dermio dermatology

**Please fill out and bring to your appointment with your photo ID and insurance cards.**

**Today's Date: _____/_____/_____**

**PATIENT INFORMATION**

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

**OK to leave message?: □ Yes □ No** **OK to leave message?: □ Yes □ No** **OK to leave message?: □ Yes □ No**

Date of Birth: _____/_____/_____ S.S.N. _____/_____/_____ Marital Status: _____ Spouse Name: _____

Age: _____ Sex: _____ Employment: □ FT □ PT □ FT-Student □ PT-Student □ Retired □ Unemployed

Email Address: _____

**PARENT OR RESPONSIBLE PARTY (if different from patient)**

Name: _____
Last First M.I.

Mailing Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____/_____/_____ S.S.N. _____/_____/_____ Age: _____ Sex: _____ Relationship to Patient: _____

**INSURANCE INFORMATION**

**Primary Insurance** Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: _____/_____/_____ Relationship to patient: _____

□ HMO (Referral Required) □ PPO □ Out of Network

**Secondary Insurance** Co. Name: _____ Policy Holder: _____

Policy Holder Date of Birth: _____/_____/_____ Relationship to patient: _____

□ HMO (Referral Required) □ PPO □ Out of Network

□ **Self-Pay**

*In selecting Self-Pay, you are waiving your right to have your insurance company billed for any non-cosmetic Services (see patient responsibility policy).*

In case of Emergency, who should be notified? _____ Phone: _____

Can we discuss your medical conditions with other members of your household? □ Yes □ No Specify: _____

Referred By: □ Physician _____ □ Family/Friend _____

How did you hear about us? □ Family/Friend □ Internet □ Advertisement □ Insurance Referral □ Other _____

I authorize the release of medical information to my primary care or referring physicians, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in an insurance plan in which we participate. For those patients, applicable copayments will be collected. We accept payment in the form of cash or credit card. If we do accept a check for payment, and the check does not clear the bank, a $25.00 service fee will automatically be added to your account. Please note that any procedure performed in the office may be billed separately in addition to the office visit fee. Your signature below signifies your understanding and willingness to comply with this policy.

**Patient/Responsible Party Signature**: _____ Date: _____/_____/_____

Name: _____ Relationship to patient: _____

***Please check all of the following boxes that apply:***

**Past Medical History**

▢ Anxiety
▢ Arthritis
▢ Asthma
▢ Atrial Fibrillation (Irregular Heartbeat)
▢ BPH (Enlarged Prostate)
▢ Bone Marrow Transplant
▢ Breast Cancer
▢ Colon Cancer
▢ COPD
▢ Coronary Artery Disease
▢ Depression
▢ Diabetes
▢ End Stage Renal Disease
▢ GERD (Gastric Reflux)
▢ Hearing Loss
▢ Hepatitis
▢ HIV/AIDS
▢ Hypercholesterolemia
▢ Hyperthyroidism
▢ Hypothyroidism
▢ Leukemia
▢ Lung Cancer
▢ Lymphoma
▢ Prostate Cancer
▢ Radiation Treatment
▢ Seizures
▢ Stroke
▢ Other: _____
▢ ***No Past Medical Problems***

**Past Surgeries**

▢ Appendix (Appendectomy)
▢ Bladder (Cystectomy)
▢ Breast:
  ▢ Mastectomy (Right Breast)
  ▢ Mastectomy (Left Breast)
  ▢ Mastectomy (Both Breasts)
  ▢ Lumpectomy (Right Breast)
  ▢ Lumpectomy (Left Breast)
  ▢ Lumpectomy (Both Breasts)
  ▢ Breast Biopsy
  ▢ Breast Reduction
  ▢ Breast Implants
▢ Colon (Colectomy): Colon Cancer Resection
▢ Colon (Colectomy): Diverticulitis
▢ Colon (Colectomy): Inflammatory Bowel Dz
▢ Gallbladder (Cholecystectomy)
▢ Heart: Coronary Artery Bypass Surgery
▢ Heart: PTCA (Angioplasty)
▢ Heart: Mechanical Valve Replacement
▢ Heart: Biological Valve Replacement
▢ Heart: Heart Transplant
▢ Joint Replacement: Knee (Right)
▢ Joint Replacement: Knee (Left)
▢ Joint Replacement: Knee (Both)

**Past Surgeries (Continued)**

▢ Joint Replacement: Hip (Right)
▢ Joint Replacement: Hip (Left)
▢ Joint Replacement: Hip (Both)
▢ Kidney: Kidney Biopsy
▢ Kidney: Nephrectomy (Kidney Removal)
▢ Kidney: Kidney Stone Removal
▢ Kidney: Kidney Transplant
▢ Ovaries: (Oophorectomy): Endometriosis
▢ Ovaries: (Oophorectomy): Ovarian Cyst
▢ Ovaries: (Oophorectomy): Ovarian Cancer
▢ Prostate (Prostatectomy): Prostate Cancer
▢ Prostate (Prostatectomy): Prostate Biopsy
▢ Prostate (Prostatectomy): TURP
▢ Skin: Skin Biopsy
▢ Skin: Basal Cell Carcinoma Surgery
▢ Skin: Squamous Cell Carcinoma Surgery
▢ Skin: Melanoma Surgery
▢ Spleen (Splenectomy): Spleen Removal
▢ Testicles (Orchidectomy): Testicle Removal
▢ Uterus (Hysterectomy): Fibroids
▢ Uterus (Hysterectomy): Uterine Cancer
▢ Other: _____
▢ ***No Past Surgical Procedures***

**Skin Disease History**

▢ Acne
▢ Actinic Keratoses (precancers)
▢ Asthma
▢ Basal Cell Skin Cancer
▢ Blistering Sunburns
▢ Dry Skin
▢ Eczema
▢ Flaking or Itchy Scalp
▢ Hay Fever/Allergies
▢ Melanoma
▢ Poison Ivy
▢ Precancerous Moles
▢ Psoriasis
▢ Squamous Cell Skin Cancer
▢ ***No Past Skin Problems***

**Skin History**

Do you wear sunscreen?
▢ Yes. What SPF do you apply? _____
▢ No

Do you tan in a tanning salon?
▢ Yes
▢ No

**Family History**

Do you have a family history of melanoma?
▢ Yes ▢ No

If yes:
▢ Mother
▢ Father
▢ Sister
▢ Brother
▢ Grandmother
▢ Grandfather

**Medications**

With your permission, can we obtain prescription information directly from your pharmacy?
▢ **Yes** ▢ **No (if no, please list all below)**
If yes, please list all non-prescription medications below:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

▢ ***No Current Medications***

**Allergies (Please list all allergies)**

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

▢ ***No Drug Allergies***

**Sexual History**
▢ Not sexually active
▢ Sexually active with one partner
▢ Sexually active with 2 or more partners
▢ Same gender partner

**Drinking Alcohol History**
▢ No alcohol
▢ Less than 1 drink per day
▢ 1-2 drinks per day
▢ 3 or more drinks per day

**Smoking History**
▢ Currently smokes daily
▢ Currently smokes but not daily
▢ Former smoker
▢ Has never smoked

**Family History of Disease**
▢ Yes

Relative and disease:

_____

Relative and disease:

_____

▢ No family history of disease

**Vaccines**
Have you ever had the pneumonia vaccine?
▢ Yes
▢ No

**Female Patients Only**

Are you pregnant?
▢ Yes Due Date: _____
▢ No

Are you breast feeding?
▢ Yes
▢ No

Are you trying to get pregnant?
▢ Yes
▢ No

**Review of Systems** Have you recently experienced any of the following:
▢ Changing, bleeding or itching mole/lesion
▢ Rash
▢ Itching
▢ Burning Skin
▢ Fever/Chills
▢ Unintentional Weight Loss
▢ Night Sweats
▢ Muscle Weakness
▢ Joint Aches
▢ Neck Stiffness
▢ Headaches
▢ Seizures
▢ Blurry Vision
▢ Chest Pain
▢ Shortness of Breath
▢ Cough
▢ Sore Throat
▢ Abdominal Pain/Nausea/Vomiting
▢ Bloody Stool
▢ Depression
▢ Hay Fever
▢ Problems Healing
▢ Burning with urination
▢ Heat or cold intolerance
▢ Frequent nose bleeds
▢ ***Does not apply***

**Alerts**
▢ Defibrillator
▢ Pacemaker
▢ Artificial Joint Placed in Last 2 Years
▢ Artificial Heart Valve
▢ Antibiotic Prophylaxis
▢ History of Scarring (Keloid)
▢ History of Passing Out (Vasovagal)
▢ Organ Transplant Recipient
▢ Immunosuppressed (Low Immunity)
▢ Allergy to Adhesive
▢ Pregnant or Planning a Pregnancy
▢ Breast Feeding
▢ Stomach Upset with Antibiotics
▢ Yeast Infection with Antibiotics
▢ Allergy to Topical Antibiotics
▢ Anti-coagulated (on blood thinners)
▢ Allergic to Lidocaine
▢ Rapid Heartbeat with Epinephrine
▢ HIV/AIDS
▢ Hepatitis C
▢ History of MRSA
▢ ***Does not apply***

**Primary Care Physician**

_____

***Fax:*** _____

Phone: _____

Address: _____

**Prescription Coverage**
▢ Yes
▢ No

**Preferred Pharmacy** _____

Phone _____

Location/Zip Code _____

**Preferred Language**
▢ English
▢ Spanish
▢ Other:
_____

**Race**
▢ White
▢ American Indian or Alaska Native
▢ Asian
▢ Black or African American
▢ Native Hawaiian or other Pacific Islander
▢ Other:
_____

**Ethnic Group**
▢ Hispanic or Latino
▢ Not Hispanic or Latino
▢ Unknown

The notice of privacy practice for the office of Dermio Dermatology is available at the front desk and on our website at www.dermiodermatology.com. Should you wish to receive your own copy to take with you please ask our receptionist. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at any time by calling our office to request a copy or mailing a written request.

**Section 1** of this document provides your acknowledgement that you have read our Notice of Privacy Practices.

**Section 2** requests your response to notification format and designation of a family member or other designee that we may contact and discuss your medical care in the event of an emergency or for the purpose of the individual items as checked below.

**Section 3** provides the opportunity to opt in or opt out of receiving marketing communication from our office.

## Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office Dermio Dermatology.

_____

*Patient Name* *Date*

_____

*Date of Birth* *MRN (office use)*

## Section 2 – Notification and Emergency Designee (REQUIRED)

I give permission to Dermio Dermatology and staff to perform the following duties in effort to maintain continuity of care:

Confirm/revise my appointment times by calling my home, business, and any other designated phone number.
▢ YES ▢ NO

Leave a message of normal test result on my home answering machine or with a specified family member.
▢ YES ▢ NO

**The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:**

**Check box for none:** ▢

_____

***Designated Person*** ***Contact Number*** ***Relationship to you***

## Section 3 – Marketing Communication

Dermio Dermatology would like to share **new products, discounts or service information directly to you,** our patient. The information may be communicated by phone call, text, letter, or email. (You are able to change your decision at any time by notifying our office.)

▢ **I wish to opt IN** Email Address _____
▢ **I wish to opt OUT** I do not wish to receive marketing information.

***I understand the information provided to me in the privacy notice and I have indicated my response to questions in each section.***

_____

*Signature* *Phone Number* *Date*

dermio dermatology

Consent for Financial/Office Policies of Dermio Dermatology:

Please remember that your health insurance is a contract between you and your insurance company. It is ***your*** responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, and lab contracts. As a service to you, we will submit a claim to your insurance company for all visit charges, but we do not share in the contract between you and your insurance company. You are responsible for any charges not covered by your insurance plan. Any amount not covered by the insured/patient's insurance is due ***within 30 days*** of the time of service. A photocopy of your ID and insurance card is needed by our billing department to assist you in filing your claim. It is the patient's responsibility to inform this office if your insurance requires pre-certification or pre-authorization of services prior to scheduling of such services. The patient will be responsible for services denied by insurance due to "No Eligibility", "Non-Covered Service", "Pre-authorization/Certification Not Obtained". Statements are released after your insurance pays, denies, or non-payment by your insurance.

**In Network Coverage:** For insurance companies that we are contracted with, we will determine your copay due at the time of the visit. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE.

**Out of Network Coverage:** For these plans, your copay is due at the time of the visit. You are responsible for the charges of the provided services, which may be higher than the similar services for an in-network provider. Copayments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are ***DUE AT THE TIME OF SERVICE.*** Feel free to be a Self-Pay patient and submit your bill for reimbursement to your insurance company.

**Co-payments, deductibles, and fees:** Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are ***DUE AT THE TIME OF SERVICE.*** Failure to produce payment may result in your appointment being rescheduled. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to patients, you, the insured. Dermio Dermatology has financial policies to enable efficient operational processes. Please see our Credit Card on File Policy.

**Self-Pay Patients:** Self-pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based upon the established Medicare fee schedule in place.

**Non-Covered Services:** Cosmetic services cannot be submitted to insurance and payment in full is due at the time of service by credit card or cash only, no checks will be accepted for cosmetic services.

**Returned Check Fee:** All returned checks will be charged a $30 processing fee.

**Credit Card on File Policy:** If you choose not to pay directly after the services are provided, ***WE ASK THAT YOU KEEP A CREDIT/DEBIT/HSA CARD ON FILE*** to be used for any unpaid balances. Due to the high number of deductible plans, and higher patient coinsurance benefits, this has become necessary at our organization. Please keep in mind, we will not charge your card if you do not owe anything.

**Once your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. PayJunction is registered with Visa and MasterCard and independently certified as a PCI-DSS Level One Service Provider.

By signing the agreement, you understand that once the health plan has paid their portion for my care that you will receive an Explanation of Benefits (EOB). The health plan EOB will state any balance remaining to be paid by the patient. Dermio Dermatology may charge my credit card the balance due when they receive a copy of the EOB. Charges will be made ONLY after the claim has been adjudicated by your insurance and you will have received an EOB from your insurance detailing the amount billed. If the charge exceeds $250 you will receive a courtesy call or email prior to authorizing the card on file. Circumstances when your card would be charged include but are not limited to missed co-payments, deductibles and co-insurance, and non-covered services and/or denial of services.

If the credit card we have on file for you changes, please notify us immediately by calling our office a (219) 228-4200. It's not uncommon for people to change or cancel their credit cards, including when it expires. If we run your credit card and it's denied for any reason, we reserve the right to charge an additional $25 declined card fee if we are not able to run a new credit card within 7 days. We will contact you or leave you a phone message if this occurs.

**Medicare Patients:** We will bill Medicare for you. We must have your signature on file and we will also bill secondary insurance carriers for you. All co-payments are due at the time for service. The patient will be responsible for any balance not paid by Medicare and secondary insurance.

**Outstanding Balances:** If your account is not paid within 30 days of receiving the first bill, you will receive a phone call. If the account balance is not paid in 60 days, your account will be turned over to a collection agency and assessed a $50 processing fee. Failure to pay bills will result in dismissal from the practice.

**Referrals:** Your insurance plan may require a referral to be completed before seeing a specialist. It is your responsibility to obtain the proper referral in order to be seen for your appointment. If you don't have a referral at your appointment time, your appointment may be rescheduled and you could be charged a missed appointment fee of $50.

**Pathology/Laboratory Services:** Dermio Dermatology uses third parties for our laboratory work and pathology services. You/your insurance will receive an additional bill from the lab service provider (Quest, Dermpath Diagnostics, LabCorp, etc.) We are unable to adjust these charges as they are provided by a separate entity.

**Missed Appointments:** Please provide at least 48 business hours' notice to cancel an appointment. We do this so your appointment slot can be offered to another patient in need of attention. You will be charged a $50 fee if you fail to keep your appointment or cancel with less than 48 business hours notice. After TWO missed appointments in a row, you may be dismissed from the practice.

**Prescription Policy:** Please call for refills during regular office hours and leave the patient's name, DOB, phone number, medication, and the pharmacy requested. Please allow 48 business hours to complete the request. Some prescriptions may be delayed due to completing a PRIOR AUTHORIZATION form set forth by the insurance companies. For oral medications, biologics, and some topical medications, the patient needs to be evaluated every 6 months. We cannot refill a prescription if the patient has not been evaluated within 12 months.

**Minor Policy:** All minor patients must be seen on the first visit with their Guardian/Representative.

I have read and understand the Financial/Credit Card on File/Office Policies of Dermio Dermatology.

Signature: _____Date: _____