SOUTHWEST DERMATOLOGY CENTER

Martin J. Safko, MD

PATIENT INFORMATION

PATIENT NAME _____ **SEX** ☐ **M** ☐ **F**
LAST FIRST MI

ADDRESS _____
STREET UNIT # CITY STATE ZIP

SOCIAL SEC. NO. ___/___/___ **CHECK ONE** ☐ **MARRIED** ☐ **SINGLE** ☐ **DIVORCED** ☐ **WIDOWED**

HOME PHONE (___) _____ **CELL NO.** (___) _____ **DOB** _____
MM/DD/YYYY

EMAIL ADDRESS _____

EMPLOYER _____ **OCCUPATION** _____

BUSINESS ADDRESS _____ **PHONE** (___) _____
STREET CITY STATE ZIP

PERSON RESPONSIBLE FOR ACCOUNT _____ **RELATIONSHIP** _____

ADDRESS _____ **PHONE** (___) _____
STREET CITY STATE ZIP

EMPLOYER _____ **PHONE** (___) _____

NAME OF NEAREST RELATIVE NOT LIVING WITH YOU _____ **PHONE** (___) _____

REFERRED BY ☐ **DOCTOR, NAME** _____ **PHONE** (___) _____
☐ **YELLOW PAGES** ☐ **RADIO / TV** ☐ **INTERNET** ☐ **OTHER**

PRIMARY PHYSICIAN _____ **PHONE** (___) _____

PRIMARY INSURANCE INFORMATION

INSURANCE CO. _____
POLICY NO. _____
GROUP NO. _____
INSURED'S NAME. _____
INSURED'S S.S. # ___/___/___
RELATIONSHIP _____ **DOB** _____

SECONDARY INSURANCE INFORMATION

INSURANCE CO. _____
POLICY NO. _____
GROUP NO. _____
INSURED'S NAME. _____
INSURED'S S.S. # ___/___/___
RELATIONSHIP _____ **DOB** _____

HAVE YOU APPLIED OR ARE YOU ELIGIBLE FOR MEDICAID? ☐ **Y** ☐ **N** **DATE APPLIED** _____

ALL REFFERALS FROM MY PRIMARY CARE PHYSICIAN (PSP), WHERE APPLICABLE, ARE MY RESPONSIBILITY. CO-PAY AND DEDUCTIBLES ARE DUE AT THE TIME SERVICES ARE RENDERED UNLESS PAYMENT ARRANGEMENTS HAVE BEEN MADE. I CERTIFY THAT THE ABOVE INFORMATION IS TRUE AND CORRECT. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ANY MEDICAL FEES NOT COVERED BY MY INSURANCE PLAN DUE TO PARTICIPANT TERMINATION OF BENEFITS, DEDUCTIBLES, AND CO-PAYMENTS.

_____ _____
DATE **PATIENT SIGNATURE (GUARDIAN OR PARENT IF PATIENT IS UNDER 18 YRS)**

OFFICE USE ONLY

ENTERED BY _____ ACCOUNT NO. _____ REVIEWED _____

ADD'L NOTES: _____

SOUTHWEST DERMATOLOGY CENTER

PATIENT MEDICAL HISTORY

NAME _____ **DATE** _____

ARE YOU CURRENTLY TAKING ANY MEDICATIONS? ☐ Y ☐ N **IF YES, PLEASE LIST** _____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Y ☐ N **IF YES, PLEASE LIST** _____

_____

DO YOU USE TOBACCO? ☐ Y ☐ N **IF YES, HOW MUCH?** _____

DO YOU DRINK COFFEE / TEA? ☐ Y ☐ N **IF YES, HOW MUCH?** _____

DO YOU DRINK ALCOHOLIC BEVERAGES? ☐ Y ☐ N **IF YES, HOW MUCH?** _____

HAVE YOU HAD ANY PREVIOUS SURGERIES? ☐ Y ☐ N **IF YES, PLEASE LIST** _____

_____

_____

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Y ☐ N **IF YES, DATE OF** _____

DO YOU OR HAVE YOU EVER USED ANY STREET DRUGS? ☐ Y ☐ N **IF YES, EXPLAIN** _____

_____

ARE YOU A POSSIBLE HIV/AIDS RISK? ☐ Y ☐ N **IF YES, EXPLAIN** _____

_____

DO YOU EXERCISE REGULARLY? ☐ Y ☐ N **IF YES, WHAT TYPE** _____

WHAT IS YOUR OCCUPATION? _____

CHECK ANY ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES AND LIST RELATIONSHIP

ARTHRITIS	☐	_____	LIVER DISEASE	☐	_____
ASTHMA	☐	_____	LUNG DISEASE	☐	_____
AUTO IMMUNE DISORDER	☐	_____	MALIGNANT MELANOMA	☐	_____
ECZEMA	☐	_____	OBESITY	☐	_____
CANCER	☐	_____	CORONARY HEART DISEASE	☐	_____
COLON CANCER	☐	_____	PSORIASIS	☐	_____
DIABETES	☐	_____	SKIN CANCER	☐	_____
GLAUCOMA	☐	_____	THYROID DISEASE	☐	_____
HAY FEVER	☐	_____			
HIGH BLOOD PRESSURE	☐	_____			
HIGH CHOLESTEROL	☐	_____			

SOUTHWEST DERMATOLOGY CENTER

CHECK ANY ILLNESSES YOU HAVE HAD OR CURRENTLY HAVE

- ☐ RECENT WEIGHT LOSS / WEIGHT GAIN
- ☐ ASTHMA
- ☐ HAY FEVER
- ☐ HIVES
- ☐ ECZEMA
- ☐ DIABETES
- ☐ CORONARY HEART DISEASE
- ☐ LUNG DISEASE
- ☐ TUBERCULOSIS
- ☐ ARTHRITIS
- ☐ HEADACHES
- ☐ NEUROLOGICAL DISEASE
- ☐ ANEMIA
- ☐ PSORIASIS
- ☐ SIMPLEX
- ☐ KELOIDS
- ☐ SKIN CANCER, TYPE _____
- ☐ THYROID
- ☐ HIGH BLOOD PRESSURE
- ☐ HEPATITIS
- ☐ KIDNEY DISEASE
- ☐ MIGRAINES
- ☐ SEIZURES
- ☐ LUPUS
- ☐ BLEEDING DISORDERS
- ☐ VENEREAL DISEASE
- ☐ HERPES
- ☐ OTHER _____

REASON FOR VISIT? _____

HAVE YOU HAD THIS PROBLEM BEFORE? ☐ **Y** ☐ **N** **IF YES, EXPLAIN** _____

HAVE YOU HAD THIS PROBLEM TREATED BEFORE? ☐ **Y** ☐ **N** **IF YES, EXPLAIN** _____

FEMALES

IS YOUR MENSTRUAL CYCLE ☐ **REGULAR** ☐ **IRREGULAR** **DATE OF LAST CYCLE** _____

DO YOU THINK YOU ARE PREGNANT? ☐ **Y** ☐ **N**

ARE YOU TAKING BIRTH CONTROL? ☐ **Y** ☐ **N** **TYPE?** _____

I, the undersigned, consent to all medical or surgical treatment prescribed by Martin J. Safko, M.D. or his assistant to the administration and performance of all examination, treatment, anesthetics, operations, photographs, or other procedure which may be deemed necessary or advisable. I understand that no guarantee or assurance has been made as to the results that may be obtained. I agree to be responsible for payments of all charges not covered by insurance. I further, understand and agree to follow the advice of the physician in securing the follow-up treatment and care. I authorize Dr. Safko to furnish my insurance company any medical information necessary for payment of my claims. I hereby authorize payment directly to Dr. Safko of the insurance benefits, otherwise payable to me, but not to exceed regular charges for his services.

In the event that I do not pay any part of my bill, I understand, I will be sent to a collection agency. And that I will be responsible to pay ALL collection/attorney fee and court costs.

Dr. Safko is authorized to release medical information as may be deemed necessary, and as permitted by law, to ensure continuity of care in the event of transfer to another facility. It is understood that this information will only be transferred to the facility to which the patient is being admitted.

Dr. Safko may disclose all or part of the patients records to any person or corporation which is or my be liable under contract to the patient or to an employer for all or part of Dr. Safko's charges, including, but not limited to, health care service plans, insurance companies, worker's compensation carriers, welfare funds, or the patients employer.

PATIENT / GUARDIAN SIGNATURE _____ **REVIEWED BY:** _____

SOUTHWEST DERMATOLOGY CENTER
PATIENT NOTICE OF PRIVACY PRACTICES AND CONSENT FORM

Our Notice of Privacy Practices provides information about how Southwest Dermatology Center may use and disclose protected health information about you. You have the right to review our Notice before signing the Consent. We may need to change the terms of our Notice, at which time you can obtain a new copy by contacting our office.

By signing this form, you consent to our use and disclosure of your protected health information for the following: your medical treatment, requesting health insurance payments, and general health operations. We provide this form to comply with the Health Insurance Portability and Accountability act of 1996 (HIPPA)

We want you to understand that:

* Your health information may be disclosed or used for your treatment, requesting insurance payment or necessary healthcare operations.

* Southwest Dermatology Center has a "Notice of Privacy Practices" posted and you as our patient have the opportunity to review this notice.

* Southwest Dermatology Center reserves the right to change the Notice of Privacy Policies.

* You, the patient, have the right to restrict the use of your information but Southwest Dermatology Center does not have to agree to treat you with those restrictions.

* The patient may revoke this consent in writing at any time and all future disclosures will then cease.

* Southwest Dermatology Center state in the Notice of Privacy Practices, that we may disclose billing information to your spouse or guardian.

Is this acceptable? ☐ **Y** ☐ **N**

IF YES, NAME OF PERSON _____ **RELATIONSHIP** _____

PATIENT OR REPRESENTATIVES

SIGNATURE _____

THIS CONSENT WAS SIGNED BY _____ **ON THE DATE OF** _____

(PRINTED NAME)

RELATIONSHIP TO PATIENT _____

IN FRONT OF _____

(PRINTED NAME OF PRACTICE REPRESENTATIVE)

SOUTHWEST DERMATOLOGY CENTER
PATIENT FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Dear Patient,

Thank you for choosing us as your health care provider. The following is our Financial Policy. If you have any questions or concerns about our payment policy, please do not hesitate to ask our Billing Department or Office Manager.

Payment for services are due at the time services are rendered. We accept cash, checks, and all major credit cards (Visa, Mastercard, American Express) Please do not assume we bill your insurance company. We will submit an insurance claim on your behalf if we have a provider contract with your insurance company. If your insurance company coverage changes, please notify the Billing Department Immediately.

PLEASE UNDERSTAND THE FOLLOWING:

***** Your insurance policy is a contract between you, your employer and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company.

* All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover. Fees for these services, along with unpaid deductibles and co-payments are due at the time of the treatment. You are responsible for knowing these amounts. You are responsible for any collection fees, court costs, etc.

* You are responsible for knowing your insurance benefits. Does your insurance require a Primary Care Physician (PCP) referral? Does your physician participate in your plan? What facilities participate in your plan? You are ultimately responsible for your referrals.

* If the insurance company does not pay in full within 30 days, we ask that you contact the insurance carrier. If your insurance does not pay in full within 45 days, we require you to pay the balance due with cash or check.

* Returned checks are subject to a $25.00 return check fee

* No call / No Show fee for an office visit is *$25.00* and for a surgical visit is *$75.00* . Notification must be at least 1 business day in advance if you cannot make your scheduled appointment.

We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

PATIENT SIGNATURE _____ **DATE** _____

SOUTHWEST DERMATOLOGY CENTER

DUE TO NEW FEDERAL REGULATIONS THE FOLLOWING INFORMATION MUST BE ADDED TO YOUR MEDICAL RECORD.

NAME _____

LANGUAGE _____

RACE / ETHNICITY _____

(NOT HISPANIC OR LATINO, ANDALUSIAN, ARGENTINEAN, ASTURIAN, BELEARIC, ISLANDER, BOLIVIAN, CANAL ZONE, CANARIAN CASTILLIAN, CATALONIAN, CENTAL AMERICAN, CENTRAL AMERICAN INDIAN, CHICANO, CHILEAN, COLOMBIAN, COSTA RICAN, CRIOLLO, CUBAN, DOMINICAN, ECUADORIAN, GALLEGO, GUATEMALAN, HISPANIC OR LATINO, HONDURAN, LA RAZA, LATIN AMERICAN, MEXICAN, MEXICAN AMERICAN, MEXICAN AMERICAN INDIAN, NICARAGUAN, PANAMANIAN, PARAGUAYAN PERUVIAN, PUERTO RICAN, SALVADORAN, SOUTH AMERICAN, SOUTH AMERICAN INDIAN, SPANIARD, SPANISH BASQUE URUGUAYAN, VALENCIAN, VENEZUELAN)

Southwest Dermatology, Dr. Martin Safko, does not and shall not discriminate on the basis of race, color, religion, gender gender expression, age, national origin, disability, martial status, sexual orientation, or military status in any of its activities or operations.