McGuiness

DERMATOLOGY

MEDICAL HISTORY FORM

Name_____ Home Phone _____

Address _____ Cell Phone _____

City_____ State _____ Date of Birth _____

Zip Code_____ DL#_____ Sex __ M __ F Age _____ SS# _____

Provide email for appointment reminders and announcements _____

Patient's Employer_____ Occupation _____

Employer's Address_____ Work Phone_____

City_____ State_____ Zip Code _____

Any other family members who have been treated here? __ Yes __ No Name _____

How did you find out about our practice? _____

REFERRED BY

For Paperwork:

- Magazine _____
- Newspaper _____
- Organization _____
- Insurance _____
- Physician _____
- Friend/Family _____
- Internet Search _____
- Social Media _____

INSURANCE POLICY HOLDER INFORMATION

Name of Insured_____ Date of Birth_____

Address_____ Home Phone_____

Relationship: Husband/Wife/Father/Mother/Son/Daughter _____ Occupation_____

Employer_____ Work Phone_____

Employer's Address_____

City_____ State_____ Zip Code _____

IN CASE OF EMERGENCY CONTACT

McGuiness Dermatology

Name _____

Name _____ Relationship _____

Address _____ Telephone _____

Our Notice of Privacy Practices (notice) provides information about how we may use and disclose protected health information about you. You have the right to review our notice before signing this consent. As outlined in our notice, the terms of our notice may change. If our notice is changed or modified, you may obtain a revised copy by request.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we are bound by our agreement.

By signing this Form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent. This consent is given freely with the understanding that:

1. Any and all records, whether written or oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as the original.
3. I may revoke this consent at any time, except where information has already been released. This consent is valid until revoked by me in writing.

_____ _____

Signature Date

PRIMARY INSURANCE CARRIER

Name of Primary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policy Holder _____ Relationship to Policyholder

_____ Name of Employer _____

Group No._____ Policy or ID No. _____ Effective Date

of Policy_____ Phone Number for Verification

_____ Phone Number for Pre-

certification _____

SECONDARY INSURANCE CARRIER

Name of Secondary Insurance Company _____

Mailing Address for Insurance Claim _____

Name of Policy Holder _____ Relationship to Policyholder

_____ Name of Employer _____

Group No._____ Policy or ID No. _____ Effective Date

of Policy_____ Phone Number for Verification

_____ Phone Number for Pre-

certification _____

Name _____

MICHAEL A.J. McGUINESS, M.D.
Payment Policy

1. We will file insurance for our PPO patients. However, all co-payment and/or deductible amounts are due at the time of the service. Any disallowed amounts are due from the patient.

2. We do not file insurance for our indemnity patients. Payment in full is expected at the time of visit and a receipt will be given for you to file with your insurance carrier.

3. There will be a twenty-five dollar ($25) fee assessed for any returned check. This fee is assessed regardless of whether the check is redeposited, because the bank has already charged us a fee for the returned item. You will subsequently receive a bill for this amount.

4. If your account has a credit balance of more than $10.00, a refund will be mailed to you within thirty (30) days.

5. Your insurance policy is a contract between you and your insurance company. It is important that you understand what physician services are and are not covered before seeing your doctor. We cannot guarantee payment of your claims by your insurance company. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred.

6. Cosmetic appointments have extended time allowed for the patient and if you miss your appointment time without twenty-four hour notice of cancellation. It will result in a missed appointment charge of $50.00 for a consult and $100.00 for any type of cosmetic procedure.

Referral Authorization

Referrals must be obtained prior to the visit. If a referral is not received at the time of the visit, the patient is responsible for payment when services are rendered.

Authorization

I authorize release of medical records to determine liability for payments or treatment, and to obtain reimbursement.

I assign all medical benefits for office visits to Dr. McGuiness, Dr. Brown, Dr. Rubianes, Dr. Kesani and Dr. Hodges. This assignment will remain in effect until revoked by me in writing. A photocopy of this instrument will have the same validity as the original.

Signature_____ Date_____

McGuiness Dermatology **Name** _____

HIPAA FORM

I, _____, give the office of Dr. McGuiness, Dr. Brown, Dr. Rubianes, Dr. Kesani, Dr. Hodges permission to speak with the following family members, spouse, roommates, etc., regarding billing issues, lab results, or any information pertaining to my treatment and care.

Family members, spouse, roommates, etc.:

_____

_____

_____

_____

_____

_____

Please list the numbers you would like us to call YOU:

Work #_____ Can we leave a message? Y N

Home #_____ Can we leave a message? Y N

Cell #_____ Can we leave a message? Y N

Name _____ **DOB** _____

Please provide for reminder and announcements:

EMAIL:_____ **CELL#:**_____

PHARMACY NAME: _____ (PRESCRIPTIONS ARE ELECTRONICALLY SENT IN)
ADDRESS:_____ (WE MUST HAVE CITY)
PHONE # _____
CROSS STREETS: _____

HISTORY AND INTAKE FORM

Past Medical History: (circle all that apply)

Anxiety	Depression	Hyperthyroidism
Arthritis	Diabetes	Hypothyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial fibrillation	GERD	Lung Cancer
BPH (prostate hypertrophy)	Hearing Loss	Lymphoma
Bone Marrow	Hepatitis	Pacemaker
Transplantation	Hypertension	Prostate Cancer
Breast Cancer	(high blood pressure)	Radiation
Colon Cancer	HIV/AIDS	Treatment
Coronary Artery	Hypercholesterolemia	Seizures
Disease	(high cholesterol)	Stroke
Other _____		NONE

McGuiness Dermatology **Name** _____

Past Surgical History: (circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (right, left, bilateral)
Lumpectomy (right, left, bilateral)
Breast Biopsy (right, left, bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (right, left, bilateral)
Joint Replacement, Hip (right, left, bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Removed (right, left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (right, left, bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other _____ NONE

Skin Disease History: (circle all that apply)

Acne
Actinic Keratoses
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

Other _____ NONE

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Medications: (Please enter all current medications)

NAME:	DOSE	STRENGTH	NAME:	DOSE	STRENGTH

DRUG Allergies: (please enter all allergies)

_____

Social History: (please circle all that apply)

SMOKING STATUS:
Current
Former
Never

ALCOHOL USE:
More than 1/day
Less than 1/day
Never Drink

WHAT STATE DID YOU GROW UP IN:
_____
WHAT IS YOUR PRIMARY LANGUAGE,
RACE, AND ETHNICITY? _____

McGuiness Dermatology **Name** _____

Review of Systems: Are you currently experiencing any of the following? (please check all that apply)

SYMPTOM (CHECK IF APPLIES)	**SYMPTOM** (CHECK IF APPLIES)	**SYMPTOM** (CHECK IF APPLIES)
Abdominal Pain	Headaches	Wheezing
Anxiety	Hay Fever	Immunosuppression
Bleeding Problems	Joint Aches	Significant UV Exposure
Bloody Stool	Muscle Weakness	Allergy to Adhesive
Bloody Urine	Neck Stiffness Night Sweats	Allergy to Lidocaine
Blurry Vision	Rash	Allergy to Topical Antibiotic
Changing Mole	Seizures	MRSA
Chest Pain	Shortness of Breath	History of Fainting
Cough	Sore Throat	History of Vasovagal
Depression	Thyroid Problems	
Fever or Chills	Unintentional Weight Loss	

Other Symptoms: _____

Do you have any upcoming physical events or travel plans? _____

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding?	Yes	No
Do you require antibiotics prior to a surgical procedure?	Yes	No
Have you had an artificial joint replacement?	Yes	No
If yes, when and what body locations? _____		
Do you have an artificial heart valve?	Yes	No
Do you have a pacemaker?	Yes	No
Do you have a defibrillator?	Yes	No
Are you pregnant or currently trying to get pregnant?	Yes	No

If you circled **No**, how are you preventing?_____

Do you wear deodorant? YES NO

Do you have concerns about cellulite? YES NO

Are you interested in skin tightening? (Circle all that apply).

Lower Face Jowls Décolletage

Neck Brows/Eyelids

Have you had any non-invasive procedures? If so, please explain_____

_____

_____

Are you interested in non-invasive fat reduction? YES NO

Would you like to hear more about any of the following? (Circle all that apply).

Injectables: Muscle Relaxers(Botox) Fillers

Body Contouring: Cool Sculpting TruSculpt Double Chin Reduction

Laser Treatments: Tattoo Removal Wrinkles Stretch Marks Scars Acne

Spider Veins Cellulite Brown Spots Sweating/Odor Reduction

Payment Agreement & Cancellation Policy

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

1. Payment is always due at time of service. We accept the following forms of payment:

a. Cash
b. Credit/debit cards
c. Check
d. Care Credit

We require that patients owing money pay their account balances to zero prior to receiving further services by our practice.

2. Cancellations/No Show Policy:

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel or reschedule an appointment, you may be preventing another patient from getting much needed treatment. Equally the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit in their place.

If an appointment is not cancelled/rescheduled at least 24 hours in advance you will be charged a $25 fee for regular visits and $50 for surgical visits; this <u>WILL NOT</u> be covered by your insurance company.

3. Late Arrivals:

If you are late for an appointment, you will be seen as soon as possible, though the office visit may need to be shorten in length. As a courtesy, when time allows, we send out reminders for your appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

If a patient is more than 15 minutes past their scheduled time we will have to reschedule the appointment.

I have read and understand the Medical Payment and Cancellation Policy and agree to be bound by its terms.

_____	_____	____/____/____
Print Name Patient	**Signature Patient/Guardian**	**Date**