Precision Dermatology, PA

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Phone Number (830)890-5181 Fax Number (830)890-5162

Name:_____ Date:_____ DOB:_____

(first) (MI) (last)

SSN:_____-_____-_____ Driver License Number:_____Gender: **Male/Female**

Height_____ Weight _____

Circle Preferred Number

Home #:_____Work #:_____Cell #:_____

May we leave voicemail's regarding your medical health? **Yes/No** May we leave a message at your work **YES/No**

Mailing Address:_____ City_____ State_____ Zip_____

Email:_____ Is it okay to contact you via email? **Yes/No**

Employer:_____ Occupation:_____

____Retired ____Student ____Unemployed -- Marital Status: **Married** **Single** Other:_____

Spouse's Name:_____ Phone Number:_____

Employer:_____ Work Number:_____

Emergency Contact:_____Phone Number:_____Relationship_____

Primary Care Provider:_____Phone Number:_____

Did this Provider refer you? **Yes/No** If not how did you hear about our practice? _____

CANCELLATION POLICY

I understand and agree that it is my responsibility to notify Precision Dermatology ***24 hours prior*** to the scheduled appointment if I am unable to keep appointment. I understand that I will be billed ***$25 for regular visits***, and ***$50 for surgery & cosmetic appointments*** if I miss the appointment without notifying the office atleast 24 hours in advance. This fee is NOT covered by insurance. An excessive amount of missed appointments could result in being dismissed from our practice.

Print Patient Name:_____ Patient Signature:_____Date:_____

Reason For Today's Visit? _____

_____

ALERTS (Do you have any of the following?)

Pacemaker Defibrillator Artificial Joints Artificial Heart Valves

Blood Thinners Bleeding Disorder Breastfeeding **Pregnant**/Planning a Pregnancy

Premedication (prior to procedures) Rapid Heartbeat with Epinephrine

Allergy to: **Adhesive Latex lidocaine** Problems with **Healing Scarring Bleeding**

Do you have any difficulty swallowing or any known muscle disorders? **Yes/ No**

Patient Medical History

Lupus erythematosus	Hepatitis B / Hepatitis C	Seizures
Dermatomyositis	Hypertension (High Blood Pressure)	Stroke
Bone Marrow Transplant	HIV/AIDS	Organ Transplant
COPD (Emphysema)	Kidney disease	Inflammatory bowel disease
Diabetes	Liver disease	Other _____
Heart disease	Rheumatoid arthritis	_____

History of Cancer:

Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Other:_____

Major Surgical History?_____

Skin Disease History:

Acne	Eczema/Dry skin	Actinic Keratosis	Flaking or Itchy Scalp
Blistering Sunburns	Precancerous Moles	Psoriasis	Other:_____

My skin is **Oily Dry Combination Sensitive**

Do you have history of Cold Sores/Fever Blisters **Y/ N** Have you been on Accutane in the last 6 months? **Y/ N**

Do you wear sunscreen? **Yes/No** Do you have family history of Melanoma? **Yes/No**

Do you tan in a tanning salon? **Yes/No**

Current Medications **Pharmacy**_____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Allergic to any medications? YES/NO

(If yes, please list below)

_____

Smoking Status: Current Everyday Social Former Never Cigar

Alcohol Consumption: Everyday Occasionally Never

Patients 65yrs of age or older ONLY: I have/ I have not received a Pneumonia vaccine

I have/ I have not received an Influenza vaccine

COSMETICS

(Please indicate if you are interested or would like to learn more about any of the following services)

Botox	Skin Care Products	Brown Spot/Age Spot Removal
Dermal Fillers	Chemical Peels	Spider Vein Treatment
Skin Tightening/Wrinkles	Reducing Chin Fat	Other_____
		_____

Do you use **Retin-A** **Glycolic Acid Products** **Hydroquinone Bleaching Agents**

Have you ever had a Chemical Peel before? **Yes/ No** If yes how many _____

Medical Records

If you are requesting to pick up a full medical history, you will be charged a $25 printing fee (this includes all cancer policy related printing. We need 1 week to get this prepared for you). For simple pathology reports, there will be no charge. Records sent to a doctor have no fee.

HIPAA Privacy Policy Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at anytime to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Name:_____

Signature:_____ Date:_____

Please list anyone who MAY have access to your medical records

1. _____
2. _____
3. _____

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. 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, we ask that you arrive to your appointment on time, if you are more than 15 min late we may ask you to reschedule. _____

Insurance: It is your responsibility to keep us updated on your correct insurance information. It is advised that as a patient, you understand your plan benefits, deductibles, co-insurance, co-payment and participating laboratories prior to your visit. *Please verify with your insurance that your particular plan is in network with our office.* _____

As a courtesy Precision Dermatology will submit your claim to your insurance carrier, **you may be responsible for any and all charges not paid for by your insurance**. Some policies require that you obtain a referral from your primary care physician prior to your visit with us, I understand that it is my responsibility to obtain the referral from my Primary Care Physician and assure it is available at the time of the visit. I understand that if I fail to present a valid referral, I will be responsible for my charges pertaining to seeing a specialist. _____

Financial Responsibility: Co-payments are due at the time of service, if you are unable to furnish your co-pay you may be asked to discuss further options. Self-pay patients are expected to pay in full at the time of your visit, Payment plans would have to be approved by our office manager. We accept cash, checks, carecredit, debit, and all major credit cards. _____

A **$25 fee** will be charged for any checks returned for insufficient funds, we will accept cash and cards for any future payments from you. _____

- Return Policy
  We offer multiple products for sale in our office, it is our policy that all skin care products cannot be returned. **Sales are final.** If you have any questions about this, please ask to speak to a manager. _____
- Cosmetic Policy
  Cosmetic procedures are **NOT** covered by insurance, however Precision Dermatology offers free cosmetic consultations to go over any goals you may have with your appearance and how we can help you get there. Although we have most fillers and botox on hand, if we need to order product specifically for you a down payment will be required. Discounts that may be offered to you at the time of your consultation, may not be offered at another a time, if you would like to be locked in at the quoted rate and schedule a separate appointment you will be asked to leave a down payment towards your product.
  *Cosmetic down payments are **NOT** refundable.* _____

Prescription Refills: Refills can take 24-48 hours for processing, please keep that in mind to avoid an interruption in your medication therapy.

***please initial next to each paragraph on line ***

I have read and understand this office policy.

Signature:_____ Date:_____

Understanding Your Health Insurance

Your health insurance policy is a contract between you and the insurance company. It is an agreement that your insurance will pay for covered medical services as long as your premiums have been paid. They may not pay for every bill or treatment. It is very important that you know which medical treatments they will pay for and what they will not cover. Please keep in mind that determination of benefits is ***NOT*** *a guarantee of payment.*

DEDUCTIBLE:

The deductible refers to the amount of money that you would need to pay before any benefits from the health insurance policy can be used. This is usually a yearly amount so when the policy is renewed, usually after a year, the deductible would be in effect again. Some services may be available without meeting the deductible first. Usually there are separate individual deductible amounts and total family deductible amounts.

CO-INSURANCE:

The insurance company has a set fee limit for each type of treatment. The insurance company will pay the maximum according to your plan policy and anything beyond that is your responsibility. This is usually a percentage amount that is your responsibility. A common co-insurance split is 80/20. This means that the insurance company will pay 80% of the procedure and you are required to pay the other 20%.

CO-PAYMENTS:

The co-payment is a fixed amount that you are required to pay at the time of service. It is usually required for basic doctor visits and when purchasing prescription medications.

OUT-OF-POCKET:

This is the cost one would pay out of their own pocket. An out of pocket expense may refer to the co-payment, coinsurance, or deductible is. Also, when the term annual out of -pocket maximum is used, that is referring to how much the insured would have to pay for the whole year out of their pocket, excluding premiums.

X _____