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

WILLIAM J. HELMS, M.D.
DERMATOLOGY CLINIC
P.O. Box 804
Russellville, AR 72811
(479) 968-8940 Fax (479) 968-8981

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 alternative 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 retaliation 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

William J. Helms, M.D.
Dermatology Clinic

First:_____ MI:____ Last:_____ DOB:_____

Gender:_____ Race:_____ Ethnicity:_____ SSN:_____

Preferred Language:_____ Email:_____

Cell Phone:_____ Home Phone:_____

Address:_____

City:_____ State:_____ Zip code:_____

Preferred Pharmacy:_____ Primary Care Physician:_____

Occupation: _____ Pt height: _____ Pt weight: _____

Parent or Legal Guardian:

First:_____ MI:____ Last:_____ DOB:_____

Relationship to patient:_____ SSN:_____

INSURANCE 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. Helms, M.D. Dermatology Clinic. I hereby acknowledge receipt of Helms Dermatology's Notice of Privacy Practices.

Name (Please Print):_____

Signature:_____ Date:_____

OR

I am a parent or legal guardian of (patient name) _____. I hereby acknowledge receipt of Helms Dermatology's notice of Privacy Practices with respect to the patient.

Name (Please Print):_____ (please circle one) Parent or Legal Guardian

Signature:_____ Date:_____

The following individual(s) may receive my protected health information (PHI)

_____

_____

_____

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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. Helms 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 _____ Date _____

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Name:_____

Vaccination Record

Pneumonia Vaccination: (Yes/No) Date: _____FLU Vaccination: (Yes/No) Date: _____

COVID Vaccination: (Yes/No) Date: _____

(65 and Older ONLY) Do you have a health care proxy: (Yes/No) If yes, who?_____

Do you have a living will? (Yes/No)

MEDICAL HISTORY

Date of Birth: _____ Reason for Visit: _____

Have you had or do you have any of the following conditions?

☐ 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 pregnancy ☐ Premedication prior to procedures ☐ Rapid heartbeat with epinephrine?

Have you had any of the following surgeries?

☐ Heart: Replace Biological Valve	☐ Heart: Replace Mechanical Valve	☐ Heart: PTCA (Stents)
☐ Heart: Coronary Artery Bypass	☐ Ovaries: Tubal Ligation	☐ Uterus: Hysterectomy
☐ Joint Replacement: Hip (R/L)	☐ Joint Replacement: Knee (R/L	☐ Defibrillator

☐ Pacemaker ☐ Other: _____

Skin Disease History:

☐ Acne	☐ Actinic Keratosis ("pre-cancers")	☐ Basal Cell Skin Cancer	☐ Squamous Cell Skin Cancer
☐ Dry Skin	☐ Eczema	☐ Psoriasis	☐ Rosacea
☐ Precancerous (Dysplastic) Moles		☐ Lupus	Other: _____

☐ **Melanoma Skin Cancer: When/Where** _____

Do you have a family history of Melanoma: YES/NO If yes, which relative? _____

Do you wear sunscreen? Yes/No. If yes, what SPF? _____ Tanning bed use? Yes/No. If yes, for how long? _____

Social History: (Circle One)

Smoking Status: Never Smoked Current Smoker Former Smoker: Total years smoking_____

Alcohol Intake: None 1 or less per day 1-2 per day 3 or more per day

Occupation: _____ (If retired, please list previous occupation)

If disabled, list disability): _____

Current Medications:

_____ _____

_____ _____

_____ _____

_____ _____

List any over the counter or herbal supplements you take: _____

Do you take any blood thinners? If so, please list: _____

Are you allergic to any medications? Yes/NO. If yes, list medications: _____

Do you have allergies to: ☐ Adhesive ☐ Lidocaine ☐ Topical Antibiotics

History of Staph Infection or MRSA Infection ☐ Yes ☐ No

Are you currently experiencing any of the following?

☐ Problems with bleeding	☐ Depression	☐ Bloody Urine	☐ Thyroid Problems
☐ Problems with Healing	☐ Joint Aches	☐ Sore Throat	☐ Muscle Weakness
☐ Problems with scarring	☐ Diarrhea	☐ Dry, Itchy Eyes	☐ Headaches
☐ Rash	☐ Nausea	☐ Blurry Vision	☐ Cough
☐ Immunosuppression	☐ Vomiting	☐ Night Sweats	☐ Seizures
☐ Fever/Chills	☐ Abdominal Pain	☐ Unintentional Weight Loss	

Signature of Patient: _____ Date: _____