Missouri Dermatology Laser & Vein Center
1011 Bowles Ave. Suite 120/121, Fenton MO 63026
Telephone: 314-200-2713; Fax: 314-200-2714

100 Chesterfield Business Pkwy Suite 110, Chesterfield, MO 63005
20 Progress Point Pkwy, Suite 202, O'Fallon, MO 63368
Telephone: 636-532-0990; Fax: 636-532-0993

VERIFICATION OF IDENTITY

Patient Name: ____ Cell / Home Phone:_________________________
Address: ____ OK to leave detailed message? yes no
City: __________________________________ State: ________ Zip: _________________________________
Date of Birth: ________________________ Email: ____
Primary Care Physician: ____ Fax: ____________________________
Referring Dermatologist: ____ Fax: ____________________________

RESPONSIBLE PARTY

Patient named above is responsible for charges not covered by insurance
Someone other than patient is responsible for charges not covered by insurance (specified below)

Name: ____
Address: ____
City: ______________________________________ State: ______________ Zip: ________ DOB:_____________

INSURANCE INFORMATION

Patient does **NOT** have health insurance coverage
Patient **HAS** health insurance coverage (Specify coverage below)

Name of Subscriber (name on insurance card):____
Patient Relationship to Subscriber: _____________________________ Subscriber Date of Birth: _______________

Secondary Insurance:

Name of Subscriber (name on insurance card):____
Patient Relationship to Subscriber: _____________________________ Subscriber Date of Birth: _______________

PERSONAL REPRESENTATIVE

Check here if someone other than the patient is completing this form

Name: ____ Relationship to patient __________________________
Authority of Personal Representative to Sign for Patient (Check one): Parent Guardian Power of Attorney Other:________________

CONSENT FOR TREATMENT/MINOR PROCEDURES

During an office visit you may undergo a minor procedure (including wart removal, skin tag removal, burning of precancerous lesions, electrodessication and curettage for superficial skin cancers, excision of moles, excision of cysts, and removal of other superficial lesions on the skin). These procedures can leave a small scar, cause minor bleeding, and can affect nerve sensation in the treated area. If you have concerns before or at any time after these minor procedures, please bring them to our attention so that we can address or correct any of your issues.

➢➢ **Patient Initials** _________

HIPAA ACKNOWLEDGEMENT

I acknowledge that a copy of Missouri Dermatology's HIPAA Notice of Privacy Practices has been made available to me.

➢➢**Signature** ____

Authority of Personal Representative to Sign for Patient (Check one): Parent Guardian Power of Attorney Other:________________
Please note: It is your right to refuse to sign this Acknowledgement indication that we have offered you a copy of our Notice of Privacy Practices.

I CERTIFY THAT I HAVE READ THE ABOVE & THAT THE INFORMATION I HAVE PROVIDED IS CORRECT.

➢➢**Signature**: ____Date: ______________

Last Name: ______________________ **First Name:**____________________ **Date of Birth:** __________

HISTORY AND INTAKE FORM

Height: ____________ **Weight:** ____________ Please note: Required for proper weight-based dosing of some medications.

Past Medical History: (please check all that apply)

NONE
Anxiety
Arthritis
Asthma
Atrial fibrillation
Benign Prostate Enlargement
Cerebrovascular Accident (stroke)
COPD
Coronary Artery Disease (heart disease)
Depression
Diabetes
End-stage Kidney Disease
Epilepsy (seizures)
GERD (acid reflux)
Hearing loss
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Hyperthyroid (high)
Hypothyroid (low)
IBD (Crohn's/UC)
Immunosuppression
Malignancy/Cancer
- Leukemia
- Lymphoma
- Lung Cancer
- Colon Cancer
- Breast Cancer
- Prostate Cancer
- Other: ____________

Radiation Treatment
Systemic Lupus (SLE)
Defibrillator/Pacemaker
Cold sores/Fever blisters

Joint Replacement: (specify joint & procedure date) ____
Organ Transplant: (specify type & procedure date) ____
Bone Marrow Transplant
OTHER ____

Skin Disease History: (please check all that apply)

Acne
Actinic Keratoses
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Melanoma
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Recurrent Staph/Skin Infection

OTHER____

Do you wear sunscreen? Yes No If yes, what SPF? __________
Do you tan in a tanning salon? Yes No
Family history of melanoma? Yes No If yes, which relative (s)? ___________________
Do you have a family history of other skin conditions? Yes No
If yes, please specify ____

Medications: REQUIRED FIELD - please enter **ALL** current medications -

We do not have access to SSM or any other outside organization's medical charts

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Permission to upload your medication history into your chart if available electronically? Yes No

Preferred Pharmacy _______________________________ Phone: _______________ ZIP:____________

Allergies: Yes (specified below) No known drug allergies

____

____

Smoking: Current smoker Former smoker (Quit date: ________) Never smoked

Vaccines: Date of most recent flu vaccination _______________ Elected not to be vaccinated

Have you ever received a pneumonia vaccine? Yes No

Advance Directive: I do not have a living will I have a living will

Power of Attorney Name: ____

Last Name: ______________________ First Name:____________________ Date of Birth: __________

FINANCIAL AGREEMENT

Please initial each line to acknowledge that you have read and understand our office policies. These guidelines are in place to provide our patients with the highest level of care and service.

➢➢_______ We will ask to see your insurance card at every visit. If you don't have your most updated card, you will be considered a self-pay patient or may be asked to reschedule your appointment. If our office is not filing an insurance claim for you, full payment is due at the time of service.

➢➢_______ It is your responsibility to know how your insurance policy works. We are not responsible for notifying you prior to your visit if any charges will be applied to your deductible or coinsurance. Additionally, if a referral is required for your services, it is your responsibility to acquire the referral before the appointment date.

➢➢_______ If we participate in your insurance, you are required to pay for all co-payments, deductibles, and coinsurance at the time of your visit. We accept checks and major credit cards. In the event that there is a remaining balance due after the claim is processed, you will be billed for that balance. Payment for the remaining balance is due at the time the statement is received or at the time of the next office visit, whichever comes first. If you cannot pay the balance at the next office visit, you will be asked to reschedule. A $30.00 charge will be assessed for all checks returned by your bank.

➢➢_______ If your balance is still unpaid upon receipt of the third mailed statement, a $25 late fee will be accrued for each additional communication that is mailed. If the balance remains unpaid following receipt of a final notice, your account will be forwarded for further collection attempts. In addition, a 40% collection fee will be added to the outstanding balance amount owed to our office. Attorney fees, court costs, and collection fees incurred in an effort to enforce payment will be the responsibility of the patient/guarantor.

➢➢_______ As a courtesy, we try to confirm your appointment. Circumstances do not always allow us to reach you. Therefore, please do not rely on us to remind you of an appointment. If you have questions about the date or time of your appointment, please call.

➢➢_______ We ask for at least a 24-hour business hour notice for all cancellations. Patients missed scheduled appointments for office visits or procedures without giving the office 24 hours' notice may be charged a fee:

- Office visit: $50 (second and subsequent occurrences)
- Procedure visit: $100 (per occurrence)
- If missed appointment fee is assessed, all future appointments will be cancelled and no further appointments will be made for the patient until the assessed fee has been paid.

➢➢_______ The "Guarantor" is the policy-holder for the insurance plan covering the patient or the party responsible for self-pay charges if patient is not covered by insurance. It is the expectation of this office that in the case of a divorce, the two parental parties will handle payment arrangements without the involvement of our office. We will only bill the Guarantor.

➢➢_______ You may have a biopsy taken in the course of today's treatment. Biopsy samples are sent to an outside lab and you will receive a separate bill from the lab/pathologist.

I have read and understand the above financial policies.

➢➢Signature: ____ Date: _______________