

Byron J. Van Dyke, M.D.

Medical, Surgical, & Cosmetic Dermatology

1158 N. Court Street, Redding, CA 96001-0436

Tel (530) 247-7546 - Fax (530) 247-7228

Patient:

Date of VISIT:

Patient's Date of Birth _____
_Single _Married _Divorced _Widowed

Gender: __Male __Female

GUARANTOR (Patient OR Parent/Guardian who brings child in if under age 18)

Social Security # _____	Employer _____
Home Address _____	Work Address _____
City/Zip code _____	City/Zip code _____
Home Phone _____	Work Phone _____
Cell Phone _____	CA Driver's Lic _____

Nearest Relative not at same address

Name of relative _____
Telephone number of relative _____

- Please:**
- 1) Present insurance and/or Medicare card to receptionist.
 - 2) Make clear whose name (your, spouse, parent) each ins. plan is under.
 - 3) Fill out **ALL** the information below even if it is on your card.

Primary Insurance

Name of Insurance _____
Insured's Name _____
Insured's SS# _____
Relationship: __ Self __ Spouse
 __ Parent
 __ (other) _____
Insured's ID# _____
Group# _____

Secondary Insurance

Name of Insurance _____
Insured's Name _____
Insured's SS# _____
Relationship: __ Self __ Spouse
 __ Parent
 __ (other) _____
Insured's ID# _____
Group# _____

Primary Insured's Employment Info

Employer Name _____

Secondary Insured's Employment Info

Employer Name _____

Who referred you to us?:
____ Dr: _____
____ Friend: _____
____ Yellow Pages ____ Newspaper Ad
____ Insurance Co. ____ Other: _____

Primary Care Physician: _____
Pharmacy of Choice: _____
Street Location _____

Other family members who are patients: _____

PLEASE NOTE THAT YOU WILL BE CHARGED \$25 FOR EACH RETURNED CHECKS AND \$25 FOR EACH APPOINTMENT CANCELLED WITH LESS THAN 24 HOURS NOTICE.

Patient Signature _____ **Date** _____

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HEALTH INFORMATION PRIVACY - HIPAA PATIENT CONSENT FORM

THIS FORM INFORMS YOU HOW WE USE DISCLOSE AND PROTECT YOUR HEALTH INFORMATION.

1. YOUR PROTECTED HEALTH INFORMATION will be used by Byron J. Van Dyke, M.D. or disclosed to others only for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of our practice and to secure the best health care for you.

2. A COMPLETE NOTICE OF PRIVACY PRACTICES is available to you for your review prior to signing this consent. We encourage you to read it. Please note, in the event of an emergency, your health information may be disclosed.

3. YOU MAY REQUEST A RESTRICTION ON THE DISCLOSURE OF YOUR HEALTH INFORMATION. Byron J. Van Dyke, M.D. may or may not agree to restrict the use or disclosure of your protected health information. If Byron J. Van Dyke, M.D. agrees to your request, the restriction will be binding on the practice as defined by the Federal Privacy Standards.

4. YOU MAY REVOKE OR CHANGE THE ABOVE CONSENT to the use and disclosure of your protected health information. This must be done in writing.

RESERVATION OF RIGHT TO CHANGE PRIVACY PRACTICES: Byron J. Van Dyke, M.D. reserves the right to modify the privacy practices outlined in the notice.

AUTHORIZED DISCLOSURES:

In an effort to protect your healthcare information yet give you choices, please list any/all names and relation of those whom we have your permission to discuss appointment dates, times, billing, and medical information. (Example: spouse, significant other, parents, other physicians, caretaker). WE CANNOT GIVE ANY INFORMATION TO ANYONE NOT LISTED BELOW.

NAME RELATION

NAME RELATION

NAME RELATION

I authorize Byron J. Van Dyke, M.D. or his representatives to leave the following information on my answering machine/voice mail at:

Telephone number: _____ Appointment Information (circle): YES NO
Laboratory & Xray Results (circle): YES NO
Pathology Results (circle): YES NO

SIGNATURE:

I have reviewed this consent form and am aware that a complete copy of the Notice of Privacy Practices is available to me. I give my permission to Byron J. Van Dyke, M.D. to use and disclose my health information in accordance with it.

SIGNATURE OF PATIENT (OR GUARDIAN) DATE

(RELATIONSHIP TO PATIENT)

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Date of VISIT: _____

ALL PATIENTS: RELEASE OF INFORMATION

I authorize the release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Guardian Signature _____ DATE _____

ALL PATIENTS: PAYMENT POLICY

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying the 20% copayment. We DO file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

HMO, PPO, or other managed care patients: You will be responsible for paying your annual deductible, copayment, and charges for any non-covered, cosmetic services.

Commercial patients: Patients who are covered by private, commercial plans in which our physicians are NOT providers will be required to pay 50% of our usual and customary charges at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient or Guardian Signature _____ DATE _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulation pertaining to Medicare assignment of benefits apply.

Patient or Guardian Signature _____ DATE _____

MEDICARE PATIENTS WITH SECONDARY INSURANCE:

If you have a supplemental policy and the Medicare Carrier automatically submits the claim, we are required to keep a separate signature on file:

I request authorized insurance benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the insurance carrier listed below any information needed to determine these benefits or the benefits payable for related services.

Secondary Insurance Company: _____

Patient or Guardian Signature _____ DATE _____

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Patient: _____

Date of VISIT: _____

PAST MEDICAL HISTORY

Are you allergic to any medications (circle): YES NO. If yes, list below:

1. _____ Rash BreathingProblems Other: _____
2. _____ Rash BreathingProblems Other: _____

Have you ever had dental anesthesia (Lidocaine)? ___ YES ___ NO Any bad reaction? ___ YES ___ NO

Do you normally take antibiotics prior to dental work: NO YES

Circle the following that you currently take: ASPIRIN COUMADIN GINKGO GARLIC GINSENG VIT E

List all medication you are currently taking (including prescription, over-the-counter, vitamins, herbs)

1. _____ 2. _____ 3. _____
4. _____ 5. _____ 6. _____
7. _____ 8. _____ 9. _____

List surgical procedures you have had in the last 6 months: _____

Skin: YES NO Details:
Have you ever had skin cancer? ___ ___ _____
Family member with melanoma? ___ ___ _____
Do you heal poorly? ___ ___ Do you bleed easily? _____
_Do you form thick keloid scars? ___ ___
Do you develop rashes in reaction to ___ Medications ___ Food ___ Environment?

Please list any current or past MEDICAL PROBLEMS:

PROBLEM	DETAILS
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

List family members (mother, father, other blood relative) who have had:

Allergies _____ Heart Disease _____
Arthritis _____ High Blood Pressure _____
Asthma/Hayfever _____ Lung Disease _____
Cancer _____ Psoriasis _____
Diabetes _____ Skin cancer _____
Eczema _____ Malignant Melanoma _____
Tuberculosis _____

SOCIAL HISTORY

Do you drink alcohol? YES NO If YES _____ drinks per day of _____
do you smoke? YES NO If YES _____ packs for _____ years
Ever used IV drugs? YES NO
HIV exposure YES NO
What is your occupation? _____

Signed by Patient: _____ **Date:** _____

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Date of VISIT:

YOUR APPOINTMENT is on _____ at _____ AM / PM

WELCOME: Welcome, and thank you for choosing our practice. Please fill out the included paperwork (and make corrections if needed) prior to your visit, and bring it along with your insurance card(s) to the visit.

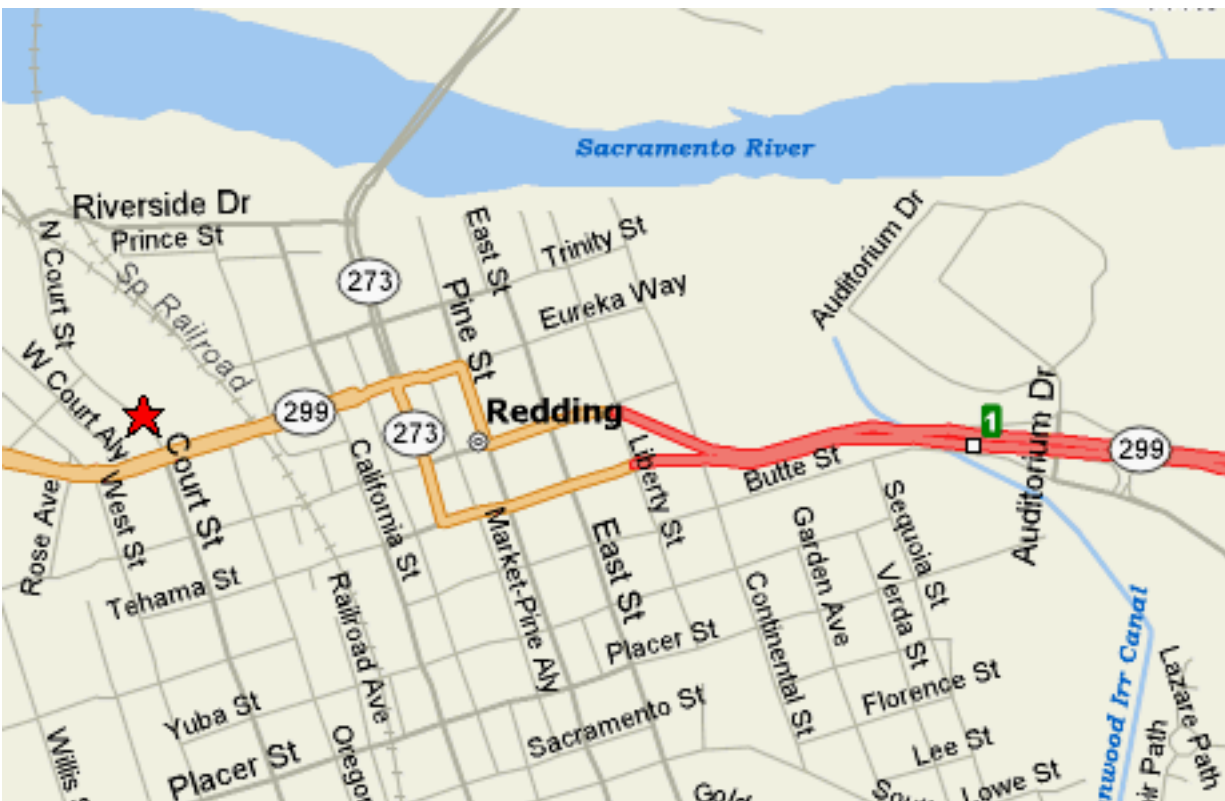
HOURS: We are open Monday through Friday, 8am until 5pm. On Wednesdays we see a limited number of patients so that Dr. Van Dyke can work teaching at the Mercy Family Medicine Clinic.

BIOGRAPHY: Byron Van Dyke is the son of a Stanford professor, and grew up on that campus with his two identical triplet brothers and one sister. He received a B.S. in Molecular Biophysics and Biochemistry at Yale. This was followed by four years at UCLA for medical school; one year as a research scholar at the National Institutes of Health, where he first became interested in dermatology; internship in Denver, Colorado; and residency at Emory in Atlanta, Georgia. He is board-certified in dermatology, and is a Fellow of the American Academy of Dermatology and the American Society for Mohs Surgery.

Following residency he spent one year at Kaiser in Santa Clara, CA. After that he worked as a traveling doctor, working for anywhere from 2 weeks to 8 months in California, Oregon, Hawaii, Georgia, and Wisconsin until settling down in Redding, where he has longtime friends. He is married to Dr. Lily Jamm, who is involved in treating pigmentary changes and fine blood vessels as well as hair removal using our Medilux Pulsed Light.

SPECIAL INTERESTS: Skin cancer surgery, Psoriasis, BoTox, Collagen, Pediatric dermatology

INSURANCE: Most insurances accepted; Medi-Cal patients should contact the Mercy Family Medicine Clinic at (530) 225-7800.



DIRECTIONS:

Take Hwy 299 WEST (toward downtown and Weaverville).

Follow 299/Eureka Way; stay in the center lane right as it zigs right and then zags left over the railroad tracks.

Turn right onto Court street and then IMMEDIATELY turn left into the driveway we share with Carl's Junior.

We are located across Court Street from the YMCA.