Explanation of Information Received

At Affiliated Dermatology you may receive information in regards to your weight, smoking, drinking, and fall risk from your appointment. This information is collected from the medical history form you fill out for our office. It is our number one goal to treat and concentrate on your skin concerns so the information will be documented and education will be given to you via our patient portal. If you want to discuss any concerns related to the information gathered that is not related to your skin issues. Please let our staff knows so we can do that at one of your visits, otherwise the education given is for your reference only.

Ultimately, the goal of the government is for doctors, hospitals, clinical researchers, payers, technology developers, individuals, and pharmacies to be able to share medical information with each other as well as patients and their caretakers, such as nursing homes and hospitals.

The Health Information Technology for Economic and Clinical Health (HITECH) program requires providers to demonstrate "Meaningful Use" or another name is (**MIPS**) of an electronic health record. Meaningful use (**MIPS**) is a CMS Medicare and Medicaid program to improve patient care.

To achieve Meaningful Use (MIPS), providers must follow a set of criteria that serve as a roadmap for effectively using an EHR.

The ultimate goal of (MIPS) is to build a learning health system by 2024. Healthcare records shared among doctors, researchers, clinical trials and pharmacists will help each segment learn from the other to better understand and treat patients and illnesses.

****This transition has made it so healthcare providers, regardless of their specialty, must document the same patient information. This information will not be used to refuse treatment of a patient at Affiliated Dermatology. The following information must be included in each patients office visit/encounter:**

- Reason for the visit
- Relevant history (medications, height/weight, personal Hx and family Hx)
- Identify health risk factors (Alcohol use, BMI, Smoking, Fall risk, Exercise)
- Patient's progress, response to treatment, changes in treatment or revisions in diagnoses should be documented
- Describe the patient's response to services such as interventions, care, treatments, etc.
- exam and prior diagnostic test results; reports if applicable
- Describe the patient's response to medications
- Assessment, clinical impression
- Document any revisions to the plan of treatment
- Plan for care