William J. Helms, M.D. Dermatology Clinic P.O. Box 804 Russellville, AR 72811

(479) 968-8940 Fax: (479) 968-8901

To better serve you, our patient, We would like to invite you to access our

Patient Portal
Which can be found at
helms.ema.md

Your username will be:
The capitalized first letter of your first name

- The capitalized first letter of your last name
- Your eight-digit birth date

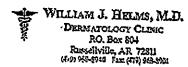
For example, if your name is John Smith and you were born on January 1, 1981 Your login would be JS01011981

Your password would be: Sunscreen50

This portal can be used to:
Review and verify your contact information, medical history, medications and allergies,
communicate with your provider and/or their staff.

Please call our office if you require assistance accessing your portal or making changes.
479-968-8940

NOTICE OF PRIVACY POLICIES



Introduction

At William J. Helms Dermatology, we are committed to treating and using protected health information about you responsibly. This Notice of Health information Practices describes the personal information we collect, and how and when we use or disclose that Information. It also describes your rights as they relate to your protected health information. This notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit William J. Helms Dermatology, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnosis, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

Basis for planning your care and treatment.

Means of communication among the many health professionals who contribute to your care,

Legal document describing the care you received,

Means by which you or a third-party payer can verify that services billed were actually provided,

A tool in educating health professionals,

- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,

A source of data for our planning and marketing

A tool which we can assess and continually work to improve the care we render and the outcomes we achieve.

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of William J. Helms Dermatology, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,

Amend your health record as provided in 45 CFR 164.528,

- Obtain an accounting of disclosures of your health information as provided by 45 CFR 164,528,
- Request communications of your health information by afternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken

Our Responsibilities:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,

Abide by the terms of this notice,

- Notify you if we are unable to agree to requested restriction, and
- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will notify you at your next appointment.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

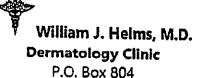
For More Information or to Report a Problem

If you have questions and would like additional information, you may contact the practice's Privacy Officer at (479) 968-8940.

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retailation for filing a complaint with either the Privacy Office or the Office for Civil Rights. The address for the OCR is listed below

Office for Civil Rights U.S. Department of Health and Human Services 200 Independence Avenue, S.W. Room 509F, HHH Building Washington, D.C. 20201

First:	MI:	Last:			DOB:
Gender: Race:		Ethnicity	/:	SSN:	·
Preferred Language:			Email:		
Cell Phone:			Home Phone:		
Address:					
					_Zip code:
Preferred Pharmacy:	 		Primary Care	Physician:	
Occupation:			Pt height:	<u> </u>	_Pt weight:
Parent or Legal Guardian:					
First:	MI:	Last:			_DOB:
Relationship to patient:			SSN:	•	
,		INSURAN	CE INFORMATION		
Primary Insurance:			Secondary Insurance:		
ID#:	Group #		. ID#:		_ Group #
Policy Holder:	DOB:_		Policy Holder:		DOB:
Relationship to Policy Holder:		· · · · · · · · · · · · · · · · · · ·	Relationship to Policy	Holder:	
I am a patient of William J. Heln Privacy Practices.	ns, M.D. Dermatolo	gy Clinic. I	hereby acknowledge r	eceipt of Ho	elms Dermatology's Notice of
Name (Please Print):					
Signature:			Date	:	····
OR					
I am a parent or legal guardian or receipt of Helms Dermatology's	·· -	actices wit	h respect to the patient	<u> </u>	I hereby acknowledge
Name (Please Print):				(please	circle one) Parent or Legal Guardia:
Signature:	 		Date):	
The following individual(s) may t	eceive my protecte	d health in	formation (PHI)		
		•			



Russellville, AR 72811 (479) 968- 8940 Fax: (479) 968-8901 No Call/No Show Policy

As a courtesy, we call to confirm your appointment at least 1 day prior to the scheduled time. Please make sure we have the accurate telephone number you would like us to call with the reminder. Patients must cancel or reschedule appointments at least 12 hours in advance of the scheduled appointment. Patients will be considered for dismissal from the practice after 3 No Call/No Shows. As a courtesy, we call 1 to 2 days prior to your scheduled appointment to remind you of the date and time. We require that you cancel or reschedule your appointment at least 12 hours in advance. With prior notice we can offer the appointment time we had set aside for you to another patient that may have an urgent need to see the provider. Thank you, in advance, for helping us accommodate all our patients by cancelling your appointment if you are unable to keep your scheduled time. If you have questions regarding this policy, you may contact our Office Manager, Donna Howell at (479)968-8940.

As a courtesy to our patient, we file insurance claims for all visits and services rendered. Your insurance is a contract between you and the insurance company, we are not part of that contract. It is your responsibility to know and understand the provisions of your medical insurance policy. Our office cannot guarantee payment of your claims; benefits and payments are determined by the insurance carrier at the time of claim submission. If you disagree with your carrier's determination; all carriers have a patient claim appeal process. You can expect to receive a bill for all deductibles, co-insurances, non-paid an/or non-covered services that your carrier has determined to be patient responsibility. Co-pays are due at the time of service. It is your responsibility to know your insurance plan's provisions and seek appropriate approval prior to your services, as coverage varies by insurance company and can vary from policy to policy.

If we do not participate with your insurance company, or if you do not have medical insurance coverage, payment for services is due at the time services are rendered. We accept cash, personal checks, money orders, Visa, MasterCard, and Discover. Any personal check that is returned for insufficient funds is subject to a \$25 service fee. In the event there is a balance due from you after your claim is processed. We will send a billing statement to you for payment in full within 15 days. Patient balances older than 60 days will be reviewed by Dr. Heims and may be referred to an outside collection agency. Payment plan options may be available for some balances. Contact our office at (479)968-8940 for further information. Patients with a past due balance must make payment arrangements prior to scheduling any further appointments.

At Helms Dermatology we are committed to providing our patients with the best possible dermatology care. As a patient, your clear understanding of our policy is important to our professional relationship.

I understand and agree that the practice and/or collection agency retained by Helms Dermatology may contact me by telephone and/or email provided by me or associated with my account. All fees associated with cellular/wireless calls or text messages are my responsibility. Collection contact may also be made by automatic dialing devices and/or through pre-recorded messages, artificial voice messages, or voicemail messages.

PATIENT	/Guardian	Signature
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		Vaccination Record	_
Pneumonia Vaccination: (Yes	s/No) Date:	FLU Vaccination: (Yes/No) I	Date:
COVID Vaccination: (Yes/No)	Date:		
(65 and Older ONLY) Do you	have a health care p	roxy: (Yes/No) If yes, who?	
Do you have a living will? (Ye			
		MEDICAL HISTORY	
Date of Birth:		_ Reason for Visit:	
Have you had or do you have			
□ Arthritis	☐ Depression	☐ Hepatitis (B or C)	□ Seizures
☐ Atrial Fibrillation	□ Diabetes	☐ HIV/AIDS	□ Stroke
☐ Coronary Artery Disease	□ COPD	☐ High Cholesterol	☐ Thyroid disorder
☐ Cancer:		☐ Hypertension/High Blood	Pressure
☐ Pregnant or planning a pre	gnancy Deremed	lication prior to procedures	Rapid heartbeat with epinephrine
Have you had any of the foll	owing surgerles?		
☐ Heart: Replace Biological V	alve E	Heart: Replace Mechanical Valve	☐ Heart: PTCA (Stents)
☐ Heart: Coronary Artery By	oass C	Ovaries: Tubal Ligation	☐ Uterus: Hysterectomy
□ Joint Replacement: Hip (R/	'נ) ב	Joint Replacement: Knee (R/L	☐ Defibrillator
□ Pacemaker □ OI	her:	····	
Skin Disease History:			
□ Actinic Ke	ratosis ("pre-cancers'	') 🔲 Basal Cell Skin Cancer	□ Squamous Cell Skin Cäncer
□ Dry Skin □ Eczema		☐ Psoriasis	□ Rosacea
☐ Precancerous (Dysplastic)	Moles	Lupus	Other:
🗆 Melanoma Skin Gancer: V	/hen/Where		
Do you wear sunscreen? Ye	s/No. If yes, what SPF	7 Tanning bed use? Y	es/No. if yes, for how long?
Social History: (Circle One)	Smoked Current	Smoker Former Smoker: To	tal years smoking

Occupation:	None	1 or less per day	1-2 per day If retired, please list pro	3 or more per day
if disabled, list disabili	ty):			·
Current Medications:				
			•	
	·······			
List any over the count	ter or herbal	supplements you take:		
Do you take any blood	44.1			
	thinners? if:	so, please list:		
Are you allergic to any	medications	? Yes/NO. If yes, list medi	cations:	opical Antibiotics
Are you allergic to any Do you have allergies t	medications	? Yes/NO. If yes, list medi	cations:	
Are you allergic to any Do you have allergies t History of Staph infecti	medications o: ion or MRSA	? Yes/NO. If yes, list medi Adhesive ULI Infection UYes UN	cations:	
Are you allergic to any Do you have allergies t History of Staph infecti Are you currently expa	medications to: ion or MRSA teriencing any	? Yes/NO. If yes, list medi Adhesive ULI Infection UYes UN	cations:	
Are you allergic to any Do you have allergies t History of Staph infecti Are you currently expending the problems with bleed	medications to: ion or MRSA eriencing any	? Yes/NO. If yes, list medi Adhesive U Infection UYes UN y of the following?	cations:	opical Antibiotics
Are you allergic to any Do you have allergies t History of Staph infecti Are you currently expe I Problems with bleed Problems with Heali	medications to: If the series of the series	? Yes/NO. If yes, list medi Adhesive U Infection U Yes U No y of the following? Depression	cations: docaine	opical Antibiotics Thyroid Problems
Are you allergic to any Do you have allergies t History of Staph infecti Are you currently expe Problems with bleed Problems with Heali Problems with scarri	medications to: If the series of the series	? Yes/NO. If yes, list medi Adhesive □ Li Infection □ Yes □ No y of the following? □ Depression □ Joint Aches	cations: docaine	opical Antibiotics ☐ Thyroid Problems ☐ Muscle Weakness
Are you allergic to any Do you have allergies thistory of Staph infection Are you currently expending Problems with bleed Problems with Healiful Problems with scarring Rash	medications to: If the second in the second	? Yes/NO. If yes, list medi Adhesive	cations: ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	opical Antibiotics ☐ Thyroid Problems ☐ Muscle Weakness ☐ Headaches
Are you allergic to any Do you have allergies t	medications to: If the second in the second	? Yes/NO. If yes, list medi Adhesive	Dry, Itchy Eyes	opical Antibiotics □ Thyroid Problems □ Muscle Weakness □ Headaches □ Cough □ Selzures

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