SUNWISE
Family Dermatology & Surgery

Jennifer LaRusso, DO, FACMS, FAOCD, FAAD
Gerard Stroup, PA-C

P (302) 364 - 2000
F (302) 329 - 8807

_____ _____/_____/_____
Name: First / Middle Initial / Last **Date of Birth**

_____
Street Address / City / State / Zip

_____@_____
Email

_____ _____ _____
Home Phone # **Work Phone #** **Cell Phone #**

_____
Employer

How did you hear about SunWise? _____

Consent to Leave a Message

By agreeing, you're allowing any SunWise Dermatology employee to leave a detailed message on your phone concerning the results of your pathology, lab results, appointments

Please select one: ☐ **YES:** I give consent ☐ **NO:** I do NOT consent

Medical Information Release Authorization

List any individuals below that your medical information can be discussed with, including appointments, pathology or lab results, and billing information. **It is your responsibility to update this information in the event information changes**

Name	Relationship	Contact Number

Demographics

☐ Decline to Specify Demographics

Language ☐ English ☐ Spanish ☐ Other

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other

Ethnicity ☐ Hispanic or Latino ☐ Not HIspainic or Latino ☐ Unknown

Race ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Native ☐ Hawiian ☐ White ☐ Other

Medical Care

_____ **Primary Care Doctor**

_____ **Primary Care Location/ Office**

_____ **Primary Care Dr. #**

_____ **Pharmacy Name**

_____ **Pharmacy Location**

_____ **Pharmacy Phone #**

Insurance Information

_____ **Primary Insurance**

Is a Referral Required? ☐ **YES** ☐ **NO**

_____ **Member Identification #**

_____ **Group #**

_____ **Policyholders Name of Insurance**

_____/_____/_____ ***Policyholder's Date of Birth***

_____ **Secondary Insurance**

Is a Referral Required? ☐ **YES** ☐ **NO**

_____ **Member Identification #**

_____ **Group #**

_____ **Policyholders Name of Insurance**

_____/_____/_____ ***Policyholder's Date of Birth***

Patient Consent for Treatment

I consent to be treated by Dr. Jennifer LaRusso DO & other healthcare practitioners providing service at SunWise Dermatology & Surgery. I understand that I am responsible for any charges (or amounts based on payment arrangements agreed to by them) that are included during my treatment and not paid or otherwise satisfied by my insurance benefits or other third party benefits. Where Medicare benefits are applicable;

(a) I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct.
(b) I assign and request payment of authorized Medicare benefits to SUNWISE DERMATOLOGY & SURGERY, LLC.
(c) I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits of related services.
(d) I consent to the use and disclosure of my health information for treatment, payment & healthcare operations purposes as described in SunWise Dermatology & Surgery Notice of Privacy Practices.

_____ _____

Signature **Date**

HIPAA Patient Privacy and Rights Disclosure

Health Insurance Portability and Accountability Act (HIPAA)
Patient Privacy and Rights Disclosure

SunWise Family Dermatology & Surgery and its employees disclose information given to us by you, your insurance company, primary care doctor and/or other medical professionals strictly for the purposes of treatment, payment of services rendered or health care operations.

We do not sell mailing lists or disclose personal information about our patients except which is needed to carry out our objectives, which is your health.

In compliance with HIPAA guidelines, the patient understands that they have the right to review any information which is documented in the patient;s record by our office and the right to add an addendum to such records of recorded information is disputed.

By signing this consent, you agree to allow SunWise Family Dermatology & Surgery to use and disclose personal information about you for the reasons above. You have the right to revoke this consent at any time but must be aware that we cannot guarantee your care unless we can communicate with other health professionals when necessary.

This notice of privacy will become a part of the patient’s medical record.

_____ _____

Signature **Date**

Financial Policy

We appreciate the opportunity to serve you, and want to thank you for choosing our clinic for you Dermatology services. We are committed to your treatment success and strive for providing you excellence in service. Prior to receiving any services, we do require you to read and sign the following statement regarding our Financial Policy:

Forms of Payment: We accept cash, check, Visa, MasterCard, American Express and Discover.

Patient Responsible Balances Due at Time of Service: Co-pays that are required by your insurance policy are due at the time of service. If you have no insurance and are self-pay, or if having an elective non-covered service, your balance in full is required at time of service. If you or any of your family members have an outstanding balance, we may ask for payment of this balance at this time.

Insurance Billing: As a courtesy to our patients, we bill most major insurance carriers directly. Your insurance policy is a contact between you and your insurance carrier. We are not a party to that contract. You are responsible for understanding how your insurance works. If your insurance denies a claim, due to inaccurate or incomplete information you have provided to us or them or your failure to obtain a referral, we may bill to you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. I authorize the release of information to process this claim and also authorize payment of medical benefits directly to SunWise Dermatology & Surgery, LLC. We will ordinarily help you as best possible to get proper and timely payment from your insurance.

Medicare Health Insurance: I request that payment of authorized Medicare benefits be made either to me or my behalf to SunWise Dermatology & Surgery, LLC for any services furnished to me by SunWise Dermatology & Surgery, LLC. I authorize any holder of Medical Information about me to be released to HealthCare Financial Administration and its agents any information needed to determine these benefits payable for related services.

Missed Appointment Fees: If you miss, cancel or reschedule an appointment within less than 24 hours of the appointment time, there may be a $25 fee assessed to your account, depending on the circumstances and previous appointment history.

Missed Surgery Appointments: We need 48 hours notice to change a surgery appointment or a fee of $50 will be assessed to your account.

Returned Check Fees: If your check is returned by the bank due to insufficient funds in your account, there will be a $36 fee assessed to your account.

Account Balances: Please pay your bill promptly or call us at your earliest convenience if you have any questions about your balances due. Our general policy is that balances due be paid within 30 days. Outstanding balances not paid within 60 days may be turned over to a collection agency, resulting in further finances charges reporting to national credit bureaus, such as Trands-Union, Experian and Equifax. Please contact us immediately if special financial circumstances arise, as we may be able to arrange a payment plan.

Thank you for taking time to read and understand our Financial Policy. Please let us know if you have any questions or concerns.

Telephone Consumer Protection Act (TCPA): You agree, in order for us to service your account or to collect monies you may owe, **SunWise Family Dermatology & Surgery,** and/or our agents may contact you by telephone or any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provided to us. Methods of contact may include using pre-records/artificial voice messages and/or use of automatic dialing devices, as applicable.

I/we have read this disclosure and agree that SunWise Family Dermatology & Surgery, its employees and/or agents may contact me/us as described above. **My signature below indicates that I have read, understand and agree to the terms of this Financial Policy.**

_____	_____/_____/_____	_____
Patient Name	**Patient Date of Birth**	**Date**
_____	_____	
Printed Name of Parent/ Guardian	**Patient or Parent / Guardian Signature**	

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Consent to Treat a Minor

I, _____, the legal guardian of, _____, authorizes SunWise Dermatology & Surgery, LLC to treat my minor without my presence. This consent includes: discuss and render treatment, perform procedures, order lab work.
This authorization extends to all Sunwise Dermatology & surgery, LLC offices, doctors, physicians assistants and office staff members.

If applicable, under the terms and conditions of divorce, separation, or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize the care should be revoked or modified in any way, the undersigned does hereby agree to notify SunWise Dermatology & Surgery, LLC as soon as possible. If parents are separated or divorced, accurate parent and insurance information is required at the time of service, and only with written consent can any parent become the responsible party. In the event of any disputes, **the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances.**

As of the date below, the undersigned states and avows to have the legal right to select and authorize health care services for the minor names above.

_____ _____
Guardian Signature **Date**

_____
Guardian Print Name

Guarantor Information

Parent or Guardian's information below

_____
Name

_____/_____/_____ _____
Date of Birth **SSN**

_____ _____ _____
Home Phone # **Work Phone #** **Cell Phone #**

_____
Employer

Request for Patient File(s)

_____ _____

To: Facility requesting file form **Fax #**

_____ _____

To: Facility requesting file form **Fax #**

REQUEST FOR PATIENT FILE

Patient Name: _____ **Date of Birth:**_____/_____/_____

Patient Address: _____

I hereby request a copy of my patient file to be forwarded to:

Sunwise Family Dermatology & Surgery

(Initial which option to be released)

1 . Entire records to be released:_____

Patient Initials

2. Specific Sections: _____ _____

(i.e. pathology, labs, cultures) **Patient Initials**

Patient Signature: _____ **Date:** _____

Medical History

Patient Name	Height	Weight	Date of Visit

(Please select all that apply)

- ☐ AIDS
- ☐ Anxiety
- ☐ Arthritis (Psoriatic/Rheumatoid)
- ☐ Asthma
- ☐ Atrial Fibrillation(Heart Attack/Stroke)
- ☐ ***Blood Thinner Use***
- ☐ COPD
- ☐ Coronary Heart Disease
- ☐ Crohn's Disease
- ☐ ***Defibrillator/Pacemaker***
- ☐ ***Dementia***
- ☐ Depression
- ☐ Diabetes
- ☐ ESRF(End-stage renal disease)
- ☐ Epilepsy (seizures)
- ☐ GERD (acid reflux)
- ☐ Hay Fever
- ☐ High Blood Pressure
- ☐ ***HIV Positive/Infection***
- ☐ Hearing Loss/Deafness
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ ***Hepatitis A***
- ☐ ***Hepatitis B***
- ☐ ***Hepatitis C***
- ☐ High Cholesterol
- ☐ Irritable Bowel Syndrome
- ☐ Leukemia
- ☐ Lupus(Discoid/Systemic)
- ☐ Malignant Lymphoma
- ☐ Malignant Tumour (Breast / Colon / Lung / Prostate)
- ☐ ***MRSA/Staph Infection***
- ☐ ***Pregnant/Breastfeeding***
- ☐ Radiation/Chemotherapy
- ☐ Raynaud's syndrome
- ☐ Seasonal Allergies
- ☐ ***Syncope (Fainting with procedures)***
- ☐ Tuberculosis

☐ Other (please specify)

Smoking Status: ☐ Current Daily Smoker ☐ Former Smoker ☐ Never a Smoker

Influenza Vaccine: ☐ Yes ☐ No

Pneumonia Vaccine: ☐ Yes ☐ No

Sunscreen Use (SPF): ☐ 10 ☐ 15 ☐ 30 ☐ 50 ☐ 75 ☐ 100 ☐ NONE

Tanning Bed Use: ☐ Past ☐ Present ☐ NONE

Skin Disease History

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ **Atypical Nevus-Mild/Moderate/Severe**
- ☐ Cold Sores
- ☐ Dry Skin
- ☐ Other Conditions (please specify)
- ☐ **Dysplastic Nevus**
- ☐ Eczema
- ☐ Flaky Scalp
- ☐ Fungal Infections
- ☐ Itching Scalp
- ☐ **Keloid Scarring**
- ☐ Molluscum
- ☐ Poison Ivy
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Shingles
- ☐ Warts

Personal Skin Cancer History

Have you ever been treated for skin cancer? ☐**YES** ☐**NO**
(If YES, please answer below)

Type (BCC/SCC/Melanoma) _____

Location Site _____

Year Treated _____

Treating Physician _____

Family Skin Cancer History

Has anyone in your family ever been diagnosed or treated for skin cancer? ☐**YES** ☐**NO**
(If YES, please answer below)

Type (BCC/SCC/Melanoma) _____ Family Member (Relationship)_____

Past Surgical Procedures *(please describe)*

_____

_____

_____

Daily Prescribed Medications *(please list)*

_____

_____

_____

☐**YES, I take daily Vitamins and/or OTC Medications (please list)** ☐**NO, *I do not take* Vitamins and/or OTC Medications.**

_____

_____

_____

☐**YES, I have allergies to Medications and/or Food (please list)** ☐**NO, *I do not have allergies to Medication and or Food*.**

_____

_____

_____