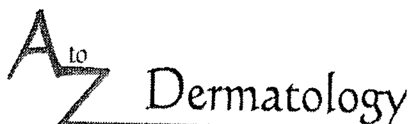


PATIENT INFORMATION

PATIENT NAME: LAST FIRST MI	SOCIAL SECURITY NUMBER	
MAILING ADDRESS STREET/ PO BOX APT#	DATE OF BIRTH	SEX (CIRCLE) FEMALE MALE
CITY STATE ZIP CODE	HOME#	CELL #
E-MAIL	MARITAL STATUS (CIRCLE) SINGLE DIVORCED MARRIED WIDOW PARTNER	
RACE (CIRCLE): CAUCASIAN AMERICAN INDIAN ALASKAN NATIVE ASIAN AFRICAN AMERICAN NATIVE AMERICAN PACIFIC ISLANDER OTHER	ETHNICITY (CIRCLE) HISPANIC NON HISPANIC	
2ND SEASONAL ADDRESS: STREET OR PO BOX APT# CITY STATE ZIP CODE		
PHARMACY NAME:	PHARMACY PHONE:	PHARMACY CROSS STREETS
MAY WE LEAVE PERSONAL MEDICAL INFORMATION ON YOUR VOICE MAIL (CIRCLE)? YES NO / HOME CELL		

PERSON RESPONSIBLE FOR CHARGES

If person responsible for payment is different from patient, then complete below.
If patient is a child please indicate if parents are (circle): MARRIED SEPARATED DIVORCED

FULL NAME	SOCIAL SECURITY NUMBER
MAILING ADDRESS	DATE OF BIRTH
CITY STATE ZIP	PREFERRED NUMBER TO CONTACT
PATIENT RELATIONSHIP TO RESPONSIBLE PARTY(CIRCLE): SPOUSE CHILD OTHER	WORK PHONE

REFERRAL INFORMATION

PRIMARY CARE PHYSICAN	NAME OF REFERRING PHYSICAN

EMERGENCY CONTACT INFORMATION

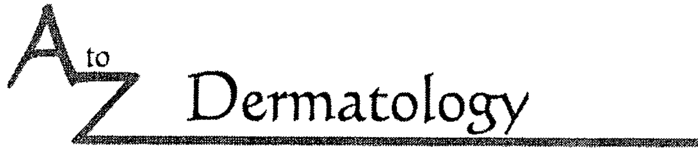
IN CASE OF EMERGENCY NOTIFY (FULL NAME):	PHONE

INSURANCE INFORMATION

PRIMARY INSURANCE	SECONDARY INSURANCE
INSURANCE NAME: ______	INSURANCE NAME: ______
POLICY/ID#______	POLICY/ID# ______
GROUP/ACCOUNT# ______	GROUP/ACCOUNT# ______
DOB:______ SS# ______	DOB: ______ SS# ______
RELATION TO PATIENT : ______	RELATIONSHIP TO PATIENT: ______

I hereby certify the above information is true and correct to the best of my knowledge. I also understand it's MY responsibility to understand my insurance coverage. I further understand that A to Z Dermatology will assist me in obtaining authorization from primary care physician or insurance company. However, if authorization is not obtained I may be financially responsible. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines. I authorize A to Z Dermatology to release any medical information including diagnosis, test results, reports and records pertaining to any treatment or examination rendered to me. I authorize payment of medical benefits to A to Z Dermatology.

PATIENT OR RESPONSIBLE PARTY SIGNATURE ______ **DATE** _



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PATIENT FINANCIAL POLICY

Thank you for choosing A to Z Dermatology for your skin care needs. We're committed to providing quality and affordable health care. Our team works hard to ensure your paperwork if filed accurately and promptly.

INSURANCE: We participate with insurance plans, including Medicare. As a courtesy we will bill whichever insurance you have indicated. Please, help us maintain current and accurate information by filling out our forms completely, legibly, and informing us of any changes (i.e. address, phone numbers, name changes, medical insurance, etc.).

KNOW YOUR BENEFITS: All insurances including Medicare have different plans and benefits. Benefits are an arrangement between you and your insurance company. It's important to know what services are covered under your specific plan. Insurance plans have their own specific criteria for services they will and will not cover; and how frequently they will cover. It's impossible to know all of the many different employer group benefits from one employer to the next. Therefore, A to Z Dermatology cannot be held responsible for notifying the patient if a particular service is or is not covered. However, our staff will make every effort in assisting you with understanding your health benefits.

PROOF OF INSURANCE/ID: All patients are required to complete our patient information form. We must obtain a copy of your driver's license and a current valid insurance card. If you are unable to present your insurance card at the time of service, or are covered by an insurance plan which we are not contracted, it's required to pay in full for services in advance.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All patient responsibility such as copays, coinsurance and deductibles must be paid at the time of service. This is the contractual agreement between you and your insurance company. Refusing to pay your patient responsibility may be considered a break of contract with your health plan. We may decline to see patients for non-emergent visits if patient responsibility is not paid at the time of service.

CLAIMS SUBMISSION: As a courtesy we will submit your claims to the insurance companies we are contracted with and assist you in any way that's reasonable to help get your claim paid. Your insurance may need additional information from you. It's your responsibility to comply within a timely manner.

NONPAYMENT: In the event your insurance company doesn't pay your claim within 60 days, the remaining balance will become your responsibility and a statement will be sent. Accounts that are 60 days past due may be turned over to a collection agency. Patients sent to collections will be discharged from the practice after 30days unless the balance is paid in full. Patients are notified by regular or certified mail that they have 30 days to establish alternative medical care. You can be seen at A to Z Dermatology for 30 days on an emergency basis.

NON-COVERED SERVICES: Your A to Z Dermatology provider may provide services that may not be covered with your insurance benefit plan. Patients or Guarantors are required to pay at the time of service for non-covered procedures not covered by your insurance plan.

PRIVATE PAY/SELF PAY: Payment is due in full at the time of service. No exceptions.

"NO SHOW" POLICY: Any patients that don't show for their **scheduled visit** and haven't called to cancel with the 24 hours will be charged $25.00. Any patient that does not show for their scheduled **surgery** appointment and hasn't called within 48 hours to cancel will be charged $300.00.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, Pathology and Lab specimens sent outside of our office are billed independently of A to Z Dermatology. You may receive a bill from the outside lab and will be responsible to pay that facility.

MINOR PATIENTS: For all services rendered to minor patients, the adult accompanying the minor is the responsible party on the child's account. All co-payments, co-insurance and deductibles are due at the time of service. If there is a remaining balance due on the account after the insurance payment is received a statement will be sent to the responsible party. We will not bill non-custodial parents, shared custodial parent, or any other third parties. Any outside financial arrangement between you and the child/children's(s) parent does not include our practice.

I have read and agree with the above Patient Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Responsible Party's Signature ______________________________ Date Signed __________

Printed Patient's Name ______________________________

Responsible Party's Printed Name (if applicable) ______________________________

A to Z Dermatology

HISTORY AND INTAKE FORM

PATIENT NAME	DOB	AGE

SKIN DISEASE HISTORY –Have you had any of the following skin conditions (Please check all that apply)

ACNE ☐	DRY SKIN ☐	PRECANCEROUS MOLES ☐	ACTINIC KERATOSES ☐
ECZEMA ☐	PSORIASIS ☐	BASAL CELL ☐	FLAKING/ITCHY SCALP ☐
SQUAMOUS CELL ☐	BLISTERING SUNBURN ☐	HAY FEVER/ALLERGIES ☐	MELANOMA ☐

FAMILY HX MELANOMA Y N (Circle One)
WHICH RELATIVES?

DO YOU WEAR SUNSCREEN? Y N (Circle One)
SPF? ______

RADIATION TREATMENT (Circle One) Y N WHEN & WHY

CURRENT OR PAST MEDICAL HISTORY (Circle One)

Artificial heart valve/Infection Y N	Artificial Joint (past 2 yrs) Y N	Cold Sores/Herpes Y N
Hepatitis, Type ______ Y N	HIV/AIDS Y N	Organ Transplant Y N
Pacemaker Y N	Staph Bacterial Infection Y N	MRSA Infection Y N
Vasovagal Reaction(fainting) Y N	Diabetes Y N	High Blood Pressure Y N
Dementia Y N	Autoimmune Condition Y N	Hyperthyroid Y N
Hypothyroid Y N	Accutane Y N	

Premedication Prior to Procedure Y N
Antibiotic: ______

Surgical Procedure (within the past 2 years):

PRESENT MEDICATIONS / DOSE

ALLERGIES (List All Allergies)

SOCIAL HISTORY (Check or Circle all that apply)

CURRENT SMOKER ☐	PAST SMOKER ☐	NEVER SMOKED ☐
Sexually Active YES NO	# of Alcoholic Drinks Per Day ______	IV Drug Use YES NO

REVIEW OF SYSTEMS: Are you currently experiencing any of the following ? (Circle Yes or No)

Changing Mole Y N	Problems with Bleeding Y N	Problems with Healing Y N
Problems with Scarring Y N	Rash Y N	Depression Y N
Thyroid Problems Y N	Chest Pain Y N	Immunosuppression Y N
Unintentional Weight Loss Y N	Bloody Urine Y N	Other: Y N

ALERTS (Check all that apply)

Pregnant ☐	Blood Thinners ☐	Defibrillator ☐	Allergy to Lidocaine ☐
Rapid Heart Beat w/Epinephrine ☐	GI Upset ☐		Allergy to Adhesive ☐

HAVE YOU RECEIVED THE FOLLOWING VACCINATIONS (Check all that apply)

Flu (Oct-Mar) ☐	Pneumonia(65+only) ☐	Shingles (50+only) ☐	Covid ☐

Reason for seeing Provider today? Briefly describe

I hereby certify that the above information is true and correct to the best of my knowledge.

Patient/Guardian Name (Print) ______ Patient/Guardian Signature ______ Date ______

Witness Signature ______ Witness Initials ______

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PATIENT CONSENTS

CONSENT FOR TREATMENT

I authorize A to Z Dermatology LLC, it's employees and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary to diagnosis and or treatment. The duration of this consent is indefinite and continues until revoked in writing. If a biopsy is performed, I authorize the Pathologist to send my specimen for a second opinion and or obtain special tests, if medically necessary to ensure and accurate diagnosis. I understand that addition costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and or supplemental policy. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

CONSENT FOR PHOTOS

I understand during the course of my treatment, photographs may be taken for clinical and education purposes. Audio taping, videotaping, or photography is not allowed by non-staff members.

CONSENT FOR FILING INSURANCE CLAIMS

I understand A to Z Dermatology required your signature on file for claims submission to your insurance company, Medicare and or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I also authorize A to Z Dermatology to appeal any denials to my insurance company, Medicare and or supplemental policy, on my behalf and authorize the release of any medical information to my insurance company, Medicare and or supplemental policy that is necessary for the processing of claims. I understand I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to A to Z Dermatology. I further understand that should my account become delinquent; I will pay the collection and attorney's fees of A to Z Dermatology, if any.

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY

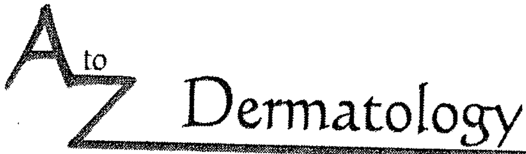
I understand that to officer the best patient care, A to Z Dermatology will retrieve my prescription history that has been ordered and filed through and HER system. I authorize A to Z Dermatology to import the prescription history obtained through an HER system into my electronic chart.

CONSENT FOR APPOINTMENT REMINDERS / THIRD PARTY COMMUNICATIONS

I authorize A to Z Dermatology to send me appointment reminders via SMS text messages, phone calls and emails. I understand that message/data rate may apply to messages sent by A to Z Dermatology under my cell phone plan. I authorize A to Z Dermatology and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ring less calls and emails to provide me with my bill and to remind me to pay for services provided by A to Z Dermatology, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notification and may opt out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive billing and payment communication by affiliates.

____ ____________________
Patient/Responsible Party (Signature) Date

____
Patient Name (Print)



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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I ______________________________ acknowledge that I have received a copy of A to Z Dermatology NOTICE OF PRIVACY PRACTICES. This notice describes how A to Z Dermatology may use and disclose my protected health information, restrictions on the use of disclosure of my health care information, and rights I may have regarding my protected health information.

______________________________ ______________________
(Signature of Patient or Personal Representative) (Date)

____
(Relationship to Patient)

Personal Representative (family members, attorney, etc.): I hereby authorize A to Z Dermatology and its employees to discuss send and or receive medical information to the following.

Please provide their names and phone numbers below:

1. Name ______________________ Relationship ______________
   Phone# ______________________
2. Name ______________________ Relationship ______________
   Phone# ______________________
3. Name ______________________ Relationship ______________
   Phone# ______________________

Communication Consent

Authorization For Communication via Voice Mail	Phone Number
I hereby allow all non-cancerous test results, blood work results, and all other communication can be put in a voice message on the phone number indicated in the box.	( )_____ - _________

By signing below, I certify that I have read the above information and my questions concerning A to Z Dermatology policies have been answered. My signature signifies my understanding and agreement with the above information. The duration of this consent is indefinite until revoked in writing.

Patient Name		Patient DOB	
Parent/Legal Guardian Printed Name		Relationship to Patient	
Signature		Date	