred Method of Communication: EMAIL HOME PHONE MOBILE PHONE			
Race	Ethnicity	Preferred Language	
Family Doctor:		Family Doctor Phone No.	
Referring Doctor if Different:		Referring Doctor Phone No.	

INSURANCE HOLDER (If other than patient) Mr. Mrs. Ms.	First Name:	MI:	Last Name:
Address:	City/State/Zip:		
Home Phone:	Work Phone:	Ext:	Date of Birth:
Gender: Male Female Other:	Social Security Number:		Relationship to Patient:

GUARANTOR (If other than patient) Mr. Mrs. Ms.	First Name: MI:		Last Name:
Address:	City/State/Zip:		
Home Phone:	Work Phone:	Ext:	Date of Birth:
Gender: Male Female Other:	Social Security Number:		Relationship to Patient:

OTHER INFORMATION

Approved Person for Medical Information release:	Relationship to Patient:

Primary Care Physician/Pharmacy	
Who is your Primary Care Physician (PCP)?	_____
Did a physician specifically refer you to our office?	_____
If yes, what is the name of the referring physician?	_____
Pharmacy Name/Location/Phone #	_____

Please list the reason(s) for your dermatology visit:

_____

_____

Preferred Method of Contact (please circle):

Cell Phone Home Phone Work Phone Email

Past Medical History (Please Circle YES or NO)			
History of non-melanoma skin cancer (basal cell, squamous cell)	YES	NO	Explain: _____
History of Melanoma	YES	NO	Explain: _____
CARDIOVASCULAR			
High Blood Pressure	YES	NO	Explain: _____
Coronary Artery Disease (CHF, Heart Attack)	YES	NO	Explain: _____
Arrhythmia (Irregular Rhythm)	YES	NO	Explain: _____
Valve Disease	YES	NO	Explain: _____
PULMONARY			
Asthma/Emphysema	YES	NO	Explain: _____
Tuberculosis	YES	NO	Explain: _____
RENAL/KIDNEY			
Renal/Kidney Insufficiency	YES	NO	Explain: _____
LIVER/GASTROINTESTINAL			
Hepatitis	YES	NO	Explain: _____
Cirrhosis	YES	NO	Explain: _____
Ulcers	YES	NO	Explain: _____
Ulcerative Colitis/Crohn's Disease	YES	NO	Explain: _____
EYE			
Cataracts	YES	NO	Explain: _____
Glaucoma	YES	NO	Explain: _____
NEUROLOGIC/PSYCHIATRIC			
Seizures/Epilepsy	YES	NO	Explain: _____
Stroke	YES	NO	Explain: _____
Migraines	YES	NO	Explain: _____
Depression/Anxiety/Other	YES	NO	Explain: _____
ENDOCRINE			
Diabetes	YES	NO	Explain: _____
Thyroid Abnormality	YES	NO	Explain: _____
High Cholesterol	YES	NO	Explain: _____
GENERAL			
Do you require antibiotics before procedures	YES	NO	Explain: _____
Due to valve or joint replacement?	YES	NO	Explain: _____
Osteoporosis	YES	NO	Explain: _____
Arthritis (Osteo or Rheumatoid)	YES	NO	Explain: _____
AIDS/HIV +	YES	NO	Explain: _____
Sun Sensitivity	YES	NO	Explain: _____
History of any cancer (other than skin)	YES	NO	Explain: _____
Any additional Medical History	YES	NO	Explain: _____

Name: _____ DOB: _____ Height: _____ Weight: _____

SMOKING HISTORY			
Current tobacco smoker	YES	NO	If so, when started?_____
Current smokeless tobacco use	YES	NO	If so, when started?_____

If you have no past surgeries, check here: ☐

PREVIOUS SURGERIES:	DATE OF SURGERY:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SIGNIFICANT FAMILY HISTORY (PLEASE CIRCLE):			
Adopted (unknown)	YES	NO	Explain:_____
Skin Cancer (non-melanoma)	YES	NO	Explain:_____
Melanoma	YES	NO	Explain:_____
- If yes, any family history of Pancreatic Cancer	YES	NO	Explain:_____
Skin Disease	YES	NO	Explain:_____
Psoriasis	YES	NO	Explain:_____
Autoimmune Disorder (Lupus, RA, Thyroid)	YES	NO	Explain:_____
Eczema	YES	NO	Explain:_____
Cancer, other than skin (Please specify)	YES	NO	Explain:_____

If you take NO medications, check here: ☐

MEDICATION	DOSAGE	PRESCRIBED BY	BAD REACTION?	
1. _____	_____	_____	YES	NO
2. _____	_____	_____	YES	NO
3. _____	_____	_____	YES	NO
4. _____	_____	_____	YES	NO
5. _____	_____	_____	YES	NO
6. _____	_____	_____	YES	NO
7. _____	_____	_____	YES	NO
8. _____	_____	_____	YES	NO
9. _____	_____	_____	YES	NO
10. _____	_____	_____	YES	NO

IMMUNIZATIONS			
Have you received the Influenza Immunization in the last year?	YES	NO	EXEMPT
If you are 65 or over, have you received either stage of the Pneumonia Vaccination?	YES	NO	

List any allergies to medication and non-drug allergens.

If you have NO allergies, check here: ☐

ALLERGIC TO:	TYPE OF REACTION:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SOCIAL HISTORY			
Do you live alone?	YES	NO	
Do you drink alcohol	YES	NO	
Are you pregnant or planning on becoming pregnant?	YES	NO	N/A
Pregnancy prevention method?	YES	NO	If so, please explain: _____

EMPLOYMENT HISTORY	
Do you work outside the home?	YES NO
Occupation:	_____
Place of Employment:	_____

Dawes Fretzin Dermatology Group

Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed, and how you can gain access to this information. Please review it carefully.

Protected health information (PHI), about you, is maintained as a written and/or electronic record of your contacts or visits for healthcare services with our practice. Specifically, PHI is information about you, including demographic information (i.e., name, address, phone, etc.), that may identify you and relates to your past, present or future physical or mental health condition and related healthcare services.

Our practice is required to follow specific rules on maintaining the confidentiality of your PHI, using your information, and disclosing or sharing this information with other healthcare professionals involved in your care and treatment. This Notice describes your rights to access and control your PHI. It also describes how we follow applicable rules and use and disclose your PHI to provide your treatment, obtain payment for services you receive, manage our healthcare operations and for other purposes that are permitted or required by law.

Your Rights Under The Privacy Rule

Following is a statement of your rights, under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff.

You have the right to receive, and we are required to provide you with, a copy of this Notice of Privacy Practices - We are required to follow the terms of this notice. We reserve the right to change the terms of our notice, at any time, and to make the new Notice provisions effective for all PHI that we maintain. We will provide you with a revised Notice if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment. The Notice will also be posted in a conspicuous location in the practice, and if such is maintained, on the practice's web site.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not described within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider, or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, fax, telephone), and/or to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and obtain a copy your PHI - This means you may submit a written request to inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable, cost-based fee for paper or electronic copies as established by federal guidelines. In most cases, we will provide requested copies within 30 days.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You have the right to request an amendment to your protected health information - This means you may submit a written request to amend your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - You may request a listing of disclosures we have made of your PHI to entities or persons outside of our practice except for those made upon your request, or for purposes of treatment, payment or healthcare operations. We will not charge a fee for the first accounting provided in a 12-month period.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI, and determines through a risk assessment that notification is required.

If you have questions regarding your privacy rights or would like to submit a written request, please feel free to contact our Privacy Manager. Contact information is provided at right under Privacy Complaints.

How We May Use or Disclose Protected Health Information

Following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests, to provide information that describes or recommends treatment alternatives regarding your care, or to provide information about health-related benefits and services offered by our office.

We may contact you regarding fundraising activities, but you will have the right to opt out of receiving further fundraising communications. Each fundraising notice will include instructions for opting out.

Health Information Organization - The practice may elect to use a health information organization, or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify, your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care, of your general condition or death. If you are not present or able to agree or object to the use or disclosure of PHI (e.g., in a disaster relief situation), then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization, or providing you an opportunity to object, for the following purposes: if required by state or federal law; for public health activities and safety issues (e.g. a product recall); for health oversight activities; in cases of abuse, neglect, or domestic violence; to avert a serious threat to health or safety; for research purposes; in response to a court or administrative order, and subpoenas that meet certain requirements; to a coroner, medical examiner or funeral director; to respond to organ and tissue donation requests; to address worker's compensation, law enforcement and certain other government requests, and for specialized government functions (e.g., military, national security, etc); with respect to a group health plan, to disclose information to the health plan sponsor for plan administration; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us, or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying the Privacy Manager at:

317-516-5000 ext. 111

We will not retaliate against you for filing a complaint.

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