SUNWISE
Family Dermatology & Surgery

Phone (302) 364-2000 Fax (302) 203-9243

102 Sleepy Hollow Drive, Suite 203
Middletown, DE 19709

260 Beiser Blvd, Suite 202
Dover, DE 19904

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

_____
Street Address City State Zip

_____ _____ _____
Email Address Home Phone Number Cell Phone Number

_____
Employer

_____ _____ _____
Primary Care Physician Location Phone #

_____ _____ _____
Pharmacy Name Location Phone #

How did you hear about SunWise? _____

Demographics

❑ **Decline to Specify Demographics**

Gender: ❑ Male ❑ Female

Language: ❑ English ❑ Spanish ❑ Other_____

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown

Race: ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American

❑ White/Caucasian ❑ Other_____

Consent to Leave a Message

By agreeing, you're allowing SunWise Dermatology employee's to leave a detailed message on your phone concerning results, appointments, billing, etc...

Please Initial Next to Answer: YES: _____ I give consent NO:_____ I do NOT consent

Medical Information Release Authorization/ Emergency Contact

This is for the purpose of when a *designated individual(s) has your permission to discuss your medical information* including: appointments,medications, pathology or lab results, treatment plan and billing information.

Name	Relationship	Contact Number

Medical Insurance Information

Primary Insurance	PolicyHolder if **NOT** Patient	DOB of Policyholder if **NOT** Patient

Secondary Insurance	PolicyHolder if **NOT** Patient	DOB of Policyholder if **NOT** Patient

Tertiary Insurance	PolicyHolder if **NOT** Patient	DOB of Policyholder if **NOT** Patient

_____ _____

Signature Date

Patient Consent for Treatment

I consent to be treated by Dr. Jennifer LaRusso & other healthcare practitioners providing service at SunWise Dermatology & Surgery. I understand that I am responsible for any charges including amounts based on payment arrangements agreed to by them, that are including treatment and otherwise not paid by the insurance carrier.

- I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct.
- I assign and request payment of authorized benefits to SUNWISE DERMATOLOGY & SURGERY, LLC.
- 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.
- 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.
- I consent for medical photographs that will not be used for educational and/or advertising purposes.

_____ _____

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 it's 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.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, photos, payment or health care operations, in order to provide health care that is in your best interest.

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 your 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, Apple/Samsung Pay.

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 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.

Missed Cosmetic Appointments: In the event that a deposit was received for a cosmetic procedure, the deposit will be lost if not rescheduled 24 hours prior to the scheduled appointment.

Returned Check Fees: If your check is returned by the bank due to insufficient funds in your account 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.Balance can be paid via our website, accessing your patient portal, and by calling into our office directly. 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 Trans-Union, Experian and Equifax. Please contact us immediately if special financial circumstances arise, as we may be able to arrange a payment plan. In the event a payment plan is granted an active card must be kept on file as well as a signed agreement from the patient within the patient portal. This agreement will be made with the patient as well as a SunWise Dermatology & Surgery Representative.

Telephone Consumer Protection Act (TCPA): You agree, in order for us to service your account or to collect the money that 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. The use of your patient portal will always be used as a means of communication if needed.

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.

Print Name _____ Date _____.

Signature of Patient or Parent/Guardian's Signature _____.

Medical History

Date ____/_____/_____

Patient Name	Height	Weight	Date of Birth
_____	_____	_____	_____

Reason for today's visit:_____

_____

Medical History

❑ NO Medical History

- ❑ **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:_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____
- ❑_____

Past Surgical Procedures

❑ NO Surgical Procedures

_____
_____
_____
_____
_____
_____

Personal Skin Cancer History

❑ NO Personal History of Skin Cancer

Type (BCC/SCC/Melanoma)	Location Site	Year Treated	Treating Physician

Family Skin Cancer History

Type (BCC/SCC/Melanoma) Family Member ❑ **NO Family History of Skin Cancer**

_____

_____

_____

Sunscreen Use: ❑ 10 spf ❑15 spf ❑ 30 spf ❑ 50 spf ❑ 75 spf ❑ 100 spf ❑ None

Tanning Bed Use: ❑ Past ❑ Present ❑ Never

Skin Disease History

❑ Acne	❑ ***Dysplastic Nevus***	❑ Poison Ivy	❑ Other:_____
❑ Actinic Keratoses	❑ Eczema	❑ Psoriasis	❑_____
❑ ***Atypical Nevus***	❑ Flaky Scalp	❑ Rosacea	❑_____
(Mild/Moderate/Severe)	❑ Itching Scalp	❑ Shingles	❑_____
❑ Cold Sores	❑ ***Keloid Scarring***	❑ Warts	❑_____
❑ Dry Skins	❑ Molluscum		❑_____

Daily Prescribed Medications ❑ **NO Daily Medications**

_____

_____

_____

_____

Daily Multivitamins and OTC Medications ❑ **NO Vitamins / NO OTC Medications**

_____

_____

_____

Allergies (Medications and Food) ❑ **NO Known Drug Allergies**

_____

_____

_____

Smoking Status: ❑ Never a Smoker ❑ Former Smoker ❑ Everyday Smoker

Influenza Vaccine: ❑ Yes ❑ No (If not, please check whether) ❑ Allergy or ❑ Refusal

Section For Patients Age 65 and Older

Pneumonia Vaccine: ❑ Yes ❑ No

Surrogate Decision Maker / Health Care Proxy: (if different from Emergency Contact on 1st page)

Contact Name:_____

Contact Phone and/or Email:_____

Request for Patient File(s)

Please provide the previous Dermatologist information that you have seen in the past 7 years:

_____ _____

To: Facility requesting file from Fax #

_____ _____

To: Facility requesting file from Fax #

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

Patient Address:

_____

_____

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

SunWise Family Dermatology & Surgery

302-203-9243 Fax 302-364-2000 Phone

Direct Mail (Provider to Provider) hsmith@sunwise.emadirect.md

Entire records to be released:_____ Specific Sections (i.e. pathology, labs,cultures):_____

Patient's Initials Patient's Initials

Patient Signature: _____ **Date:** _____

Consent to Treat a Minor

I, _____, the legal guardian of, _____,***DO*** **authorize SunWise Dermatology & Surgery, LLC to treat my minor without my presence.** In the event this information changes I will send written permission prior to the visit.

I, _____, the legal guardian of, _____, **DO NOT authorize 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.

_____ _____

Print Name of Guardian **Date**

_____

Signature of Guardian

Guarantor Information

Parent or Guardian's information below:

_____

Name

_____/_____/_____ _____

Date of Birth SSN

_____ _____ _____

Home Phone # Work Phone # Cell Phone #

_____

Employer