ZIMMET
VEIN & DERMATOLOGY

TODAY'S DATE _____

NEW PATIENT REGISTRATION

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

AGE _____ DATE OF BIRTH _____

DRIVER'S LICENSE # _____ EXPIRATION _____

PRIMARY PHONE _____ SECONDARY _____ WORK _____

PRIMARY CARE PHYSICIAN _____

REFERRED BY _____

GENDER ☐ M ☐ F MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED

EMPLOYER _____

SPOUSE'S NAME _____ PHONE _____

Interested in specials, upcoming events and news?

☐ Yes, I would like to subscribe. ☐ No, I would not like to subscribe.

Your privacy is important to us. Your information will not be shared with other parties.

☐ EMAIL _____ ☐ TEXT _____

Medicare Opt-out

Dr. Zimmet opted out of Medicare. Therefore, any treatments you receive from Dr. Zimmet, including those deemed medically necessary, **will NOT be covered under Medicare**. Are you currently eligible for or covered by Medicare? ☐ YES ☐ NO

Please complete the following if the patient is a minor:

PERSON COMPLETING FORM: LAST NAME _____ FIRST _____

RELATIONSHIP TO PATIENT ☐ MOTHER ☐ FATHER ☐ GUARDIAN ☐ OTHER: _____

ADDRESS (IF DIFFERENT FROM PATIENT) _____

PHONE _____

Emergency contact

LAST NAME _____ FIRST NAME _____ MIDDLE INITIAL _____

RELATIONSHIP TO PATIENT _____ PHONE NUMBER _____

STREET ADDRESS _____

CITY _____ STATE _____ ZIP _____

PLEASE READ AND SIGN

I authorize Steven Zimmet, MD to release medical information necessary to communicate on my behalf with my insurance company or pharmacy.

SIGNED _____ DATE _____

Payment is due at the time that services are rendered. I understand that I may receive separate bills for certain services provided outside this office, such as radiology or laboratory services. I certify that the information I have provided above is correct.

SIGNED _____ DATE _____

1500 West 34th Street • Austin TX 78703 • TEL 512.485.7700 • FAX 512.485.7702
EMAIL info@drzimmet.com • WEBSITE www.drzimmet.com

ZIMMET
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PATIENT HISTORY FORM

PATIENT NAME _____ DATE _____

DATE OF BIRTH _____

Medical History (*Check as many as apply*)

	Y	N
Anemia/blood disorder	☐	☐
Bleeding problems	☐	☐
Cold sores	☐	☐
Deep vein thrombosis (blood clot)	☐	☐
Defibrillator	☐	☐
Diabetes	☐	☐
Heart disease	☐	☐
High blood pressure	☐	☐
Keloids/abnormal scars	☐	☐
Migraine headaches	☐	☐
Pacemaker	☐	☐
Pigmentation problems	☐	☐
Poor wound healing	☐	☐
Prosthetic heart valve	☐	☐
Radiation treatment	☐	☐
Skin cancer	☐	☐
Thyroid disorder	☐	☐
Other cancer	☐	☐
Other medical problems (*Please specify*)	☐	☐
Are you pregnant?	☐	☐
Are you breastfeeding?	☐	☐
Any metal implants? (*Please specify locations*)	☐	☐

_____

_____

Current Medications (*Check as many as apply*)

	Y	N
Aspirin	☐	☐
Birth control	☐	☐
Blood thinner	☐	☐
Heart medication	☐	☐
High blood pressure	☐	☐
Hormones	☐	☐
Insulin	☐	☐

Other medications (*Please specify*)

_____

_____

Allergies (*Check as many as apply*)

	Y	N
Latex	☐	☐
Lidocaine	☐	☐
Antibiotics (*Please specify*)	☐	☐

_____

_____

_____

Other (*Please specify*)

_____

_____

Is there anything else we should know about your medical history?

_____

_____

How did you hear about us?

☐ Physician (*Please specify*)

_____

☐ Our website (www.drzimmet.com)
☐ Google
☐ Bing
☐ Yahoo!
☐ Citysearch
☐ YELP
☐ Friend
☐ Print Ad: (*Please specify magazine*)

_____

☐ Other _____

_____

ZIMMET
VEIN & DERMATOLOGY

SKIN & VEIN CARE NEEDS

To help us provide you with the services you desire, please answer a few questions regarding your skin and vein care needs.

PATIENT NAME _____ DATE _____

Please indicate your concerns about your skin or veins.

SKIN

- ☐ Acne
- ☐ Acne Scarring
- ☐ Age spots
- ☐ Aging chest/neck
- ☐ Aging skin (face)
- ☐ Crows feet
- ☐ Frown lines
- ☐ Hyperhidrosis (sweating)
- ☐ Hyperpigemtation/Melasma
- ☐ Large pores
- ☐ Lips/Mouth
- ☐ Moles
- ☐ Precancerous lesions
- ☐ Rash
- ☐ Rosacea
- ☐ Saggy/loose skin
- ☐ Scars
- ☐ Smile lines
- ☐ Sun damage
- ☐ Tattoo removal
- ☐ Unwanted body fat
- ☐ Unwanted hair
- ☐ Wrinkles

VEIN

- ☐ Broken capillaries
- ☐ Hand veins
- ☐ Leg pain/heaviness
- ☐ Leg swelling
- ☐ Leg ulcers
- ☐ Spider veins—facial
- ☐ Spider veins—legs
- ☐ Varicose veins

Other _____

_____

Please indicate the treatments about which you would like additional information.

COSMETIC DERMATOLOGY

- ☐ Advanced FotoFacial (IPL)
- ☐ Blu Light
- ☐ Body Contouring
- ☐ Botox
- ☐ EndyMed
- ☐ Fillers/Collagen stimulators
- ☐ Fractional Resurfacing
- ☐ Skin tightening
- ☐ Ultherapy
- ☐ UltraShape
- ☐ Venus Legacy

VEIN SERVICES

- ☐ Diagnostic Ultrasound
- ☐ EVLT
- ☐ Foam sclerotherapy
- ☐ Phlebectomy
- ☐ Sclerotherapy
- ☐ Spider veins
- ☐ Varicose veins

OTHER SERVICES

- ☐ Chemical peels
- ☐ Electrolysis
- ☐ GentleWaves
- ☐ Laser hair removal
- ☐ Microdermabrasion
- ☐ Microneedling
- ☐ Skin analysis/treatment plan
- ☐ Skincare products consult

Other _____

_____

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ZIMMET
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PATIENT CONSENT FOR USE OF EMAIL COMMUNICATIONS

To better serve our patients, Zimmet Vein & Dermatology (ZVD) has established an email address for some forms of communication. For routine matters that do not require immediate response, please feel free to contact us at info@drzimmet.com. This form of communication is not appropriate for use in an emergency. The turnaround time for routine patient communications is 24 hours.

If you require urgent or immediate attention, email is not appropriate. Please call our office directly at 512.485.7700 or call 911 if you have a medical emergency.

When sending email communications, please put the subject of your message in the subject line so we can process it more efficiently. Please include your name, date of birth and return telephone number in the body of the message. We also ask that you acknowledge receipt of emails coming from our office.

Communications relating to diagnosis and treatment will be filed in your medical record.

This office is dedicated to keeping your medical record information confidential. Despite our best efforts, due to the nature of email, third parties may have access to messages. When communicating from work, you should be aware that some companies consider email corporate property and your messages may be monitored. Even when emailing from home, you may feel that access to your email is not well controlled, so you should take that into consideration. In addition, you should be aware that, although addressed to me, my staff will have access to this information.

I do/do not authorize information regarding appointments, procedures, lab results left on my voicemail as indicated below (circle for each):

Home Voicemail Y / N Office Voicemail Y / N Cell Voicemail Y / N

I understand that this office will not be responsible for information loss, or delay or breaches in confidentiality that are due to technical factors beyond this office's control.

I understand and agree to the above email policy.

By signing below, I am agreeing that ZVD may send medical related correspondence to me via email, and that they may respond to my emails to them via email.

PATIENT SIGNATURE _____ DATE _____

PATIENT NAME (PRINTED) _____

WITNESS SIGNATURE _____

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CANCELLATION/DEPOSIT POLICY

Please let us know as soon as possible if you need to cancel or reschedule your appointment or if you anticipate a late arrival. Chronic no-shows or late cancellations may result in the formal termination of the professional relationship. There is a $30 cancellation fee assessed for no-shows and cancellations with less than 24 hours notice.

I understand and agree to these terms:

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Your Rights

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

Your Choices

You have some choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

Our Uses and Disclosures

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record
- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to amend your medical record
- You can ask us to amend health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we'll tell you why in writing within 60 days.

Request confidential communications
- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share
- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information
- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice - You can ask for a paper copy of this notice at any time.

Choose someone to act for you
- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will ensure the person has this authority before we take any action.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:
- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

If you are not able to tell us your preference we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.

In these cases we never share your information unless you give us written permission:
- Marketing purposes • Most sharing of psychotherapy notes • Sale of your information
- In the case of fundraising we may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

We typically use or share your health information in the following ways.

We can use your health information and share it with other professionals who are treating you.

We can use and share your health information to run our practice, improve your care, and contact you when necessary.

We can use and share your health information to bill and get payment from health plans or other entities.

Electronic Exchange. Your information may be shared w/ other providers, labs and radiology groups through our EHR system as listed:

Cockerell Dermatopathology Clinical Pathology Laboratory (CPL)

How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.

Help with public health and safety issues

We can share health information about you for certain situations such as:
- Preventing disease • Preventing or reducing a serious threat to anyone's health or safety
- Helping with product recalls • Reporting suspected abuse, neglect, or domestic violence
- Reporting adverse reactions to medications • Do research • Comply with the law
- Respond to organ and tissue donation requests • Work with a medical examiner or funeral director.

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

We can use or share health information about you:
- For workers' compensation claims • For law enforcement purposes or with a law enforcement official
- With health oversight agencies for activities authorized by law
- For special government functions as military, national security, and presidential protective services
- Respond to lawsuits and legal actions

Our Responsibilities
- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

You Have A Right To File A Complaint If You Feel Your Privacy Has Been Violated

- **If you feel your Privacy Rights have been violated, please ask our staff for a Privacy Complaint Form. Our Security Officer will review the form and promptly notifiy you of the actions our office will take.**
- or You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting http://www.hhs.gov/hipaa/filing-a-complaint/complaint-process/index.html
- We will not retaliate against you for filing a complaint.

Zimmet Vein & Dermatology

HIPAA Compliance Officer: Colleen Cassady

Phone: 512-485-7700

This Notice of Privacy Practices is effective December 1, 2017

Patient Name: _____ Signature: _____ Date: _____

Witness: _____

ZIMMET
VEIN & DERMATOLOGY

I have reviewed and agree to the terms of the Zimmet Vein & Dermatology privacy policy:

PATIENT SIGNATURE _____ DATE _____

WITNESS SIGNATURE _____ DATE _____

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