DERMATOLOGY
AND CUTANEOUS SURGERY™

Health History Form

Patient Name: _____ **DOB:** _____ ***Date:*** _____
Last First M. (MM/DD/YY) (MM/DD/YY)

Primary Reason for Visit Today:
- ☐ Full Skin Exam
- ☐ Other:

Pertinent Surgical History (type/date): _____

_____

_____

Pharmacy _____

Phone: _____ **Fax:** _____

Health History:

☐ None Apply

- ☐ Allergies
- ☐ Anxiety / Depression
- ☐ Anemia or Blood Disorder
- ☐ Antibiotics Before Dental Work
- ☐ Arthritis / Joint pain
- ☐ Artificial Heart Valve
- ☐ Artificial Joints
  - Knee L / R / Both
  - Hip L / R / Both
- ☐ Asthma / Hayfever
- ☐ Autoimmune Disorder
- ☐ Bleeding Disorder or Excessive Bleeding
- ☐ Blood Clots
- ☐ Cancer, type _____
- ☐ Celiac Disease
- ☐ Connective Tissue Disease
- ☐ Coronary Bypass
- ☐ Crohn's Disease
- ☐ Defibrillator
- ☐ Diabetes
- ☐ Ear scaling, itch or rash
- ☐ Emphysema/COPD
- ☐ Eye dryness itch or sensitivity
- ☐ Enlarged lymph nodes
- ☐ GERD
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Valve Replacement
- ☐ Heart Murmur / Irregular Rhythm
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV
- ☐ Hypercholesterolemia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ Implants
- ☐ Irritable Bowel Disease
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Lupus
- ☐ Migraines
- ☐ MRSA
- ☐ Pacemaker
- ☐ Pregnant / Breast Feeding
- ☐ Organ Transplant
- ☐ Radiation Therapy/Chemo
- ☐ Seizures
- ☐ Stroke
- ☐ Swelling of legs
- ☐ Thyroid Disorder
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Other: _____

Skin History:

☐ None Apply

- ☐ Accutane
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Atypical Nevus
- ☐ Blistering Sunburn
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Eczema
- ☐ Excessive Moles
- ☐ Fever Blisters
- ☐ Scars/ Keloid
- ☐ Laser Treatments
- ☐ PDT Treatments
- ☐ Psoriasis
- ☐ Rosecea
- ☐ Shingles
- ☐ Tanning Bed Use
- ☐ Ulcers
- ☐ Urticaria / Hives
- ☐ UV Light Treatments
- ☐ Vitiligo
- ☐ Warts
- ☐ Other: _____

Skin Cancer History:

- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Malignant Melanoma

_____ _____
Provider Signature Date Patient Signature Date

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Health History Form

Patient Name (Last, first): _____ **DOB:** _____

Family History: (List Affected Family Member Next to Condition)

☐ None Apply

- ☐ Allergies
- ☐ Asthma
- ☐ Autoimmune Disorders
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Eczema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Irritable Bowel Disease
- ☐ Malignant Hyperthermia
- ☐ Psoriasis
- ☐ Other:_____

Family Skin Cancer History:

- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Malignant Melanoma

Smoking Status: ☐ Not Applicable

- ☐ Current Smoker
  - Started:_____
- ☐ Former Smoker
  - Started: Ended:

Alcohol Use:

- ☐ No Alcohol Use
- ☐ Alcohol Use Socially
- ☐ Alcohol Use Daily

Recreation Drug Use:

- ☐ Yes
- ☐ No

Medication Allergies	Other Allergies	Other Allergies Cont.

Current Medications: (Include dose and other over-the-counter, vitamin, and herbal meds.)

1	6	11
2	7	12
3	8	13
4	9	14
5	10	15

Review of Systems: (Please check current and related issues below)

Constitutional:

- ☐ Fever
- ☐ Chills
- ☐ Fatigue
- ☐ Malaise
- ☐ Weight Loss

Skin:

- ☐ Rash
- ☐ Sores
- ☐ New or Changing lesions
- ☐ Itching/Burning
- ☐ Facial Flushing

Gynecologic: (Female Only)

- ☐ Currently Pregnant/Trying
- ☐ Currently Nursing
- ☐ Hormone Replacement Therapy
- ☐ Birth Control/IUD
- ☐ Last Menstrual Period _____

_____ _____

Provider Signature Date Patient Signature Date

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Patient Communication and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) requires Dermatology and Cutaneous Surgery to obtain your authorization to allow communications regarding your protected health information. This authorization allows Dermatology and Cutaneous Surgery to discuss your health care with a spouse, child, friend, or other family member that you designate. It also allows Dermatology and Cutaneous Surgery to leave recorded messages at your home, work, or on your cell phone related to your medical care and treatment, payment, appointment status, or follow-up. It also allows Dermatology and Cutaneous Surgery to send electronic messages via the patient portal related to your medical care and treatment, payment, appointment status, or follow-up.

List phone number(s) in order of preference for receiving appointment reminder and/or patient care calls:

Please circle type:		***Please circle patient care messaging preferences below:***				
1. Landline / Cell / Email	_____	no message	/	message to call	/	detailed message
2. Landline / Cell / Email	_____	no message	/	message to call	/	detailed message
3. Other	_____	no message	/	message to call	/	detailed message
4.						

☐ Yes, please contact me for news and events in our practice. Email: _____
☐ No, I do not want to provide my email address.

(We will not share your email address.)

Due to the HIPAA privacy rules, if you are over the age of 18 and would like medical care discussed with others (parent/guardian/family members), please complete this section.

This authorization allows Dermatology and Cutaneous Surgery to discuss <u>all aspects</u> of my protected health information with the individual listed below:

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

<u>Please initial each line item and sign below.</u>

Initial:_____Records Release: I authorize the release of my health information by Dermatology and Cutaneous Surgery for the purposes of my current treatment, including release of information to my referring or primary care provider and other health care providers participating in my current treatment, or as otherwise necessary for Dermatology and Cutaneous Surgery to provide treatment to me. I authorize the release of medical information (including billing information) as necessary for payment purposes, including release by Dermatology and Cutaneous Surgery to my insurance company, the responsible party named above, and any other person or entity responsible for payment for my medical treatment. I authorize the release of my health information to business associates of Dermatology and Cutaneous Surgery as necessary for the purposes of Dermatology and Cutaneous Surgery healthcare operations.

Initial:_____Assignment of Benefits: I authorize payment of medical benefits to Dermatology and Cutaneous Surgery for services rendered to myself and/or dependent.

<u>For Medicare recipients only:</u>

Initial:_____Medicare Authorization: I request that payment of authorized Medicare benefits be made on my behalf to Dermatology and Cutaneous Surgery for any services furnished me by that physician / clinic / supervisor. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Initial:_____MEDIGAP: I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits payable for related services.

I understand I may refuse to sign this authorization and realize this may result in a delay of treatment and/or have potential adverse health consequences. This authorization will expire in one year from the date signed; however, I may change or revoke it at any time.

_____ _____ _____

Signature of Patient or Legal Representative | Print Name | Date

DERMATOLOGY
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PATIENT FINANCIAL POLICY

Thank you for choosing Dermatology and Cutaneous Surgery for your dermatology care. We are committed to providing you with dedication and excellence as we meet your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the guidelines listed below. If you have any questions or need clarification regarding this policy or your bill, please feel free to contact our ***Billing Office toll-free at (844) USS-SKIN or (844) 877-7546*** **(option 2).**

General

We participate in most insurance plans including Medicare, however it is your responsibility to make sure our clinic and providers are considered in-network with your insurance plan. We are happy to bill your insurance company on your behalf, but we need a copy of your insurance card/s at the time of service in order to do so. Please bring your current insurance card/s and picture ID to every appointment. If the correct insurance information is not given to us, it may be necessary for us to bill you for the services rendered. Please keep in mind that you are ultimately responsible for the payment for all services rendered.

Copay/Deductible/Co-insurance

If a copay is required by your insurance, it is to be paid at the time of service. Remember insurance companies often apply different copay amounts to specialists. Please come prepared to pay this amount. Many insurance policies have a yearly deductible that must be met by the patient before the insurance will pay their percentage. Additionally, many insurance plans have co-insurance. For example, after your copay is paid and your deductible is met, you may still be liable for a percentage of the charge if your plan has co-insurance. You are responsible for understanding your insurance plan and your financial obligations.

Office Visit vs. Procedure

An office visit is defined as the examination and/or consultation with our provider. Please keep in mind that annual or preventative examinations do not fall under dermatology guidelines. Examinations by our providers can only be billed as office visits. In addition to your office visit, you may be charged for any procedures such as cryosurgery, cautery, chemical destruction, biopsies, or shave excisions. These procedures fall under the surgical code guidelines and carry additional charges above the office visit charge. It is the patient's responsibility to inquire about any additional costs before any procedure is performed. An adjustment will not be made to your bill because you were unaware of your insurance plan coverage.
Patients may receive a separate bill for pathology services.

Referrals

Some health insurance policies allow you to make an appointment directly with a specialist while others require a referral from your primary care provider. Often these referrals are given a designated number which is attached to your claim and allows your insurance provider to make a payment on your claim. Other insurance companies require only a note from the primary care provider. If you have questions regarding referral requirements, please contact your insurance carrier. Individual policies vary greatly; however, it is your responsibility to obtain a referral and provide us with a copy of the referral, if one is required. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.

Payments and Refunds

All co-payments and non-covered services are due at the time of service. All cosmetic procedures and services are paid in full at the time of service. For your convenience we accept credit/debit cards, checks, and cash as methods of payment. You will be asked to pay any unpaid balances when you check in for your appointment. In the event surgery is required, and you do not have health insurance coverage, we must receive a down payment of no less than 50% of the estimated doctor's fees before we will schedule surgery.

All patient balances are due in full within 30 days of statement date. Insufficient funds checks, or if your account is sent to collections due to nonpayment, will result in a $25.00 fee. In addition, patients in collections will not be provided services unless it is a medical emergency. If an overpayment is made, we will issue a refund if there are no other outstanding debts on other accounts with the same guarantor or financial responsible party.

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If you require financial assistance or to set up a payment plan after your insurance has processed your claim(s), please contact the clinic manager or our ***Billing Office toll-free at (844) USS-SKIN or (844) 877-7546*** **(option 2).**

Self-Pay

Self-Pay patients are defined as individuals who **do not have health insurance coverage.** It may also mean our providers and clinics are considered out of network with the patient's insurance plan. Self-pay patients understand that any benefits, if at all, may be paid at a significantly reduced rate, which may include a higher deductible and/or coinsurance amount. These lesser benefits may increase your overall financial responsibility to the practice. Self-pay patients accept responsibility for any deductible, coinsurance, copay, and/or non-covered services amounts not paid by health insurance plan as a result of **out-of-network** benefits. Any payment for these amounts is due at the time the services are provided.

Cancellation and No Show Fee

In order for us to provide exemplary service to you and other patients, it is paramount that you arrive to your appointment on time. Please be courteous and call our clinics as soon as possible, but no later than **24 hours prior to your scheduled appointment** if you are unable to attend. Appointments are in high demand, and your early cancellation will allow another patients access to timely medical care. Patients who fail to show up to their scheduled appointment or do not notify the office within 24 hours of their scheduled appointment time, may be subject to **$40 "No Show/Cancellation" fee.** In the event of an actual emergency where prior notice could not be given, consideration may be granted and a one-time exception may be made. You will be asked to provide your credit card information in order to re-schedule the appointment. If you do not arrive to your scheduled appointment or cancel within 24 hours, the non-refundable "No Show/Cancellation" fee may be automatically charged to your credit card on file.

Electronic Communications

We may contact you via phone, text or email to discuss your medical records, appointment reminders, and/or account status. These may be automated and text message charges may apply.

Release of Information, Assignment of Benefits and Financial Responsibility

In order to expedite payment of my claims, I authorize the practice to release by electronic means or otherwise any medical and/or billing information concerning my care, including copies of my medical records to the following:

a. Any person or entity responsible for payment for the medical services rendered to me at the practice, including third party payers, self-insurers, worker's compensation carriers and government agencies or any person or entity acting as the agent or contractor of such party responsible for payment, to obtain payment for any medical services rendered to me at the practice by any provider.
b. Federal, State or other governmental or quasi-governmental agencies or such other parties required by law for reporting purposes or for purposes of determining eligibility in government sponsored benefit programs.
c. Any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the practice and /or any person providing services at the practice.
d. Any health professionals involved in my care for the purpose of facilitating the continuity of my medical care.

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PATIENT FINANCIAL POLICY

Notice of Annual Financial Policy/Patient Acknowledgment

I acknowledge that I have read the annual financial policy. I understand that printed copies of this document are available at the front desk upon request. I understand that I am responsible for all charges whether or not they are reimbursed by my insurance plan. I acknowledge that the above authorization has no expiration date and authorizes the release of medical records and billing information at any time a valid request is received.

I hereby authorize my Medicare and/or medical insurance benefits to be paid directly to the practice. I understand that I am financially responsible for non-covered services as well as any deductibles, coinsurance or amounts in excess of insurance benefits. If coverage is denied, I give my express consent to appeal to the insurance on my behalf and request that payment of authorized Medicare benefits be made to the practice for any services provided to me by the practice. I consent that any holder of my medical information may disclose it to the practice and its agents for the purposes of determining the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

Signature:_____ **Date:**_____

Patient Name (please print):_____ **If minor, parent/guardian name:** _____

This consent will be in effect unless cancelled in writing.

Notice of HIPAA Privacy Practices/Patient Acknowledgment

I have received the practice's Notice of Privacy Practices. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of its Notice of HIPAA Privacy Practices, and to make new provisions effective for all protected health information it maintains. I understand that I can obtain this practice's Notice of HIPAA Privacy Practices on request.

Signature:_____ **Date:**_____

Patient Name (please print):_____ **Date of birth:** _____

If minor, parent/guardian name:_____ **Relationship to patient:**_____

Credit Card on File and Authorization

We require all patients to **maintain a valid credit or debit card on file** with us. It is our policy to follow all federal and state laws regarding identity theft and financial privacy. Your credit card will automatically be charged for any unpaid balances older than 2 billing cycles. A $25 collection fee will be added for any invalid credit card information given and the balance will be forwarded to a collection agency. Patients in collections will not be provided services unless it is a medical emergency.

If you require financial assistance or to set up a payment plan after your insurance has processed your claim(s), please contact the clinic manager or our ***Billing Office toll-free at (844) USS-SKIN or (844) 877-7546*** **(option 2).**

Signature:_____ **Date:**_____

Financial policy last updated: 11/5/2019