Precision Dermatology, P.A.

Name:_____ DOB:_____ Date:_____

SSN:_____ - _____ - _____

Gender: **M** **F**

Mailing Address:_____

_____

Email:_____
Is it okay to contact you via email? **Y** **N**

Home #_____ Work #_____ Cell #_____

Employer:_____ Retired:_____ Student:_____ Unemployed:_____

Marital Status: **Married** **Single** Other:_____

Spouse's Name:_____ Phone #_____

Employer:_____ Work #_____

Person to notify in case of an emergency:_____ Relationship:_____

Emergency contact number:_____

Primary Care Provider:_____ Phone #_____

Preferred Pharmacy:_____ Phone #_____

May we leave a message about medical issues on voicemail or a home answering machine? **Y** **N**
May we leave a message at work for you to call us? **Y** **N**
May we discuss your medical condition with another person? **Y** **N**

If yes, whom _____ Relationship:_____

If patient is a minor, please enter responsible party information.
Name:_____ Relationship:_____

Address:_____

Home #_____Work #_____Cell #_____

How did you hear about our practice?_____

Were you specifically referred by another health care provider? **Y** **N**
Referring Provider:_____ Provider's Number:_____

Reason For Today's Visit:

_____

_____

_____

_____

Review of Systems:

Changing Mole Artificial Heart Valve Artificial Joint(s) Pacemaker or Defibrillator

Pregnant Breast Feeding Allergy to Adhesive Allergy to Latex

Fever Currently Swollen lymph Nodes Night Sweats Unintentional Weight Loss

Problems with: Healing Scarring Bleeding

Do you take Blood Thinners? Y N

Past Medical History:

Arthritis Coronary Artery Disease Hepatitis B or C Hyperthyroidism Seizures

Asthma Depression High Blood Pressure Hypothyroidism Stroke

Bone Marrow Diabetes Hepatitis B or C Immune-Suppressed

Breast Cancer End Stage Renal Disease HIV/AIDS Organ Transplant

COPD GERD High Cholesterol Radiation Treatment

Cancer other than skin cancer. If so, what type(s)?_____

_____

Past Surgical History:_____

_____

Skin Disease History:

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

Blistering Sunburns Dry Skin Eczema Pre-cancerous Moles

Psoriasis Sensitive Skin Other:_____

Do you have a relative that has had melanoma? **Y N** Relationship:_____

Do you wear sunscreen? **Y N** Do you use tanning salons? **Y N**

Current Medications: If you have a list, please skip and provide list to staff.

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergic to any medications? Y N
If yes, please list below

_____

_____

Smoking Status: Current Everyday Social Former Never Cigar

Alcohol Screening: Everyday 3 Drinks/Week Occasionally Never

Please list any Diseases or Conditions:_____

_____

_____

Consent For Care
Assignment of Benefits
Acknowledgment of Receipt of Privacy Notice

Patient Name:_____ DOB:_____

Guardian Name:_____ DOB:_____

I, the undersigned, consent to the use and disclosure of my protected health information by Precision Dermatology, P.A. For the purpose of carrying out my treatment, obtaining payment for my health care or for carrying out health care operations.

I, understand that I have a right to review our notice of Privacy Practices prior to signing this document. I acknowledge that I was given the opportunity to review Precision Dermatology's Notice of Privacy Practices or to request a copy of it. The Notice of the Practices provides information about how Precision Dermatology, PA may use and disclosure protected health information about me. A copy of this notice is provided in the waiting area of out office.

Precision Dermatology, P.A. Reserves the right to change the privacy practices that are described in Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or by asking for one at the time of my appointment.

I acknowledge that I have the right to request that the use of my protected health information be restricted in carrying out my treatment, obtaining payment for my healthcare or for carrying out healthcare operations. However, I understand that Precision Dermatology, PA is not obligated to agree to any such restrictions. If Precision Dermatology, PA and I agree upon any restrictions, such restrictions will be in writing and will both Precision Dermatology, PA and I will agree to terminate any such restriction in writing.

My “protected health information” includes all individually identifiable which is created or received by Precision Dermatology, PA and which relates to my past, present or future physical or mental health or condition, the provision of health care to me or to the past, present or future payment for the provision of health care to me.

I hereby assign all medical, surgical, and/or third party payer benefits to which I am entitled, including private insurance, medicare and/or any health plan to: Precision Dermatology, PA for any services furnished me by Precision Dermatology, PA. I authorize Precision Dermatology, PA to release any medical information to such private insurance, the centers for Medicare and Medicaid services and/or any health plan to the extent such information is needed to determine benefits or benefits payable for related services. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance. If the above services are being provided to a minor, the personal representative below agrees that he/she is financially responsible fall all charges whether or not paid by said insurance.

I agree that I will pay all collection agency costs and/or reasonable attorney fees if my account is placed in collections. I understand that all applicable co-pays associated with specialty care will be collected on the day of service. I further acknowledge that Precision Dermatology, PA has a $25 fee for returned checks, and my failure to cancel a follow up appointment within 24 hours prior to the appointment time will result in a $25 fee. Furthermore, my failure to cancel a scheduled surgical appointment within 24 hours prior to the appointment will result in a $100 fee.

A photocopy of this consent and assignment of benefits is to be considered as valid as the original.

Patient Signature:_____ Date:_____

Parent/Guardian Signature:_____ Date:_____

Precision Dermatology, P.A.

Office Policy

Our goal is to provide and maintain a good physician-patient relationship. Letting you know in advance of our office policy allows for a good flow of communication and enables us to achieve our goal. *Please read each section carefully and initial.* If you have any questions, do not hesitate to ask a member of our staff.

APPOINTMENTS:

We value the time we have set aside to see and treat you. If you are not able to an appointment, we require a 24-hour notice. **There is a $25 fee for a missed clinic appointment and $100 fee for a missed surgical appointment.**

- If you are late for your appointment it may be necessary to reschedule your appointment.
- We strive to minimize any wait time; however, emergencies to occur and will take priority over a scheduled visit. We appreciate your understanding.
- If you no show for 2 clinic/surgical appointments you will be dismissed from our practice.

Initial:_____

INSURANCE PLANS:

- It is your responsibility to keep us updated with your correct insurance information. **If the insurance company you designate is incorrect, you will be responsible for payment of the visit and to submit the charges to the correct plan for reimbursement.**
- It is your responsibility to understand your benefit plan with regard to, for instance, covered services and participating laboratories.
- It is your responsibility to know if a written referral or authorization is required to see specialists, whether preauthorization is required prior to a procedure, and what services are covered.

Initial:_____

FINANCIAL RESPONSIBILITY:

- You are responsible for any and all co-payments,deductibles, and coinsurance's as applicable.
- Co-payments are due prior to seeing the provider. If you are unable to furnish your co-pay you **MUST** reschedule your appointment.
- Self-pay patients are expected to pay for services in **FULL** at the time of the visit.
- If we do not participate in your insurance plan, payment in full is expected from you at the time of your visit. We will supply you with an invoice that you can submit to your insurance for reimbursement.
- Patient balances are billed immediately on receipt of your insurance plan's explanation of

benefits. Your remittance is due within business days of your receipt of your bill.

- If previous arrangements have not been made with out finance office, any balance outstanding longer than 60 days will be forwarded to our collection agency.
- We accept cash, checks, visa, master card, and credit cards.
- A $25 fee will be charged for any checks returned insufficient funds.

Initial:_____

TRANSFER OF RECORDS

- If you transfer to another physician, we will provide a copy of your record and your last visit to your physician, free of charge, as a courtesy to you. We need 48 hour notice.
- A copy of your complete record is available for the usual and customary rate.

Initial:_____

PRESCRIPTION REFILLS

- For monthly medication refills, we require 48 hour notice, during regular business hours. Please plan accordingly.

Initial:_____

ADDITONAL PAPERWORK

- If you require any additional paperwork completed by the staff of Precision Dermatology, PA there will be a $25 fee. Paperwork will be ready for pick up in 7 days. (I.E. Disability Policies, Cancer Policies, etc.)

Initial:_____

I have read and understand this office policy and agree to comply and accept the responsibility for any payment that becomes due as outlined previously.

Patient Name:_____

Patient Signature:_____

Parent/Guardian Name:_____ Relationship:_____

Parent/Guardian Signature:_____

On completion, if you would like, we will provide you with a copy for your records.