PRECISION DERMATOLOGY, PA

INTAKE FORM

PERSONAL INFORMATION

Full Name :

Date of Birth : ______ / ______ / ______ **Gender :** ☐ Male ☐ Female

Address :

Cell Phone # : **Other Phone # :**

E-Mail:

Driver License # : **Social Security Number :**

Status : ☐ Single ☐ Married ☐ Other

Occupation : **Are You:** ☐ Retired ☐ Student ☐ Unemployed

Primary Care Provider :

Phone :

Did this provider refer you? ☐ Yes ☐ No

EMERGENCY CONTACT DETAILS

Contact Name : **Home Number :**

Relationship : **Mobile Number :**

PARENT OR RESPONSIBLE PARTY

Name : **Relation :**

Phone # : **DOB :** **Gender :**

Address :

More Information :

712 Hill Country Dr Ste 100 Kerrville, TX

830 890-5181 (Office)
830 890-5162(Fax)

www.precisiondermtx.com

	Yes	No
SCANNED INSURANCE CARD	☐	☐
SCANNED SECONDARY INSURANCE	☐	☐
SCANNED DL or ID CARD	☐	☐

REASON FOR TODAY'S VISIT

____

____

____

ALERTS & ALLERGIES

Mark the box if you have any of the following :

- ☐ Pacemaker
- ☐ Blood Thinners
- ☐ Pre-Medication
- ☐ Defibrillator
- ☐ Bleeding Disorder
- ☐ Artificial Joints
- ☐ Artificial Heart Valves
- ☐ Breastfeeding
- ☐ Pregnant/Planning to be pregnant
- ☐ Rapid Heartbeat with Epinephrine

Allergy to:

- ☐ Adhesive
- ☐ Latex
- ☐ Lidocaine
- ☐ Other ______________________________

Problems With:

- ☐ Healing
- ☐ Scarring
- ☐ Bleeding
- ☐ Other ______________________________

MEDICATIONS & MEDICATION ALLERGIES

Current Medications :

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

Allergic to Any Medications? **YES** ☐ **NO** ☐

If YES, please list:

______________________________ ______________________________

______________________________ ______________________________

Pharmacy Name : ______________________________

Pharmacy Phone # : ______________________________

PATIENT MEDICAL HISTORY

Do you have/have had any of the following [PLEASE CIRCLE] :

Lupus Erythematosus
Dermatomyositis
Bone Marrow Transplant
COPD (Emphysema)
Diabetes
Heart Disease

Hepatitis B
Hepatitis C
HIV / AIDS
Kidney Disease
Liver Disease
Rheumatoid Arthritis

Seizures
Stroke
Organ Transplant
Ulcerative Colitis
Chron's Disease
Cancer
type: ____________________

Other Autoimmune : ____________________

Other : ____________________

Major Surgical History? :

____

____

____

Family History of Melanoma? : YES NO
If YES, whom? ____________________

History of cold sores/fever blisters? YES NO

Have you been on Accutane in the last 6 months? YES NO

Skin Disease History :

- ☐ **Discoid Lupus**
- ☐ **Acne**
- ☐ **Blistering Sunburns**
- ☐ **Eczema/Dry Skin**
- ☐ **Actinic Keratosis**
- ☐ **Flaking/Itchy Scalp**
- ☐ **Psoriasis**
- ☐ **Precancerous Moles**
- ☐ **Other**

- ☐ **Basal Cell Carcinoma** **Date:** ____________________
- ☐ **Squamous Cell Carcinoma** **Date:** ____________________
- ☐ **Malignant Melanoma** **Date:** ____________________

Do you wear sunscreen? YES NO

Do you use a tanning bed? YES NO

OFFICE POLICY

Or goal is to provide and maintain a good physician-patient relationship. Letting you know about our office policy in advance allows a strong communication flow 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.

PLEASE INITIAL IN THE BOX AT THE END OF EACH SECTION

Appointments: We value the time we have set aside to see and treat you. We ask that you arrive at your appointment on time. If you are more that 15 minutes late, we may ask you to reschedule. ☐

Insurance: It is your responsibility to keep us updated regarding your correct insurance information. Please verify with your insurance that your plan is in-network with our office. It is your responsibility to understand your insurance plan coverage. You may with to contact the number on the back of your card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or diagnosis codes which they will not cover. ☐

Some policies require that you obtain a referral from your primary care physician [PCP] and ensure it is available at the time of your visit. **I understand if I fail to present a valid referral, I will be responsible for my charges with regard 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. If you are without insurance, you will be considered a self-pay patient. Payment in full for services provided are due at the the time of service for self-pay patients. Payment plans are possible if approved by our office manager. We accept cash, checks, CareCredit, debit cards, and all major credit cards. ☐

A **$25 fee** will be charged for any returned checks. We will then only accept cash or credit/debit card for future payments. ☐

Return Policy: We offer multiple products for sale in our office. It is our policy that all skin care products cannot be returned. **ALL SALES ARE FINAL.** If you have any questions about this, please speak to a manager. ☐

Prescription Refills: Refills can take up to 48 hours for processing. Please keep that in mind to avoid interruption in your medication therapy. ☐

My signature below acknowledges that I have read and understand this office policy:

Signature: ______________________________ **Date:** ______________________________

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 conduct:

- 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 health care 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 for time to time and that I may contact you at any time 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 conduct treatment, payment, and health care operations, but Precision Dermatology, PA is not required to agree to these restrictions. However, if Precision Dermatology, PA does agree, then they are bound to comply with the requested restrictions.

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.

Printed Name: ____
Signature: ____ Date: __________________________

List anyone you grant permission to access you medical records

____
____
____
____

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 if your premiums are paid. Even so, your insurance may not pay for for every bill or treatment. It is especially 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 paymeny.

DEDUCTIBLE:

The deductible refers to the amount of money that you would need to pay before any benefits (payments) from your health insurance are allowed. This is usually a yearly amount so when the policy is renewed, the deductible for that year starts over again (must be met again). Some services may be available without meeting a deductible first. Usually there are separate individual deductible amounts and total family 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 amount is usually expressed as a percentage. 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% of the cost.

CO-PAY:

The co-payment is a fixed amount that you are required to pay at the time of service. It is usually required for primary care doctors, another for specialists, and when purchasing prescription medication.

OUT-OF-POCKET:

This is the cost that a patient pays out of their own pocket. It may refer to your co-payment, co-insurance, or deductible. Also, when the term ‘annual out-of-pocket maximum’ is used, that refers to how much the insured would have paid for the the entire year out of their pocket; excluding premiums.

My signature below acknowledges that I have read and understand this document:

Printed Name: ____________________________________

Signature: ____ Date: _______________________