Nima Skin Institute

P: 312.266.NIMA (6462) | F: 312.266.6481
1460 N. HALSTED ST. | STE. 505 | CHICAGO, IL 60642
nimaskininstitute.com

PATIENT REGISTRATION INSTRUCTIONS

Option 1: Download this form to your computer and fill it out.
Scan or take photos of your ID and both sides of your insurance card(s). Email completed form & scans of your ID and Insurance card(s) to:

submit@nimaskininstitute.com

Option 2: Print out this form, fill it out and bring completed form with your ID and insurance card(s) to your appointment.

We need copies of your identification and insurance card(s).

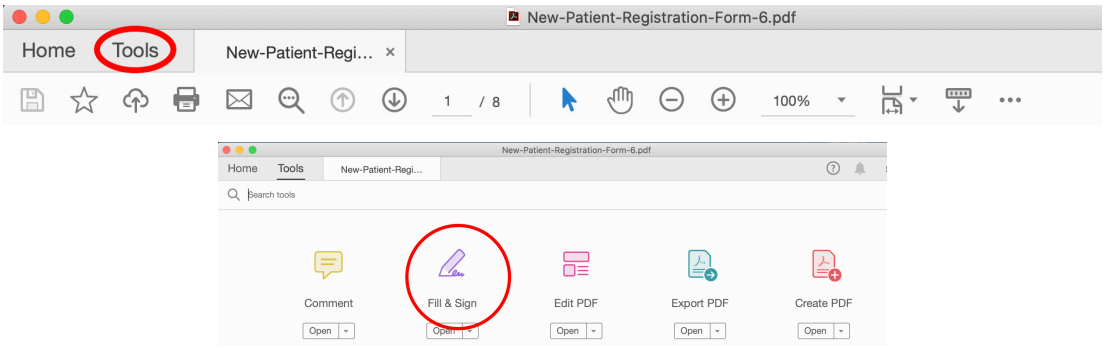
ID — Driver's License, Passport or other form of photo ID (ie. school ID for minors)

If using Option 1, how to sign a PDF

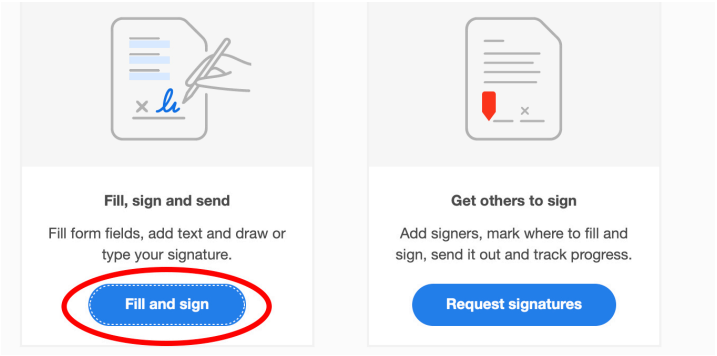
Already have a digital signature? Use it here. Click in the Signature box and import your signature.

Don't have a digital signature? Write your name on plain white paper, take a photo with your phone or digital camera and import it to your computer. 1. Open this PDF form that you want to sign.

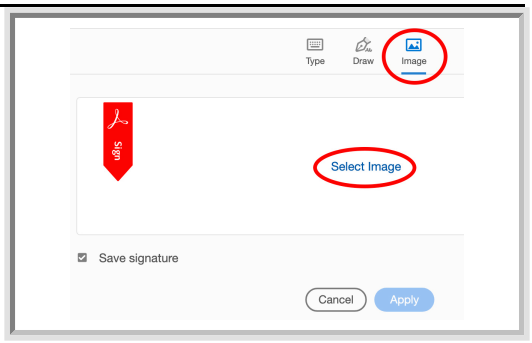
2. Choose **Tools >Fill & Sign**



3. The Fill & Sign tool is displayed. Click **Fill & Sign** here, then click **Add Signature** in the next window.



4. Signature panel opens up.
5. Click the **Image** button; then click **Select Image.**
6. Browse to find the signature you created and select it.
7. Click **Apply** and place the signature into the signature box.



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PATIENT REGISTRATION FORM

Note: Fields in red are required

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ AGE _____ SSN _____

GENDER _____ MARITAL STATUS M ◯ S ◯ W ◯ D ◯ SEP ◯ PARTNERED ◯

ADDRESS _____ APT # _____

CITY _____ STATE _____ ZIP _____

Please provide a phone number where we may leave a message for you.

Phone Number(s): Home _____ Work _____ Cell _____

Email _____

Referred By _____

Emergency Contact Name and Relation _____ _____

Emergency Contact Phone Number _____

Primary Insurance Holder Information (If different than above)

LAST NAME _____ FIRST NAME _____

DATE OF BIRTH _____ GENDER _____ SSN _____

Relationship to patient _____

Insurance Information (fill out only if insurance card not available)

Insurance Company _____

Insurance Company Address _____

Insurance Company Phone Number _____

ID# _____ Group # _____

Do you have a secondary insurance? Yes ◯ No ◯

Insurance Company _____

Insurance Company Address _____

Insurance Company Phone Number _____

ID# _____ Group # _____

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Treatment and Use/Disclosure Form

Consent for Treatment

I acknowledge and understand that, in presenting myself for treatment with Nilam K. Amin, D.O., S.C., d/b/a NIMA Skin Institute ("Practice"), I authorize and consent to the administration and performance of all necessary tests and treatments which may be ordered by the physician or mid-level provider and carried out by members of the medical staff.

Signature of Patient/Guardian _____ Date _____

Consent to Use and Disclosure of Medical Information for Treatment, Payment and Health

I consent to the use and disclosure of my medical information by Nilam K. Amin, D.O., S.C., d/b/a NIMA Skin Institute ("Practice"), for thepurpose of diagnosing, providing treatment, obtaining payment for my treatment or to conduct health care operation of the practice.

I understand that I have the right to request restrictions as to how this information is used or disclosed for treatment, payment, or healthcare operations and that the Practice is not required to agree to the restrictions that I may request, but that if the Practice agrees to a restriction it will be bound by such agreement.

I have the right to revoke this consent, in writing, except where the Practice has already made disclosures in reliance on prior consent.

I have been provided with a copy of the Practice's Notice of Privacy Practices, which explains how the Practice may use and disclose my medical information. I acknowledge that I have received and read a copy of this Notice of Privacy Practices prior to signing this consent.

Nilam K. Amin, D.O., S.C., d/b/a NIMA Skin Institute, has the right to change the constituents that are described in the Notice of Privacy Practice. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy via mail or by obtaining a copy when I am in the office.

Signature of Patient/Guardian _____ Date _____

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Insurance Consent Forms

Insurance Assignment and Release/Financial Policy

I, the undersigned, have insurance coverage and assign directly to Nilam K. Amin, D.O., S.C., d/b/a NIMA Skin Institute ("Practice"), all medical benefits payable for the services rendered to me by the Practice. I understand that it is my responsibility as the patient to verify that the Practice participates in my individual insurance plan. I also understand that I will be financially responsible for any co-pays, deductibles, or non-covered services. I hereby authorize the Practice to release all information necessary to secure the payment of any and all insurance benefits. I authorize use of this signature on all my insurance submissions whether manual or electronic.

Signature of Patient/Guardian _____ Date _____

Medicare Authorization (For patients with Medicare Only)

I request that payment of authorized medical benefits be made on my behalf to Nilam K. Amin, D.O., S.C., d/b/a NIMA Skin Institute ("Practice"), for any services furnished to me by the Practice. I authorize release of medical information by any holder of such information needed to determine these benefits or the benefits payable for related services. I hereby authorize the Practice to release all information necessary to secure the payment of benefits. If other health insurance is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms, or electronically submitted claims, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the Practice agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

Signature of Patient/Guardian _____ Date _____

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Medical History

Name: _____ Age _____ DOB _____

Reason for your visit _____

Please answer the following:

Do you have any history of the following medical problems?

- ☐ Anxiety
- ☐ Arthritis/Joint Deformity
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bladder Problems
- ☐ Bowel/Stomach
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease/ Kidney Problems
- ☐ Fainting
- ☐ GERD/Acid Reflux
- ☐ Hearing Loss
- ☐ Heart Attack
- ☐ Heart Murmur/Irregular Heart Beat
- ☐ Hepatitis: If yes, which kind? _____
- ☐ High Blood Pressure/Hypertension
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Lung Cancer
- ☐ Lymphoma/Leukemia
- ☐ Multiple Sclerosis
- ☐ Prostate Problems/Cancer
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Vascular

Other medical history _____

_____

List any surgical procedures you have had: _____

_____

_____

Have you had any of the following skin conditions?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Cancer
- ☐ Blistering Sunburns
- ☐ Cold sores/Fever Blisters
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/ Allergies
- ☐ Melanoma
- ☐ Oily Skin
- ☐ Poison Ivy
- ☐ Confirmed Precancerous/Atypical Moles
- ☐ Psoriasis
- ☐ Squamous Cell Cancer
- ☐ Other Skin Conditions _____

Do you use sunscreen regularly? Yes ◯ No ◯ If yes, what SPF number? _____

Any history of tanning bed use? Yes ◯ No ◯ If yes, past or current tanning bed use? Past ◯ Current ◯

Any history of sunbathing? Yes ◯ No ◯ If yes, past or current sunbathing? Past ◯ Current ◯

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Family History

Do you have a Family History of Melanoma? Yes ◯ No ◯ If yes, which Relative? _____
Do you have a Family History of Multiple Sclerosis? Yes ◯ No ◯ If yes, which Relative? _____

Current medications:

_____
_____
_____
_____

Do you have any known drug allergies? Yes ◯ No ◯
If yes, please list with reaction _____

Please answer the following:

Do you take aspirin daily? Yes ◯ No ◯ If yes, what strength/dose _____
Smoking Status: everyday ◯ some days ◯ former ◯ never ◯ status unknown ◯
Alcohol use: none ◯ less than 1 drink/day ◯ 1-2 drinks/day ◯ 3 or more drinks/day ◯
Do you use ilicit drugs? Yes ◯ No ◯ Please explain _____
Exercise status: several times a day ◯ once a day ◯ few times a week ◯ few times a month ◯ never ◯
Caffeine status: several times a day ◯ once a day ◯ few times a week ◯ few times a month ◯ never ◯

What is your occupation? _____
What are your hobbies? _____
Do you have a family history of any medical conditions or cancers? _____
_____

Alerts and Review of Systems-Please check all that apply:

- ☐ Pregnant or planning on getting pregnant
- ☐ Blood Thinners
- ☐ Problems with Bleeding
- ☐ Artificial Joints (within the last 2 years)
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Artificial Heart Valve
- ☐ Rapid heartbeat with epinephrine
- ☐ Allergy to latex or nitrile
- ☐ Allergy to lidocaine
- ☐ Allergy to adhesive
- ☐ Allergy to topical antibiotic ointments
- ☐ Premedication prior to procedures
- ☐ Stomach upset with antibiotics
- ☐ Yeast Infections with antibiotics
- ☐ Problems with healing
- ☐ Problems with scarring/Keloids
- ☐ Fever or chills
- ☐ Night sweats
- ☐ Unintentional weight loss or gain
- ☐ Anxiety
- ☐ Depression
- ☐ Immunosuppression
- ☐ Hay Fever
- ☐ Vision Changes
- ☐ Headaches
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Sore Throat
- ☐ Bloody Urine
- ☐ Bloody Stool
- ☐ Abdominal Pain
- ☐ Neck Stiffness
- ☐ Muscle Weakness
- ☐ Joint Aches
- ☐ Chest Pain
- ☐ Other:
- ☐ Other:

Pharmacy Information: Name: Address: Phone:

Who referred you/how did you hear about us? _____

By signing below, I acknowledge that I have reviewed and agree with above information given.

_____ _____
Signature of Patient/Guardian Date

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KEEP A COPY OF THESE TWO PAGES FOR YOUR RECORDS

NOTICE OF PRIVACY PRACTICES

NIMA Skin Institute, 1460 N. Halsted Street, Suite 505, Chicago, IL 60642

Privacy Officer: Office Manager Adriana Lopez, phone (312) 266-6462

Effective Date: 09/16/2013

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in an electronic health record/personal health record. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.

2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.

3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.

5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.

6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.

7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization.

9. Required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.

10. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.

11. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.

12. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.

13. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

14. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

15. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.

16. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

17. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.

18. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.

19. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.

20. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.

21. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. We may use e-mail or regular mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information

Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.

3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision.

4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.

5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to: OCRMail@hhs.gov. The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.