PATIENT INFORMATION

EPI DERMATOLOGY

Patient Name:_____ **Date:**_____

Date of Birth:_____ Age:_____ Sex: □Male □Female

Race: □White □Black or African American □Asian □American Indian/Alaskan Native □Native Hawaiian

□Other_____ □Decline to answer

Ethnicity: □Hispanic □Non-Hispanic □Unknown Preferred Language: _____

Address: _____

City: _____ State:_____ Zip:_____

Home Phone (_____)_____ Cell Phone: (_____)_____

Social Security #:_____ Drivers License #:_____

Employer:_____ Occupation:_____

Work Phone: (_____)_____ Do you authorize us to leave a message on your phone?

Email Address:_____ □Yes □No

PHARMACY

Preferred Pharmacy Name:_____ Phone Number:_____

Pharmacy Address:_____

EMERGENCY CONTACT

Name: _____ Relationship to Patient:_____

Address:_____ Phone: (_____)_____

PRIMARY INSURANCE INFORMATION (*In order for us to file a claim on your behalf, this section must be completed in its entirety.*)

Primary Insurance Name: _____ Phone: (_____)_____

ID #:_____ Group / Account #:_____

Subscriber Name:_____ Subscriber's Date of Birth:_____

Relationship to Patient: _____ Subscriber's Social Security #:_____

Subscriber's Address (Street, City, State, Zip):_____

SECONDARY INSURANCE INFORMATION (*If applicable*)

Secondary Insurance Name: _____ Phone: (_____)_____

ID #:_____ Group / Account #:_____

Subscriber Name:_____ Subscriber's Date of Birth:_____

Relationship to Patient: _____ Subscriber's Social Security #:_____

Subscriber's Address (Street, City, State, Zip):_____

HOW DID YOU HEAR ABOUT EPIDERMATOLOGY?

□Insurance □Friend

□Doctor _____ □Internet / Our Website / ZocDoc / Google (*Circle One*)

□Magazine Ad (which one?):_____ □Other:_____

ACKNOWLEDGEMENT OF OFFICE POLICIES

EPI DERMATOLOGY

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

Please review and initial each policy listed below:

Receipt of Notice of Privacy Practices: I have had the opportunity to review the Notice of Privacy Practices of EpiDermatology. (This document is available at our front desk or on epidermatology.com)

Cancellation Policy: If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 48 hours of the scheduled appointment. **Please note: EpiDermatology reserves the right to charge a $40 fee if a patient does not cancel their appointment within 48 hours or a $100 fee for surgical appointments not cancelled within 72 hours.**

Release of Medical Information:

I do / do not (*circle one*) authorize EpiDermatology, PLLC and its designated representatives to release my medical information to my primary care physician. If authorized, please provide name of physician:_____.

If at any time you should need a copy of your medical records, we require a written release to be signed and dated. The form is available at our front desk and can be requested by email. Please allow 10-15 business days to complete your request. If your request is urgent, please mark the request as urgent and someone from our staff will contact you to expedite your request. Absent providing a secure fax number, records must be MAILED to your address of record. Copies of blood work and pathology reports are provided at no charge, copies of your complete medical record or office notes will require prepayment of the $25 records fee.

Our office requires a written records release form to transmit records to any physician or medical organization that is not listed as your referring physician. If you have a consulting physician you would like to have listed as an authorized recipient of your medical information, please request and complete a release form for each physician you wish to be authorized.

Contact Permission: In the event that EpiDermatology, PLLC needs to contact you (the patient), regarding an appointment, lab result, medication, or any other reason; it is permissible to:

Yes **No** (*circle one*) Leave a message on an answering machine or voicemail.

Yes **No** (*circle one*) Speak with other authorized individuals listed below.

Name: _____ **Relationship:**_____

Name: _____ **Relationship:**_____

Name: _____ **Relationship:**_____

Consent to Treatment: I consent to the performance of diagnostic procedures, examinations and rendering treatment by the medical provider and their designated medical office staff as it is deemed necessary in the medical provider's judgment.

Unaccompanied Minors (Under 18 Years Old): New patients who are minors must have a parent or legal guardian present for the new patient visit.

Many times parents/guardians find themselves unable to accompany their teen or young adult children to appointments. Should you wish for us to see your teen/young adult child when they arrive at the office unaccompanied please read, indicate and sign below:

YES **NO** (*circle one*) I hereby grant the physicians and providers at EpiDermatology, PLLC permission to treat my child when they arrive at the office unaccompanied. I understand this may include changes in current therapy my child is receiving including treatment or minor skin surgery.

Signature:_____ Date:_____

Proof of Identity: EpiDermatology requires proof of identity on file. I understand that I must provide a photo ID such as a driver's license at check-in. This will be scanned into your private medical record as a means to document who we are treating.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

_____ _____

Signature of Patient or Guardian **Date**

FINANCIAL AGREEMENT

EPI DERMATOLOGY

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

Thank you for choosing EpiDermatology. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit please contact our billing department as soon as possible. We strongly encourage each patient to contact their insurer directly prior to receiving services to ensure that they fully understand their benefits and coverage. We accept cash, checks, MasterCard, Visa, Discover, American Express.

Please review and sign after reading each policy listed below.

Private Pay (Self-Pay): I understand that if I do not have health insurance, full payment is due at the time of service.

Policy Benefits / Non-Covered Charges: I understand it is my responsibility to know my insurance policy coverage and benefits and to notify EpiDermatology of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not paid by your insurer. Routine in-office procedures include but are not limited to biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths and Mohs surgery. These are billed separately from your office visit and may be subject to your deductible or coinsurance.

Copayments: I understand that all copays are due at the time of my appointment and before I see the provider. Due to the fact that EpiDermatology physicians are specialists, a higher copay may be required.

Deductibles: EpiDermatology has become aware that many routine office procedures are now being applied to patient deductibles under the new health insurance plans issued after 2013. If it is determined that your insurance policy has an unmet deductible, payment for services at the contracted rate between EpiDermatology and your insurer will be due at the time of service.

Managed Care (HMO) Plans: I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires them. We will strive to keep you informed of visits remaining on a referral and/or its expiration date but it is ultimately the responsibility of the patient to track this information and to make the necessary arrangements through their primary care physician. Signing this form acknowledges your understanding that failure to obtain a referral, if required by your insurance for coverage, will result in your bearing complete financial responsibility for any services received.

Benefit Representation: I understand that the staff of EpiDermatology will make every effort to accurately verify my insurance benefits, but I will not rely on this preliminary verification as a basis for making financial decisions regarding treatment. I understand that I have a right to refuse any and all services before they are rendered if I think they are non-covered services or non-payable by my insurance. I understand that the final determination regarding my benefits and any amounts owed will be made by my insurer at the time of claim processing according to the provisions of the policy contract that I have with them.

Assignment of Benefits: I understand I must provide a copy of my current insurance card in order to file an insurance claim. I assign directly to the providers at EpiDermatology, PLLC all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor(s) to release any information necessary to secure all payments or approvals of benefits. I authorize the use of my signature below on all insurance submissions.

Payment for Ancillary Services (Laboratory/Pathology): I understand that EpiDermatology utilizes the services of outside laboratories for pathology (biopsies), microbiology (cultures) and blood chemistry. These laboratories will bill their services separately from EpiDermatology. I acknowledge that payments made to EpiDermatology are for services rendered by EpiDermatology and authorize the use of outside laboratories as deemed necessary and warranted by my doctor(s). I understand that this may result in a financial responsibility to the laboratory providing these diagnostic services.

Worker's Compensation: I understand that EpiDermatology does not accept Worker's Compensation cases and warrant that my visit is not a part of a worker's comp case.

Returned Checks / Credit Cards: I understand that checks presented as payment for services rendered and subsequently returned by my bank for insufficient funds or *any other reason as unpaid* will be charged a returned check fee of $35. EpiDermatology, PLLC may re-present my returned check for its face value plus the returned check fee electronically and I authorize EpiDermatology, PLLC to do so. Balances must be handled by cash, credit card or money order. EpiDermatology will charge my account a fee for valid credit card charges that I dispute with my card issuer.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter. Past due accounts turned over to collection agencies will incur a collections fee of 35% of the outstanding balance.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand and accept all of the above policies.

_____ _____

Signature of Patient or Guardian/Guarantor **Date**

Patient Name: **DOB:** **DATE:**

Past Medical History: (please circle all that apply)		
Anxiety Arthritis Asthma	GERD (Acid Reflux)	Lymphoma
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH (Large Prostate)	Hepatitis *A B C*	Radiation Treatment
Bone Marrow Transplant	Hypertension	Seizures
Breast Cancer Colon Cancer	HIV/AIDS	Stroke / *TIA*
COPD	Hypercholesterolemia	*Blood Clots*
Coronary Artery Disease	Hyperthyroidism	*Pulmonary Embolism*
Depression	Hypothyroidism	*Tuberculosis*
Diabetes	Leukemia	*Other:* _____
End Stage Kidney Disease	Lung Cancer	

Past Surgical History: (**please circle all that apply**)		***Skin Disease History:***
Appendix Removed Bladder Removed	Kidney Biopsy	**(circle all that apply)**
Mastectomy (Right, Left)	Kidney Stone Removal	Acne
Lumpectomy (Right, Left)	Kidney Transplant / Removal	Actinic Keratoses
Breast Biopsy	Liver Surgery: _____	Asthma
Colectomy: Colon Cancer Resection	Ovaries Removed: (reason)_____	Basal Cell Skin Cancer
Colectomy: Diverticulitis	Tubal Ligation	Blistering Sunburns
Colectomy: Inflamm Bowel Disease	Pancreas	Dry Skin
Gallbladder Removed	Prostate Biopsy/Cancer/TURP	Eczema
Valve Replacement: Mechanical vs. Biological	Rectum : APR / LAR	Flaking or Itchy Scalp
Coronary Artery Bypass Surgery	Skin: Basal Cell Cancer	Hay Fever/Allergies
Heart Transplant	Skin: Melanoma	Melanoma
Angioplasty or Heart Stents	Skin: Squamous Cell	Poison Ivy
Joint Replacement, Knee (Right, Left)	Spleen Removed	Abnormal Moles
Joint Replacement, Hip (Right, Left)	Testicles Removed (Right, Left)	Psoriasis
Joint Replacement within last 2 years	Hysterectomy: Fibroids	Squamous Cell Skin Cancer
Joint Surgery (Non-replacement)	Hysterectomy: Uterine Cancer	*Fever Blisters / Cold Sores*
Other Surgeries:	*Other Organ Transplant:*	Other:

Do you wear Sunscreen? □ Yes □ No
If yes, what SPF? _____
Tan in a tanning salon? □ Yes □ No
Family history of Melanoma? □ Yes □ No
If yes, which relative(s)? _____

Smoking: daily / social / past / never
Alcohol: How often_____ Drug Use: Y / N
Occupation*:* _____
Employer: _____
Retired: No / Yes (prior work:_____)

Family history of Other Skin Cancer? □ Yes □ No
If yes, which relative(s)? _____

MEDICATIONS (inlcude Aspirin, Herbal meds, Vitamins):

NAME	DOSE	FREQUENCY

ALLERGIES:

Medical Problems in the family	Problem:	Family Member:
(Parents, Kids, Siblings only)	Problem:	Family Member: