MOHS SURGERY & DERMATOLOGY CENTER

ELK GROVE DERMATOLOGY, S.C. EST 1986

PATIENT DEMOGRAPHICS AND POLICY NOTIFICATION

Name_____ Today's Date _____
Last First MI

Date of Birth_____ M___F___ Patient's SS# _____

Address _____
Street City State 9 Digit Zip Code

Home Phone (___)_____Work Phone (___)_____Cell Phone (___)_____

Race_____ Ethnicity _____ Primary Language _____ (EMR required)

Email Address _____ Preferred Method of Contact ☐ phone ☐ email ☐ text

Alternate Contact: _____Relationship: _____Phone_____
(Different than Patient's Home #)

Employer (Parent's if minor) _____

Employer Address_____
Street City State Zip

Responsible Party *(if patient is under 18)*_____
(Name) (Relationship to Patient)

Address_____
Street City State Zip

Home Phone_____ Work Phone_____ SS# _____
(Include Area Code) (Include Area Code)

Primary Care Physician_____ Phone _____
(Include Area Code)

_____
Street City State Zip

Were you referred by a physician? _____yes _____no

If yes, physicians name _____
Or (choose all that apply): □Yellow Pages □Article/Newspaper □Word of Mouth □Walk-In □Website □Other

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Mohs Surgery and Dermatology Center

The physicians in this office are Participating Providers with Medicare and several other health plans. Please note that we are not responsible to know and understand each patient's insurance plan and/or the coverage of said insurance plans. If you have questions about your insurance benefits, please contact your insurance company prior to your appointment. Co-Pays are expected at the time of service. If we are not contracted with your insurance plan, PAYMENT IS EXPECTED AT THE TIME OF SERVICE unless other arrangements have been made in advance. We require a 24 hour notice of appointment cancellation. A fee of $35.00 will be billed for late cancellation or failure to keep your scheduled appointment. We accept payment by cash, check or credit card. Any account not paid after 90 days will be considered delinquent and may be submitted to an independent collection agency and reported to the Credit Bureau. In the event your account is referred out for collection, you will be responsible for all collection costs up to thirty percent (30%) of the past due balance. A minimum charge of $25.00 will be added to your account for any check returned to us by your bank.

Your signature below signifies your understanding and agreement with these policies.

Patient's Signature (or responsible party)_____Date_____

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PATIENT CONSENTS, POLICIES, AND RESPONSIBILITIES

Consent for Treatment: In presenting myself for treatment at Mohs Surgery & Dermatology Center, I give my consent to Dr. Suleman J. Bangash, Dr. John W. Cox, Dr. Tyler Conway, Jacob Klaustermeier, PA-C, Chelsy Conrad, PA-C, Kathy Guerra, PA-C, Tamara Pride, PA-C, Ashley Jansen, PA-C, Denise McNatt, PA-C, and all agents under their direction, for treatment, medical and surgical, as recommended and directed by the above-listed providers.

Consent to Treat A Minor Patient: All minors (under age 18) must be accompanied by a parent or legal guardian at their first visit. At that time parent or legal guardian may sign a release allowing patient to present himself/herself for treatment unaccompanied by parent or legal guardian.

Privacy Policy: Mohs Surgery & Dermatology Center maintains complete compliance with all HIPAA regulations regarding privacy and protection of patient medical and financial information. In accordance with HIPAA guidelines, presentation of your insurance card as payment for your services, allows Mohs Surgery & Dermatology Center permission and authorization to file claims electronically and to release private medical information concerning your claims to your insurance company. You may request a copy of our HIPAA privacy policy anytime.

Release of Medical Records: Medical records are released to other medical providers in accordance with HIPAA guidelines concerning continuity of care. There is a minimum $15 charge for processing and copying records, at the patient's request, for any reason other than continuing care as directed by a provider in this office.

24-Hour Notice: We require a 24 hour notice of appointment cancellation. A $35 fee will be charged for less than 24 hour cancellation or failure to keep your scheduled appointment.

Assignment of Benefits: My signature below gives full assignment of my insurance benefits for my treatment to Mohs Surgery & Dermatology Center.

Financial Policy: My signature below attests that I have read, understand and accept responsibility for compliance with the Financial Policy of Mohs Surgery & Dermatology Center as follows:

1. Full payment is expected at the time of service unless we are contracted with your insurance company. We accept cash, checks, debit cards, and all major credit cards.
2. Insurance co-pays are due at the time of service.
3. Balances after insurance processing of your claim are due within 30 days. This balance may include, and not limited to, deductibles and co-insurance. Any balances over 30 days are considered past due.
4. Past due balances requiring collection activity will be subject to a charge equal to 30% of the full balance.
5. A fee of $25 will be charged to your account for any check returned to us by your bank.

_____	_____	_____
Patient Name	Signature of Patient/Parent/Guardian	Date

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MEDICAL HISTORY

Patient Name _____ Date _____

Reason for today's visit _____

Please check any of the following concerns/interest that you have:

Y__N__ Acne Prone Skin
Y__N__ Aging Skin
Y__N__ Sun Damaged Skin
Y__N__ Irregular Pigment
Y__N__ Irregular Moles and Lesions
Y__N__ Loss of Skin Tone
Y__N__ Daily Skin Care
Y__N__ Prevention of Skin Aging
Y__N__ Prevention of Sun Damage
Y__N__ Improvement of Skin Health
Y__N__ Improvement in Skin Appearance
Y__N__ Aesthetic Procedures

Please check any of the following conditions that you now have (or have ever had):

Y__N__ Asthma
Y__N__ Hay Fever
Y__N__ Seasonal Allergies
Y__N__ Hives
Y__N__ Allergic reaction to local Anesthetics
Y__N__ Skin cancer Type:_____
Y__N__ Family history of skin cancer
Y__N__ Sun poisoning
Y__N__ Cold sores/fever blisters
Y__N__ Pacemaker
Y__N__ Mitral valve prolapsed
Y__N__ Artificial heart valve
Y__N__ Artificial joints
Y__N__ High blood pressure
Y__N__ Chest pain
Y__N__ Heart attack
Y__N__ Heart murmur
Y__N__ Irregular heartbeat
Y__N__ Joint pains/arthritis
Y__N__ Thyroid problems
Y__N__ Kidney disease
Y__N__ Bowel disorder
Y__N__ Stomach problems
Y__N__ Liver disease
Y__N__ Hepatitis
Y__N__ Exposure to AIDS
Y__N__ Eczema
Y__N__ Blood clot in leg
Y__N__ Blood clot in lung
Y__N__ Seizures
Y__N__ Nervous disorders
Y__N__ Shingles
Y__N__ Stroke
Y__N__ Faint easily
Y__N__ Glaucoma
Y__N__ Cataracts
Y__N__ Diabetes
Y__N__ Positive skin test for Tuberculosis
Y__N__ Anemia
Y__N__ Irregular periods

Y__N__ I take aspirin

Y__N__ I take a blood thinner

Y__N__I take antibiotics before I see my dentist

I take the following medications/vitamins/herbal supplements: _____

_____

Autoimmune disorders: _____

Alcohol Use Y__ N__ Daily or Socially (circle) Pregnant Y__ N__ Nursing now Y__ N__

Smoker Y__ N __ Former Smoker Y__ N__ (when did you quit): _____

Family history of other skin diseases: _____

I am allergic to the following medications: _____

I have had the following surgeries: _____

I have the following medical conditions not mentioned above: _____

My personal physician's name and address: _____

Preferred Pharmacy: _____

Form completed by: _____Patient _____Nurse

Reviewed/Date:_____ Reviewed/Date:_____ Reviewed/Date:_____ Reviewed/Date:_____

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND DESIGNATION OF PERSONAL REPRESENTATIVE

With your consent, MOHS SURGERY & DERMATOLOGY CENTER may use and disclose Protected Health Information (PHI) about you to carry out Treatment, Payment and health care Operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, MOHS SURGERY & DERMATOLOGY CENTER may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent MOHS SURGERY & DERMATOLOGY CENTER may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. **If you decline to sign this consent, we may decline to provide treatment for you.**

_____ _____

Signed (Patient or representative) Patient's date of birth

_____ _____

Printed name (Patient or representative) Date

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As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION

I, _____ (print name), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me. This person may receive information regarding my health care treatment.

_____ _____

Print name of personal representative Signed (Patient)

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PATIENT CONSENT TO LEAVE VOICEMAIL MESSAGES

MOHS SURGERY & DERMATOLOGY CENTER staff may contact you by phone with information such as test results, medication needs, treatment plans, appointment needs or instructions from your doctor. We can leave detailed medical information on your voice mail with your consent.

By signing this "Patient Consent to Leave Voicemail Messages" you consent to MOHS SURGERY & DERMATOLOGY CENTER allowing the staff to leave a message containing detailed medical information on the phone number(s) listed below. This information can include, but is not limited to medical information (diagnosis, medications, test results, etc.) financial information (billing questions, cost of procedures) and the name of the hospital, department within a hospital or physician practice where you received services.

Which phone number(s) may we leave messages that contain the above referenced medical information?

Cell ( ) /_____.

Home ( ) /_____.

Work ( ) /_____.

I understand that MOHS SURGERY & DERMATOLOGY CENTER cannot require me to sign this consent form in order to receive treatment.

I understand I have the right to revoke this consent at any time by signing a written request to MOHS SURGERY & DERMATOLOGY CENTER. My decision to revoke this consent does not apply to any information disclosed in a voicemail prior to the date of my revocation of this consent.

_____ _____

Signed (Patient or representative) Patient's Date of Birth

_____ _____

Printed Name (Patient or representative) Date