

PATIENT INFORMATION (please use your legal name)

Last Name		First Name		Middle Name	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/> Dr <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed	
Other Names Used (if any)		Date of Birth	Age	Birth Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female Gender Identity: Preferred Pronoun:	Race: _____ Ethnicity: _____ Preferred Language: _____	
Street Address				City	State	ZIP Code
Home Phone: () () ()			Work Phone: () () ()		Cell Phone: () () ()	
Is it okay to leave a voice message for the communication of detailed test results? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, what is your preferred number? <input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Other: () () ()			Would you like for us to be able to discuss your personal health information with any friends or relatives? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please specify whom:			
Occupation and Employer				Primary Care Physician		
Did a physician request that you seek a consultation with a dermatologist? <input type="checkbox"/> Yes <input type="checkbox"/> No				If yes, what is the name of the physician and the reason for the consultation?		
Please list any family members who are seen in this practice:						
Would you like access to our online patient portal? <input type="checkbox"/> Yes <input type="checkbox"/> No The Patient Portal is a system that allows for you to access and update your records. You can also view office visit summaries, as well as information on your diagnoses and treatment plans. If yes, please provide you email address: _____						

PREFERRED PHARMACY

Please fill in as much information about your pharmacy as you can: *If you are using a **mail order pharmacy**, please indicate

Name: _____

Address: _____

Phone #: _____

IN CASE OF EMERGENCY

Name of Local Friend or Relative: _____ Relationship: _____

Phone #: () () ()

HEALTH HISTORY/MEDICAL INFORMATION

Do you have a history of any of the following medical conditions? Select all that apply:

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Lupus
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Polycystic ovarian syndrome
<input type="checkbox"/> Asthma	<input type="checkbox"/> Depression	<input type="checkbox"/> Prostate cancer
<input type="checkbox"/> Atrial fibrillation (irregular heartbeat)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Problems healing
<input type="checkbox"/> Bone marrow transplant	<input type="checkbox"/> End stage renal disease	<input type="checkbox"/> Radiation treatment
<input type="checkbox"/> Breast cancer	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Seizures
<input type="checkbox"/> Cirrhosis of the liver	<input type="checkbox"/> Hepatitis C	<input type="checkbox"/> Stroke
<input type="checkbox"/> Colon cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Ulcerative colitis
<input type="checkbox"/> COPD (lung disease)	<input type="checkbox"/> Keloid/thick scars	<input type="checkbox"/> None
		<input type="checkbox"/> Other: _____

Women: Are you pregnant? Yes No Planning a pregnancy? Yes No Breastfeeding? Yes No

Past surgeries. Select all that apply:

<input type="checkbox"/> Joint replacement Which joint? _____ When? _____	<input type="checkbox"/> Heart: Pacemaker <input type="checkbox"/> Heart: defibrillator <input type="checkbox"/> Heart: valve replacement Circle: mechanical or biological	<input type="checkbox"/> Skin: Basal cell carcinoma <input type="checkbox"/> Skin: Squamous cell carcinoma <input type="checkbox"/> Skin: Melanoma <input type="checkbox"/> Skin: Cancer unknown <input type="checkbox"/> Skin: Mohs surgery <input type="checkbox"/> None <input type="checkbox"/> Other:
<input type="checkbox"/> Organ Transplant Which organ? _____ When? _____	<input type="checkbox"/> Heart: Coronary artery bypass <input type="checkbox"/> Heart: balloon angioplasty (PTCA) <input type="checkbox"/> Heart: stent placement	

Have you had any of the following skin conditions? Select all that apply:

<input type="checkbox"/> Acne <input type="checkbox"/> Actinic keratoses <input type="checkbox"/> Asthma <input type="checkbox"/> Basal cell skin cancer <input type="checkbox"/> Blistering sunburns	<input type="checkbox"/> Dry skin <input type="checkbox"/> Eczema <input type="checkbox"/> Flaking or itchy scalp <input type="checkbox"/> Hay fever/allergies <input type="checkbox"/> Melanoma	<input type="checkbox"/> Poison oak/ivy <input type="checkbox"/> Precancerous moles <input type="checkbox"/> Psoriasis <input type="checkbox"/> Squamous cell skin cancer <input type="checkbox"/> Other:
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Do you wear sunscreen? Yes No If yes, what SPF? _____ **Do you tan in a tanning salon?** Yes No Not anymore

Do you have a family history of melanoma? Yes No Unknown
If yes, which relative? _____

List of current medications (no need for doses):

<input type="checkbox"/> Aspirin <input type="checkbox"/> Ibuprofen <input type="checkbox"/> Naproxen <input type="checkbox"/> Coumadin/warfarin <input type="checkbox"/> Plavix <input type="checkbox"/> Vitamin E <input type="checkbox"/> Fish oil <input type="checkbox"/> None	<input type="checkbox"/> Others: Please list over-the-counter medicines, vitamins/supplements, and prescriptions
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Allergies. Select all that apply:

<input type="checkbox"/> No known drug allergies <input type="checkbox"/> Allergy to adhesive <input type="checkbox"/> Allergy to lidocaine <input type="checkbox"/> Allergy to antibiotic ointments <input type="checkbox"/> Allergy to medications	Please list medication allergy and reaction below:
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Social History Details
Please select smoking status: never smoker former smoker current every day smoker current some day smoker
Please select alcohol usage: none less than 1 drink per day 1-2 drinks per day 3 or more drinks per day
Other recreational drug use: _____

Are you currently experiencing any of the following? Select all that apply:

<input type="checkbox"/> Weakness <input type="checkbox"/> Changing moles <input type="checkbox"/> Rash <input type="checkbox"/> Problems with healing <input type="checkbox"/> Problems with scarring <input type="checkbox"/> Problems with immunosuppression <input type="checkbox"/> Hayfever <input type="checkbox"/> Chest pain <input type="checkbox"/> Fever or chills <input type="checkbox"/> Night sweats <input type="checkbox"/> Unintentional weight loss	<input type="checkbox"/> Thyroid problems <input type="checkbox"/> Sore throat <input type="checkbox"/> Mouth lesions <input type="checkbox"/> Blurry vision <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloody stool <input type="checkbox"/> Nausea <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody urine <input type="checkbox"/> Genitourinary problems <input type="checkbox"/> Swollen or enlarged lymph nodes	<input type="checkbox"/> Joint aches <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Headaches <input type="checkbox"/> Seizures <input type="checkbox"/> Dizziness <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Cough <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing
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Are you interested in the listed procedures or treatments? Select all that apply:

<input type="checkbox"/> Skin Tightening <input type="checkbox"/> Laser skin resurfacing <input type="checkbox"/> Laser treatment for brown spots <input type="checkbox"/> Laser treatment for red spots <input type="checkbox"/> Skin discoloration	<input type="checkbox"/> Botulinum toxin <input type="checkbox"/> Fillers <input type="checkbox"/> Removal of skin lesions <input type="checkbox"/> Wrinkles <input type="checkbox"/> Laser hair reduction	<input type="checkbox"/> Scar treatment <input type="checkbox"/> Aging skin <input type="checkbox"/> Leg veins <input type="checkbox"/> non-invasive fat removal <input type="checkbox"/> Other:
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SIGNATURE
The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize the physician or my insurance company to release any information required to process my claims. If patient is a minor, this form must be signed by a legal guardian.

X _____ Patient/Guardian Signature	_____ Print Name Here	_____ Date
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OFFICE FINANCIAL POLICY

Patient Name _____ Insurance _____

Our goal is to provide and maintain a good physician-patient relationship. Letting you know of our financial policy in advance allows for a good flow of communication and enables us to achieve our goal. If you are a returning patient, please consider this a reminder and thank you for continuing your care with our office.

- If we are contracted providers of your insurance:
 1. We will bill your insurance for all covered services
 2. You are expected to pay your copay and any non-covered services at the time of service
 3. You are responsible to pay all deductibles and co-insurance amounts
- If we are not contracted with your insurance and/or for Self-Pay and Cosmetic Services:
 1. You will be expected to pay at the time of service.
 2. In dermatology, there are many procedures that are considered by Medicare and private insurers as **non-covered**, including removal of skin tags, cosmetic treatment of spider veins, cosmetic removal of whiteheads, warty keratoses and “age spots”, as well as others. If you are coming in for a non-covered service, please be prepared to pay for the service **in full**.
 3. Under the [No Surprises Act](#), health care providers are required to give patients who don’t have insurance or who are not using insurance an estimate of the bill for medical items and services.
 4. We want you to understand your potential costs before your visit and have a billing team available to help you with this upon request.

PRICE RANGES

The ranges provided shows the cost of items and services that may be reasonably expected for your health care needs for an item or service. The ranges do not include any unknown or unexpected costs that may arise during the treatment. Additional procedure and/or service performed during an office visit is an incremental cost.

VISIT COST

Office visits for evaluation and management are billed based on time and complexity. The time includes not only face-to-face time with your provider, but also the time spent reviewing old records in preparation for your visit, ordering tests and medications, documenting in your medical record, and communication with other providers involved in your care.

Visit Cost	Cost of Visit
Office and Video visits	\$75 - 290

ADDITIONAL ADD-ON PROCEDURES

Your provider may perform simple procedures during your medical office visit. These procedures are billed at a cost that is additional to the cost of the office visit.

Additional Add-on Procedures	Cost of Add-on Procedure
Biopsy	\$160 (does not include pathology fee)
Biopsy Add-on	\$50
Freezing of lesions	\$100 - \$220
Kenalog Injection	\$90- \$105
Pathology Fee (billed by pathology lab to patient directly)	\$ 80-250+ If additional staining is required additional fees are added by the pathologist
Stand-Alone Procedure	Cost of Stand-Alone Procedure
Excision and Repair	\$500 - \$1,000 per lesion (dependent on the complexity)
Electrodessication and Curettage	\$140 - \$280 per lesion

I understand that I am responsible for knowing the terms of my insurance policy. If I choose to have any service done that is not covered by my insurance, I understand that I will be responsible for payment of the services that I have incurred. I also understand that it is my responsibility to know if a written referral is required to see a specialist, if pre-authorization is required prior to a procedure, and what services are covered.

I understand that I am responsible to provide a current insurance card at the time of service. I understand that I will be responsible for payment of the visit should I fail to do so in a timely manner.

If I am covered by Medicare and am provided notice, in advance, that certain procedures will not be covered, I understand that I will be responsible to pay for the incurred charges.

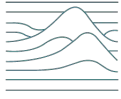
I understand patient balances are billed monthly after receipt of my insurance plan's explanation of benefits and are due upon receipt of my bill.

I understand that I have a contractual obligation with my insurance company to pay any copayments at the time of service.

I have read the above policies and agree to the terms.

Signature: _____ Date: _____

Your copayment or balance may be paid by cash, check, Visa, Mastercard, Apple Pay or Google Pay. Please feel free to discuss billing concerns and questions with the Billing Manager or Practice Administrator.



CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

I understand that as part of my healthcare, the physician originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

1. A basis for planning my care and treatment
2. A means of communication among the many healthcare professions who contribute to my care
3. A source of information for applying my diagnosis and surgical information to my bill
4. A means of which a third-party payer can verify that billed services were actually provided
5. A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals, and/or governmental mandated follow-up of some types of skin cancer surgery

I understand that I have the right:

1. To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the practice is not required to agree to the restrictions requested.
2. To revoke this consent in writing, except to the extent that the practice has already taken action reliance there on

I hereby acknowledge that I have been presented with a copy of the physician's notice of privacy practices.

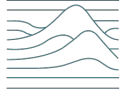
Patient's Name

Patient's Date of Birth

Preferred phone number, w/ voicemail, for communications of detailed test results

Signature of Patient or Legal Representative

Date



CANCELLATION / NO SHOW POLICY

PLEASE READ THIS NOTICE CAREFULLY

Thank you for choosing our clinic as your dermatologic provider. In order to offer our patients, the greatest flexibility in scheduling and timely access to care, we have implemented a CANCELLATION / NO SHOW POLICY.

General dermatology and Mohs micrographic surgery are provided here in our clinic. We very much value our patients. However, failure to notify our office of any cancellation means we cannot offer that time to other patients. For this reason, we must enforce a fee for a “no show” or a cancellation made less than 24 hours prior to your appointment.

General dermatology office visits: \$50
Surgery and Procedures: \$100
Mohs micrographic surgery: \$250

Laser/cosmetic procedures appointments: If you cancel or reschedule your treatment less than 48 hours before the day of the treatment/procedure, you will be charged the total cost of the treatment/procedure.

Please remember to arrive early for your appointment. To prevent prolonged wait times, if you are more than 10 minutes late, we may have to reschedule your appointment to a later date. We understand that on occasion a situation may arise that requires you to cancel your appointment last minute or miss your appointment altogether. Please let us know if you have any extenuating circumstances that prevent you from being able to comply with our policy. We appreciate your cooperation in this matter.

I have read the Cancellation / No Show Policy. I fully understand my financial responsibility to this office.

Print Patient Name: _____ Date: _____

Signature of Patient or Responsible Party: _____