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 Code _____

Email Address _____ Home Phone Number _____ Cell Phone Number _____

Employer _____

Primary Care Physician _____ Location _____ Phone Number _____

Pharmacy Name _____ Location _____ Phone Number _____

**How did you hear about SunWise Family Dermatology & Surgery?** _____

## 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 are allowing SunWise Family Dermatology & Surgery, LLC employees to leave a detailed message on your voicemail concerning pathology and/or lab results, appointments, billing, etc.

Please Initial: YES, I give permission _____ NO, I do not give permission _____

## 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 and/or lab results, treatment plans, 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 |
|---|---|---|
| | | |

_____ _____

Patient (18+) and/or Patient's Guardian Signature Date

## Patient Consent for Treatment

I consent to be treated by Dr. Jennifer LaRusso and/or other Healthcare Providers providing services at SunWise Family Dermatology & Surgery, LLC. I understand that I am responsible for any charges including amounts based on payment arrangements agreed upon by them, that are including but not limited to 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 FAMILY DERMATOLOGY & SURGERY, LLC.
- I authorize any holder of medical or other information about me to release to Medicare and its agents that is needed to determine the benefits of related services.
- I consent to the use of disclosure of my health information for treatment, payment, and healthcare operation purposes as described in SunWise Family Dermatology & Surgery Notice of Privacy Practices.

## HIPAA Patient Privacy and Rights Disclosure

HIPAA - Health Insurance Portability and Accountability

SunWise Family Dermatology & Surgery, LLC and it's employees disclose information given to us by you, your insurance company, your Primary Care Provider and/or other medical professionals strictly for the purposes of treatment, payment of services rendered and/or healthcare operations.

We do not sell mailing lists or disclose personal information about our patients except which and when it 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 when disputed.

When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your healthcare information including, treatment information, medical photos, payment and/or healthcare operations.

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

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

_____ _____

Patient (18+) and/or Patient's Guardian 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 do not have insurance and are 'self-pay', or if you are having an elective non-covered service, the balance in full is required at time of the 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 Family 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 Family Dermatology & Surgery, LLC for any services furnished to me by SunWise Family Dermatology & Surgery, LLC. I authorize any holder of Medical information about me to be released to Healthcare Financial Administration and its agents that is needed to determine these benefits payable for related services.

**Missed Medical 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 Surgical Appointment Fees:** We need a 48 hour notice to change a surgery appointment or a fee of $50 will be assessed to your account.

**Missed Cosmetic Appointment Fees:** In the event that a deposit was received for a cosmetic procedure, the deposit will be lost if the appointment was 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, 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 Family Dermatology & Surgery, LLC 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, LLC, 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, 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, LLC, 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 (18+) and/or Patient's Guardian Signature Date .

# Medical History

Date ____/_____/_____

_____ _____ _____ _____

Patient's Name Height Weight Date of Birth

Reason for today's visit: _____

_____

**Medical History** ☐ **NO Medical History**

☐ **AIDS**
☐ Anxiety
☐ Arthritis (Psoriasis/Rheumatoid/Osteo)
☐ Asthma
☐ Atrial Fibrillation
☐ **Blood Thinner Use**
☐ COPD/Emphysema
☐ Coronary Heart Disease
☐ Crohn's Disease
☐ **Defibrillator / Pacemaker**
☐ Dementia
☐ Depression
☐ Diabetes
☐ Kidney Disease (End-stage Renal disease)
☐ Epilepsy/Seizures
☐ GERD (Acid Reflux)
☐ Hay Fever
☐ Hypertension (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 Tumor** (Colon/Lung/Prostate/Breast)
☐ MRSA / Staph Infection
☐ **Pregnant / Breastfeeding / Trying to Conceive**
☐ Raynaud's Disease
☐ Seasonal Allergies
☐ Syncope (Fainting with procedures)
☐ **Tuberculosis**

**Past Surgical History** ☐ **NO Surgical History**

_____
_____
_____
_____

**Personal Skin Cancer History** ☐ **NO Personal History of Skin Cancer**

Type (BCC | SCC | Melanoma) Location Site Year treated Treating Physician

_____
_____
_____
_____

**Family Skin Cancer History** ☐ **NO Family History of Skin Cancer**

Type (BCC | SCC | Melanoma) Family Member

_____
_____
_____

**Sunscreen Use:**

☐10 SPF ☐15 SPF ☐30 SPF ☐50 SPF ☐60 SPF ☐100 SPF ☐None

**Tanning Bed Use:**

☐ Past ☐Present ☐Never

**Skin Disease History**

☐ Acne
☐ Actinic Keratosis/es
☐ Atypical Nevi (Atypical Moles) (Mild/Moderate/Severe)
☐ Cold Sores
☐ Dry Skin
☐ Eczema
☐ Flaky/Scaly scalp
☐ Hives
☐ Itchy scalp
☐ Keloid scar
☐ Molluscum
☐ Poison Ivy
☐ Psoriasis
☐ Rosacea
☐ Shingles
☐ Wart
☐ Other: _____

**Daily Prescribed Medications** ☐ **NO Daily Prescribed Medications**

_____
_____
_____
_____
_____

**Daily Multivitamins and OTC Medications** ☐ **NO Vitamins or OTC Medications**

_____
_____
_____
_____

**Allergies (Medications & Food)** ☐ **NO Known Drug/Food Allergies**

_____
_____
_____
_____

**Smoking Status:**

☐ Never a Smoker ☐ Former Smoker ☐ Everyday Smoker

**Influenza (Flu) Vaccine:**

☐ Yes ☐ No (If no, please indicate reason: Allergy _____ Refusal _____)

***Section For Patients Age 65+***

**Pneumonia Vaccine:**

☐ Yes ☐ No

**Surrogate Decision Maker / HealthCare Proxy** (If different from Emergency Contact on page 2)

_____

Name Relationship Phone Number

## 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) hwest@sunwise.emadirect.md**

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

Patient's Initials Patient's Initials

_____ _____

Patient (18+) and/or Patient's Guardian Signature Date

## Consent to Treat a Minor

I, _____, the legal guardian of _____, **DO** authorize SunWise Family 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.

**OR**

I, _____, the legal guardian of _____, **DO NOT** authorize SunWise Family Dermatology & Surgery, LLC to treat my minor without my presence. This consent includes: discussion and render of medical treatment, perform medical procedures, and/or order lab work.

This authorization extends to all SunWise Family Dermatology & Surgery, LLC offices, Physicians, Physician Assistants, Nurse Practitioners, and office staff.

If applicable, under the terms and conditions of a divorce, separation, and/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 and/or modified in any way, the undersigned does hereby agree to notify SunWise Family 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 the healthcare services for the minor named above.

_____ _____
Print Name of Parent/Guardian Date

_____
Signature of Parent/Guardian

## Guarantor Information

Parent or Guardian's information below:

_____
Name

_____/_____/_____ _____
Date of Birth SSN

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

_____
Employer