Center For Dermatology

PATIENT INFORMATION

Last Name ________________________________ First Name ____________________ MI _____ DOB____/_____/____

Sex: □ M □ F Marital Status: □Single □Married □Divorced □Widowed SSN___________________________

Home Address ____ Apt or Unit #_________________________

City____ State_______________________Zip_______________________

Phone: **H**ome ___________________**M**obile __________________ **W**ork _________________ Preferred: □**H** □ **M** □ **W**

May we leave a detailed message at your preferred number? □ **Yes** □ **NO**

Email Address ____ **Authorize Email?** □ Y □ N

Employment Status: □ Employed□ Unemployed □ Student □ Retired Employer Name ____________________________

Emergency Contact __________________________________Relationship ____________________ Phone________________

Preferred Language ______________________ Race_____________________________ Ethnicity__________________

RESPONSIBLE PARTY INFORMATION, PARENT/LEGAL GUARDIAN (If patient is under 18yrs)

Last Name _________________________________ First Name _________________________ DOB______/______/______
Relationship to Patient ____________________________ SSN _________________________
Home Address: ___________________________________City _________________ State ________ Zip ________________
Home Phone __________________________ Cell Phone_____________________ Work phone________________________

INSURANCE INFORMATION

Primary Insurance Company _____________________________________ Subscriber Name_________________________
Subscriber SSN#/ID ____________________________ DOB____/____/____ Relationship______________________
Secondary Insurance Company __________________________________ Subscriber Name _________________________
Subscriber SSN #/ID ______________________________ DOB____ /___/_____ Relationship________________________

REFERRAL INFORMATION

Were you referred by a doctor's office? □ Yes □ No
Physician/Practice Name______________________________________ Address/Phone________________________________
How did you hear about us? □ Physician □ Insurance □ Internet ___________________ □Print _________________
□ Family ______________________________________ □ Friend ____

COMMUNICATION CONSENT

Your provided information may be used to contact you by telephone/text/mail/email for appointment reminder, treatment, payment, and/ or health care operations. We may leave a detailed message on your preferred phone number regarding biopsy reports, test results and prescriptions. If you have any restrictions, please let us know on this line.

____

I authorize Center for Dermatology, LLC to obtain/ have access to my medication history.
I hereby consent to treatment of myself, my child or above-named minor for whom I accept responsibility; and the release of medical information to primary care physician/referring physician, any insurance carrier and/or direct payment to Center for Dermatology, LLC for any authorized treatment or examination rendered. I hereby acknowledge and accept final responsibility for payment or charges for medical services rendered. I acknowledge above information is accurate. I understand that I am to inform Center for Dermatology LLC, of any changes as soon as they occur.

Patient /Guardian Name ____ Date________________________

Center For Dermatology

Medical History

Patient Last Name__________________**Patient First Name**_______________________ **DOB**__________

PHARMACY _______________ Pharmacy Address___________________________ City_______________

Consent to download pharmacy benefits and my e-prescribe history. ____________ Initial

Primary Physician: ___________________________**Referring Physician** _________________________________

REASON FOR VISIT: ____

ALLERGIES ____ Latex Allergy: □Yes □No _______

MEDICATIONS____

____

____

MEDICAL HISTORY (At today's visit, do you have any?)

□Arthritis	□Depression	□Hypertension	□Seizures
□Asthma	□Diabetes	□Hyperthyroidism	□Stroke
□*AFib/Irregular Heart Beat*	□End Stage Renal Failure	□Hypothyroidism	□Seasonal Allergies
□Bone Marrow Transplant	□GERD (Reflux)	□Leukemia/Lymphoma	□Treatment with gold
□Breast Cancer	□Hearing Loss	□Irregular periods	□Accutane use in past
□*Cold sores/Fever blisters*	□*Hepatitis*	□Lupus	When_________
□Colon Cancer	□*Herpes*	□Lung cancer	
□COPD/Emphysema	□*HIV/AIDS*	□Radiation Treatment	□**NONE**

Do you have any **other medical conditions?** ____

List any **surgical procedure** you had in the past ____

REVIEW OF SYSTEMS *Please check all that apply.*

□ Abdominal discomfort	□ Fever	□ *Allergy to lidocaine*	□*HIV*
□ Blood in urine	□ Headache	□ *Allergy to Antibiotic ointment*	□*Liver Problems*
□ Blood in stools	□ Itching	□ *Artificial Heart Valve*	□*Latex Allergy*
□ Blurry vision	□ Joint Pain	□ *Artificial Joints*	□*MRSA*
□ Crusting/Bleeding lesion	□ Muscle weakness	□ *Blood thinner*	□*Pacemaker*
□ Current infection	□ Nausea/Vomiting	□ *Defibrillator*	
□ Diarrhea/ loose stool	□ Neurological symptoms	□ *Dizziness with Procedure*	□*NONE*
□ Dry skin	□ Recent weight loss	□ *Epinephrine Sensitivity*	
□ Fatigue	□ Sore throat	□ *Heart Murmur*	□*Other*_________________
	□ Sun sensitivity		

FOR FEMALE PATIENTS

Are you Pregnant?	□Yes □No	Birth Control Method_______________________________			
Are you Planning Pregnancy?	□Yes □No	Tubal Ligation	□Yes □ No	Hysterectomy	□Yes □No
Are you Nursing/Breastfeeding?	□Yes □No	Menopause	□Yes □ No		

All medicines, including topical creams, have varying concerns during pregnancy or while nursing an infant

Center For Dermatology

Patient Last Name____________________ Patient First Name____________________ DOB __________

SKIN DISEASE HISTORY **Please check all that apply.**

□Acne
□Actinic Keratosis
□Basal Cell Carcinoma
□Blistering Sunburns
□Eczema
□Poison IVY
□Precancerous Moles
□Psoriasis
□Squamous Cell Carcinoma
□ **None**
□ **Other:** ____

SOCIAL HISTORY

Do you Smoke? □ Never □ Past □ Daily □Occasional
Do you drink Alcohol? □ Yes □ No If yes, □ less than 1 drink/day □2-3 drinks/day □3 +drinks/day

OCCUPATION ______________________________

FAMILY HISTORY Please check all that apply

		Which Relative?
Eczema	□ Yes □ No	
Asthma	□ Yes □ No	
Psoriasis	□ Yes □ No	
Basal Cell Carcinoma	□ Yes □ No	
Melanoma	□ Yes □ No	
Squamous Cell Carcinoma	□ Yes □ No	
Lupus	□ Yes □ No	
Genetic Disorder	□ Yes □ No	
Type:		

Have you had received a pneumonia vaccination with in the last 3 year? Yes / No
Have you had the flu vaccine this flu season? Yes / No
Have you received shingles vaccine? Yes / No

Do you have a living will? Yes / No

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes / No

Which of the following best applies to you?

___ Do not intubate, I do not want a breathing tube to save my life

___ Do not resuscitate, I do not want CPR to save my life

___ Use any means necessary to save my life

A yearly full skin exam is recommended for early detection of skin cancers. Would you like to have a full skin exam?
□Yes, Today (If time permitting). □Yes, Next visit □ No, I decline.

I certify that the medical history provided is correct and complete to the best of my knowledge.

____

Patient Signature; and if minor, parent, or guardian signature

Authorization for Release of Information to Family Members

Patient Name_______________________________________ Date of Birth_____________________

Many of our patients allow family members such as their spouse, parents, or others to call and request medical billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members you must sign this form. Signing this form will only give information to family members indicated below.

I authorize Center for Dermatology to release my medical and /or billing information to the following individuals(s):

1. ___________________________________ Relation to Patient __________________________________

2. ___________________________________ Relation to Patient __________________________________

3. ___________________________________ Relation to Patient __________________________________

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that the information disclosed to any above recipient is no longer protected by the federal or state law and may be subject to re-disclosure by the above recipient. You have a right to revoke this consent in writing.

Signature: ____ Date: ______________________

Receipt of Notice of Privacy Practices

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. We have copies of this Notice available in our office. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations; however, we are not required to agree to this restriction.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Signature: ____ Date: _______________________

SUMMARY OF OFFICE POLICIES

We are committed to providing you with best possible medical care. In our effort to better communicate with you, following information is provided to avoid any misunderstandings.

FINANCIAL:

The health insurance is a contract between you and the insurance company. As such you may have obligations such as co-payments, co-insurance, deductible, non-covered services, referral requirements, and pre-existing conditions to name a few.

All co-payments, applicable deductibles, and coinsurance are due at the time of service. Regardless of insurance coverage, you are responsible for full and timely payment of all charges incurred. Center for Dermatology cannot waive/discount any co-insurance, copayment or deductible. This includes charges for non-covered services. If the balance has not been received, or other payment arrangements have not been made, your outstanding balance may be sent to collection agency within 90 days of the first billing statement. Any services charges incurred due to inaccurate information, fees required by the collection agency or banks for returned checks will be assessed to you.

Medicare Patients: If you have regular Medicare Part B only and have not met your deductible, we will collect the deductible amount along with your 20% co-insurance at the time of the visit. If you have met with your deductible, we will only collect your 20% co-insurance at the time of your visit.

Self-Pay Patients / Non-covered Services: Payment in full will be collected at the time of the office visit.

BILLING SERVICE:

This office utilizes services of an outside billing company to file claims to the insurance companies, send billing statements to patients, and collect balances as necessary.

TREATMENT OF MINOR:

Center for Dermatology requires minors (<18) to be accompanied by their legal guardian. We reserve the right to cancel or reschedule the visit if this criterion is not met. Safety: Please observe young children as appropriate in terms of contact with medical equipment, hazard bins, rolling stools etc.

REFERRALS:

I understand that it is my responsibility to obtain any referral required by my insurance company from my primary care physician or referring physician.

MEDICAL RELEASE:

All records request must be submitted in writing and required a signed release from patient. All record requests require 3 business day.

PRESCRITION REFILL POLICY:

Please read carefully of our office policy regarding prescription refills.

1. Prescription should be filled at the time of the visit.
2. Prescriptions and refills are handled only during regular office hours.
3. Topical medications may be refilled up to six months from your last visit.
4. Oral medications may be refilled up to three months from your last visit.
5. Please allow up to 24-48 hours to fill the prescription.

After this time, we will not refill your prescription without seeing you for a follow up appointment. If you need a refill, it is your responsibility to make sure that you have been seen within this time frame.

PHONE MESSAGE POLICY:

Any message left for the staff of Center for Dermatology will be returned as soon as possible and could take up to 48 hours. This includes but is not limited to: pathology reports, prescription refills, prior authorizations, billing, after hour calls, and any other non-emergency question.

LABORTARY & PATHOLOGY FEES:

At times, it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, you will receive a separate bill from the pathologist or laboratory for these tests. If your insurance plan has a preferred provider for blood work or pathology, please notify our office staff prior to any procedure for special handling. Although the lab will file with your insurance, you are responsible for any bill you may receive from the laboratory or pathologist. Please discuss any billing errors or discrepancies with those institutions.

APPOINEMENT CANCELLATION & NO SHOW POLICY:

We will reserve your appointment time specifically for you. If there is a need to cancel or reschedule an appointment, we request that you give us a minimum of 24-hour notice to provide the best possible service and availability to all our patients. The office may charge $50 for any appointments not cancelled 24 hours in advance and patient may be asked for deposit before the next appointment will be reserved. This deposit will be fortified if the appointment is not kept.

Surgical & Cosmetic appointments required 48 business hours' notice to cancel an appointment & may incur a higher charge.

COSMETIC SERVICE POLICY:

Cosmetic services are not covered by insurance and must be paid in full at the time of service if prepayment has not been made. 50% Payment is required at the time of scheduling for Laser, Juvederm, skin tags. A down payment of $50.00 will be required at the time of scheduling for all other cosmetic service.

If you cancel your appointment less than 48 business hour notice or you no show for your appointment deposit will be fortified.

You will be asked to sign the form on an electronic pad at reception desk.

Thank you.

NO SHOW POLICY

In order to serve our patients in a timely manner, we do not overbook appointments. Failure to cancel or keep a scheduled appointment prevents us from being able to see other patients. For this reason, it is our policy to charge a $50 fee when an appointment is missed or is cancelled with less than 24 hours' notice.

Confirmation calls are made 24 to 48 hours in advance to remind patients of their appointment. Messages will be left on the patient's phone (when possible) to allow time for the patient to cancel the appointment.

I have read the above policy and understand that I will be charged a $50 fee if I fail to show up to my scheduled appointment or if I give less than 24-hours' notice of cancellation.

____

SIGNATURE

____

PRINT NAME & DATE OF BIRTH

____

TODAY'S DATE