Patient Information Form

Name: ______________________________ ____

(First) (Last)

Date of Birth: __ __ / __ __ / __ __ __ __ GENDER: M F Marital Status: ______________

SSN #: __ __ __ - __ __ - __ __ __ __

Address: ____ Suite / Apt: _____________

City: __________________ State: __ __ Zip Code: __ __ __ __ __

Home Phone: (__ __ __) __ __ __ - __ __ __ __ Work Phone: (__ __ __) __ __ __ - __ __ __ __

Mobile Phone: (__ __ __) __ __ __ - __ __ __ __

E-Mail: ____

Preferred Contact Method (Circle one): HOME MOBILE WORK

Patient does **NOT** have health insurance coverage.

Insurance Policy Holder (Parent or Guardian):

Name: _________________________ __________________________ DOB: __ __ / __ __ / __ __ __ __

(First) (Last)

Relationship to patient: _____________________

Personal Representative

Check here if someone other than the patient is completing this form.

Name: __________________________ Relationship to patient ______________________

Authority of Personal Representative to Sign for Patient (Check one):

Patient _____ Guardian ______ Power of Attorney _____ Other _________________

SPECIALISTS IN DERMATOLOGY & COSMETIC MEDICINE

Medical History Form

Reason for Visit and Location of Problem: ____

Height:__________ **Weight:**_________

Past Medical History: (Check all that apply. If NONE, please check NONE)

__ Allergies (Seasonal)
__ Asthma
__ Bleeding Disorder (or bleeding issue)
__ Cancer: ____________________
__ Coronary Artery Bypass
__ Depression
__ Diabetes
__ Fever Blister
__ Heart Valve Replacement
__ High Blood Pressure
__ High Cholesterol
__ HIV/AIDS
__ Joint Replacement
__ Kidney Transplant
__ Liver Disease
__ Lumpectomy
__ Lupus/ Rheumatoid Arthritis
__ Mastectomy
__ Organ Transplant
__ Thyroid Disease
___Hyper or Hypo (Circle one)
__ **NONE**

Do you have a history of Skin Cancer or Skin Disorders?
(Examples: acne, actinic keratosis, basal cell, eczema, melanoma, psoriasis, squamous cell)
Yes____ No ____ If yes, please indicate condition or disorder: ______________________________

Family History of Melanoma? (circle one) **Yes Relation:** ___________ **No**

Medications: ____
(Enter all current medications including non-prescription and birth control: if none mark N/A)

Allergies: ____
(Please enter all allergies including allergy to medications, if none mark N/A)

Review of Symptoms: (Check all that apply. If NONE, please check NONE)

__ Problems with bleeding
__ Problems with healing
__ Problems with scarring/keloids
__ Fever or Chills
__ Other: _________________
__ Night Sweats
__ Unintentional weight loss
__ Joint Pain
__ **NONE**

Alerts: (Check all that apply. If NONE, please check NONE)

__ Allergy to Adhesive
__ Allergy to Lidocaine
__ Allergy to Topical Antibiotics
__ Artificial Heart Valve
__ Blood Thinners
__ Are you pregnant or currently trying to get pregnant? Notify physician verbally
__ Breastfeeding
__ MRSA
__ Pacemaker
__ Require antibiotics prior to surgical procedure
__ Rapid heartbeat with Epinephrine
__ Defibrillator
__ **NONE**

Preferred Pharmacy Name: _____________________________ **Telephone: (** _ _ _ **)** _ _ _ **-** _ _ _ _

Address (or cross street): _______________________________ **City:** _____________________

Patient Intake Form

This is a requirement by the government center for medical services based on the merit-based payment system.

Date: _ _ / _ _ / _ _ _ _

Print Name: ____

Are you a smoker? **Current** **Former** **Never**

Do you consume Alcohol? **Yes** **No** **Occasional**

Did you have a flu vaccine this year? **Yes** **No**

Have you ever had a pneumonia vaccine? **Yes** **No**

Referring Physician / Primary Care Physician: ____

Signature: ____

Please initial on each line that you have read and understand each statement;

______*I hereby authorize the release of any information necessary to complete and process my insurance claim. I understand that I am responsible for payment of my account in full or for that portion not covered by my insurance. I further understand that if there is any delay or dispute regarding my insurance, I will be responsible for payment on my account within a reasonable period of time. I understand that I will be responsible for 100% of all cosmetic charges incurred in this office, regardless of any provider discount through my insurance carrier**. I understand that it is my responsibility to obtain all necessary insurance referrals from my PCP. If services are denied due to lack of an insurance referral, I am responsible for payment in full.**

______ *I understand that Specialist in Dermatology and Cosmetic Medicine has adopted strict Privacy Practices in Compliance with HIPAA regulations. Specialist in Dermatology and Cosmetic Medicine reserves the right to change its practice to maintain compliance with privacy regulations. More complete review of their privacy practices are available upon request. In the event of an emergency, Specialist in Dermatology and Cosmetic Medicine will disclose information related to your emergency condition.

FINANCIAL AGREEMENT

Please initial each line – to acknowledge that you have read and understand our office policies.

We will ask to see, scan and enter your insurance card/cards at the time of your visit.
It is your responsibility to be sure you give us your most updated information at the time of each of your visits. If you do not have the most updated insurance card/cards you will be considered a self-pay patient and may be asked to pay upfront $75 for the office visit and then payment due in full after visit is completed.

It is your responsibility to know how your insurance policy works.
If your insurance requires a referral it is your responsibility to acquire that referral before the appointment date and be sure we have it in our office prior to your appointment.

If we participate in your insurance, you are required to pay for any co-payments, deductibles, and coinsurance due. Co-payments will be collected at the time of your visit. Payment for the remaining balance is due at the time your statement is received or your next visit, whichever comes first. All cosmetic services are due at the time of services.

If your balance is still unpaid upon the receipt of your third mailed statement we will try and contact you one more time before sending you to our Collection Company.
At this time a $25.00 fee will be applied for your account for Collection Company fees.

Please give us a 24-hours' notice for all cancellations. There are many patients that need to get in that we can offer these appointments to. If we do not get a notification from you, your account will be charged a $50.00 NO SHOW FEE.

The "Guarantor" is the policy-holder for the insurance plan covering the patient or the party responsible for self-pay charges if patient is not covered by insurance. It is the expectation of this office that in case of a divorce, the two parental parties will handle payment arrangements without the involvement of our office. We will only bill the Guarantor.

You may have a biopsy taken in the course of today's treatment. Biopsy samples are sent to an outside lab and you will receive a separate bill from the lab/pathologist.

We will charge a 3% Credit Card Processing Fee on charges of $100 or more. No processing fee will be charged on debit, checks or cash.

I have read and understood the above financial policies.

Signature: ____ Date: _____________________

PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of tests, procedures and financial information. Under the requirements for H.I.P.A.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical information, any diagnostic test results and/or financial information released to any family members you must sign this form. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Specialist In Dermatology & Cosmetic Medicine (Lawrence E. Samuels, M.D. Inc.) to release my records and any information requested to the following individuals.

1. ________________________________ Relation to Patient: _______________________

2. ________________________________ Relation to Patient: _______________________

3. ________________________________ Relation to Patient: _______________________

4. ________________________________ Relation to Patient: _______________________

Patient Name (PLEASE PRINT) ____

Patient Signature ____

Date ___________________