the skin docs
DERMATOLOGY

PATIENT INFORMATION

NAME (First, M.I., Last):

DOB:	AGE:	SEX: ☐ Male ☐ Female ☐ Other ___________	SSN: _ _

RACE / ETHNICITY: ☐ Prefer not to answer ☐ Black / African American ☐ White / Caucasian ☐ Not sure ☐ Other ______________________ ☐ Asian or Pacific Islander ☐ Native American ☐ Hispanic / Latino

PREFERRED LANGUAGE: ☐ English ☐ Spanish ☐ Other ______________________

ADDRESS (City, State, Zip):

PRIMARY PHONE: ☐ Cell ☐ Home	SECONDARY PHONE: ☐ Cell ☐ Home

EMAIL ADDRESS:
(Please PRINT CLEARLY!)

MARITAL STATUS: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

EMERGENCY CONTACT: ☐ Parent/Legal Guardian of Patient	Name (First, Last):
Phone:	Relationship to Patient:

PRIMARY CARE PROVIDER / CLINIC NAME:
☐ I don't have one

OCCUPATION (optional):

PARENT / LEGAL GUARDIAN INFORMATION (IF PATIENT IS A MINOR)

RESPONSIBLE PARTY'S NAME (First, Last):

DOB:	SSN: _ _

ADDRESS (City, State, Zip):
☐ Same as Patient's Address Above

INSURANCE INFORMATION

PRIMARY INSURANCE NAME:	POLICY HOLDER'S NAME (if different from patient):	
	DOB:	Relationship to Patient:
SECONDARY INSURANCE NAME:	POLICY HOLDER'S NAME (if different from patient):	
	DOB:	Relationship to Patient:

How did you hear about us?
☐ Insurance ☐ Primary Care Referral ☐ Friend/Family ☐ Street Sign ☐ Internet Search ☐ Internet Ad ☐ The Skin Docs website ☐ ZocDoc.com ☐ Healthgrades.com ☐ Instagram ☐ Yelp ☐ Facebook ☐ Other: ______________________

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SKIN CANCER HISTORY	
Do you have a PERSONAL history of:	☐ Skin Cancer ☐ Squamous Cell Carcinoma ☐ Melanoma ☐ Basal Cell Carcinoma ☐ None of the above
Do you have a FAMILY history of:	☐ Skin Cancer ☐ Squamous Cell Carcinoma ☐ Melanoma ☐ Basal Cell Carcinoma ☐ None of the above

GENERAL MEDICAL HISTORY	
Please list all *other* past and current medical conditions below:	

SURGICAL HISTORY	
Surgery Name	Date
☐ Mohs Surgery Location:	
☐ Skin Cancer Surgery Location:	

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MEDICATIONS

☐ I am NOT taking any medications

Name	Strength	Dosage Frequency	Reason

PHARMACY: (Name & Location)	

ALLERGIES

☐ I have NO known allergies

Medication/Allergen Name	Type of Reaction

If you are 65 years of age or older please answer the following:

Did you ever have a pneumonia vaccine? ☐ Yes ☐ No

Do you have any of the following? ☐ Advance Directive ☐ Living Will ☐ Health Care Proxy ☐ No

Which statement best reflects your wishes on advance care planning?

☐ I do not wish to have a breathing tube, even if it is necessary to save my life

☐ If my heart were to stop, I do not wish to have chest compressions or a defibrillator to restart my heart

☐ I want full cardiopulmonary resuscitation efforts to be made to save my life

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REASON FOR VISIT					
Name:				DOB:	
If you are only here for a routine skin exam, please skip to MEDICAL CHECKLIST					
Severity of Problem:	☐ Mild		☐ Moderate		☐ Severe
Type of Problem:	☐ Rash	☐ Lesion	☐ Spot	☐ Mole	☐ Wart
	☐ Acne	☐ Cyst	☐ Ulcer	☐ Scar	☐ Blister
	☐ Skin Tag	☐ Discoloration	☐ Other____________________		
Symptom(s) associated with problem:	☐ Painful	☐ Itchy	☐ Burning	☐ Stinging	
	☐ Bleeding	☐ Unsightly	☐ Spreading	☐ Tingling	
	☐ Other ____________________				
Area(s) of body affected:	☐ Scalp	☐ Face	☐ Ear	☐ Neck	
	☐ Chest	☐ Back	☐ Abdomen	☐ Nails	
	☐ Right Upper Extremity		☐ Left Upper Extremity		
	☐ Right Lower Extremity		☐ Left Lower Extremity		
How long has it been present? ____________________					
Treatment used for condition:	☐ YES	☐ NO			

MEDICAL CHECKLIST			
Do you have a bleeding disorder?	☐ YES	☐ NO	
Are you taking any blood thinners?	☐ YES	☐ NO	
Do you have a pacemaker/defibrillator?	☐ YES	☐ NO	
Frequent sun exposure?	☐ YES	☐ NO	
Are you currently suffering from seasonal allergies?	☐ YES	☐ NO	
Do you drink alcohol?	☐ YES: ______ drinks per ☐ Week ☐ Day		☐ NO
Are you a current or former smoker?	☐ YES: ______ packs per day ______ years of smoking	Quit Date____________	☐ NO
Did you get a flu vaccine within the past year?	☐ YES	☐ NO	

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CONSENT TO DISCLOSE HEALTH INFORMATION

Name:	DOB:

I give The Skin Docs Dermatology, their clinicians (physicians, NPs, PAs) and staff, authorization to disclose my protected health information to the following family, friends, and/or caregivers:

Name	Phone	Relationship

In the event The Skin Docs Dermatology may need to communicate your test results or medical information via telephone, please check all communication options below that may be used:

☐ Leave a detailed voice message on your: ☐ Cell phone ☐ Home phone
☐ Other: ______________________________

☐ Call you at the following numbers: ☐ Cell phone ☐ Home phone
☐ Other: ______________________________

☐ Only speak to YOU directly

****THE AUTHORIZATION IN THIS FORM EXPIRES: ☐ Never ☐ 1 year from today**

Please check and sign only <u>ONE</u> of the following:

☐ I allow The Skin Docs Dermatology to share my sensitive health information as noted above per the communication options checked on this form.

____

Signature *Date*

☐ I DO NOT allow The Skin Docs Dermatology to share my sensitive health information with anyone but myself.

____

Signature *Date*

By signing above, I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to information shared in the process of treatment, payment or healthcare operations as cited in the Notice of Privacy Practices.
I understand that authorizing the disclosure of this health information is voluntary. The Skin Docs Dermatology and its entities will not condition treatment, payment, enrollment or eligibility for benefits on providing, or refusing to provide this authorization. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by Federal Confidentiality Rules. If I have questions about the disclosure of my health information, I can refer to my Notice of Privacy Practices. ***PLEASE ASK US IF YOU WOULD LIKE A COPY OF OUR PRIVACY PRACTICE POLICY.***

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FINANCIAL POLICY

Thank you for choosing The Skin Docs Dermatology. We are dedicated to providing the best possible careand services for you. Knowing your financial responsibility is an essential part of your care. Please read the following carefully.

<u>Insurance</u>

It is the responsibility of the patient to provide accurate insurance and personal information. Accepting your insurance does NOT place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our office by another physician does not guarantee that your insurance will cover our services.

<u>*TIP:</u> It is your responsibility to **inform us prior to follow up appointments if there are any <u>changes</u> in your insurance**. If you do not update your insurance information with our office, the visit will NOT be covered and that will leave you with a balance/bill.

<u>Double-Covered Patients (excludes Medicare patients)</u>

If you have more than one insurance, you must disclose ALL insurance plans you have or else both of your insurances will deny coverage/payment of services, WHICH THEN BECOME YOUR RESPONSIBILITY TO PAY unless/until you resolve the situation.

<u>*TIP:</u> If you are double covered, it is YOUR responsibility to complete a **"<u>COORDINATION OF BENEFITS</u>"** prior to your visit by calling each insurance company to assign each insurance as "primary" or "secondary." If this is not done, both insurances will deny coverage/payment of our services and you will be responsible for paying out of pocket until you complete that coordination of benefits.

<u>Co-Pays and Outstanding Balances</u>

- It is the policy of The Skin Docs Dermatology that payment is due at the time of service. Co-Pays must be paid in full. If you have an all-deductible plan, you are responsible for paying towards your deductible on the day of your visit.
- All balances on your account must be paid prior to, or at the time of your visit, which includes, but is not limited to co-insurance and deductibles. **If you cannot pay your balance at the time of visit, you will need to reschedule your appointment.**
- **If you fail to pay your balance within 180 days, you will be sent to collections.**
- **You are ineligible for medication refills if you have an unpaid balance that is more than 90 days old.**

<u>Self-Pay and Cosmetic Appointments</u>

Payment is expected in full at the time of service.

<u>Cancellations and Missed Appointments</u>

- Office Visits: I understand that it is my responsibility to cancel my appointment at least 24 hours before the scheduled date and time; otherwise a $50.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.
- Surgical Appointments: I understand that it is my responsibility to cancel my appointment at least 24 hours before the scheduled date and time; otherwise a $200.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.
- **If you no-show to your appointment more than 2 times without any explanation or notice, you will be ineligible to schedule future appointments at our office.**
- We understand that unexpected life events and illnesses do occur. If this happens, please call our office as soon as possible to cancel or reschedule your appointment.

<u>Referrals</u>

If your insurance requires a referral, it is your responsibility to provide the referral prior to your visit.

Pathology
On occasion, pathology is ordered by physicians to properly diagnose certain skin disorders. To provide qualitycare for our patients, we utilize an independent licensed lab with analysis performed by a Board-Certified Dermatopathologist who specializes in the microscopic diagnoses of skin disorders. Charges for these services are in addition to your office visit and procedure charge.

Requests for Medical Records / Forms (FMLA)
There is a $25.00 fee for medical records, plus the cost of mailing and/or electronic device. FMLA, medical, and other such policy forms that need to be filled out by our office will require a $10.00 fee. These fees must be paid before the records/forms will be sent.

Accepted Payment Methods
The Skin Docs Dermatology accepts cash, Visa, Mastercard, Discover, and personal checks with proper identification (valid Driver's License or photo ID), checks can be made payable to "The Skin Docs Dermatology".There will be a $30.00 charge for any returned checks.

ACKNOWLEDGEMENT OF FINANCIAL POLICIES
I have read the above financial policies and understand my financial responsibilities as a patient at The Skin Docs Dermatology. I understand that failure to make a payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees. If I do not sign this consent, The Skin Docs Dermatology may decline to provide treatment to me.

AUTHORIZATION TO RELEASE MEDICAL RECORDS
I hereby authorize The Skin Docs, LLC to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered.I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co- insurance, deductible, and non-covered services.

ACKNOWLEDGEMENT OF PRIVACY POLICY
I acknowledge that I have been advised of The Skin Docs Notice Of Privacy Policy (NOPP) by being offered totake a physical copy of The Skin Docs Privacy Policy (available at the front desk) OR view it online at theskindocs.org.

FOR MEDICARE PATIENTS ONLY
I request that payment of authorized Medicare benefits be made either to me or on my behalf The Skin Docs,LLC for any services furnished to me by their providers. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

I HAVE READ, UNDERSTOOD AND AGREE TO THE ABOVE:

______________________________ ______________________

Name of Patient or Responsible Party | Relationship to Patient

______________________________ ______________________

Signature | Date