Chart #____________________________

We Welcome You…

…and thank you for selecting **The Dermatology Clinic, PLLC** for your healthcare needs. We are dedicated to providing you with the best possible healthcare. To help us, please fill out this form *completely* in ink. If you have any questions, please ask us. We will be happy to assist you.

1. Personal Information

Date of Birth______________________________

Patients' name (Mr. / Mrs. / Ms /Dr) ____

Patient Mailing Address ____

City/ State/ Zip ____

Male ____ Female____ **Social Security # ________ - ______ - ________**

Race______________; Ethnicity_________________; Preferred Language_________________

Minor _____; Single _____; Married _____; Divorced _____; Separated _____; Widowed _____

Employer ____________________________________ Occupation ____________________________________

EMAIL:___________________________________

2. Telephone Information

Home Phone __________________ Work Phone __________________ Cellular Phone__________________

In the event of an emergency, who should we contact?

Name ____________________________________Relationship ________________ Phone _________________

3. Responsible Party (If not Patient)

Who is responsible for the account? ____

Address/City/State/Zip____

Relationship to patient_____________________ Soc. Sec. #_____-____-_____ Date of birth _____________

Employer ___________________________________ Occupation ______________________________________

Work Phone ________________________________ Home Phone _____________________________________

4. Insurance Information

Primary Insurance	*Secondary Insurance*
Name of Insured _____________________________	Name of Insured _____________________________
Relationship to patient _______________________	Relationship to patient _________________________
Insured's Birth date ___________________________	Insured's Birth date _____________________________
Social Security # _______ - ______ - ________	Social Security # ________ - ______ - ________
Employer ___________________________________	Employer _____________________________________
Insurance Co. _______________________________	Insurance Co. _________________________________
Employee I.D./Cert.# _________________________	Employee I.D./Cert.# ___________________________
Group # _____________________________________	Group # _______________________________________

5. No Show/ Cancellation Policy

The Dermatology Clinic, PLLC requires a 24 hour cancellation notice for all scheduled appointments. **If you do not cancel 24 hours prior to your scheduled appointment, you will be charged a $50.00 cancellation /no show fee. This fee is not reimbursable by insurance and will be due at the time of your next visit.**

6. Additional Charges from Outside Facilities

If you have a biopsy performed, wound culture swabbed, or lab work drawn, there will be an additional charge billed to you and/or your insurance company directly from the lab for performing the test

7. Authorization and Release (*please sign below*)

I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or other health practitioners.
I authorize and request my insurance company to pay directly to the doctor, insurance benefits otherwise payable to me.
I understand that my insurance carrier may pay less than the actual bill for the services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Medicare Patients:

I request the payment of authorized benefits be made to the Dermatology Clinic, PLLC on my behalf for any services furnished to me by the provider.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

X____

Signature of patient (or parent if minor) **Date**

____

PRINTED NAME OF PATIENT

Chart #___________________________

the
Dermatology
Clinic PLLC

Patient Questionnaire

Please answer the following questions (please print)

Name____ **DOB** _____/______/________ **Today's Date**____/_____/_______

Reason for today's visit____
____
How long have you had this problem? ____
List Any Previous Treatment for the problem____
Please list all Allergies (medication or other) ____
List all **Medications** you are currently taking (over-the-counter meds; Vitamins and herbals/Dosage and Frequency)
____
____
____
Have you ever had dental anesthesia (Novocaine)? __Yes __No Any bad reaction? __Yes __No
Do you have a pacemaker/defibrillator? ___Yes _____No
List all surgical procedures and year performed (within the last 10 years) ___________________________ _____________
____
Do you smoke? ___ Yes ___ No
Do you drink alcohol? ____Never ___ Occasionally ___ Frequently
Are you pregnant? _________Breastfeeding? ___________
What is your occupation (or past occupation if retired)? ____

Please check any of the following problems **you** might have or had**:**

Skin	**Hematologic/Lymphatic**	**General Symptoms**	**Ears/Eyes/Nose/Throat**
___keloids	____anemia	____weight loss	____glaucoma
___poor healing	____bleeding problems	____fever	____hearing aid
___Eczema	____enlarged lymph nodes	____weak, tired	____cosmetic surgery
___Psoriasis	____Blood clots/DVT	____nausea, vomiting, diarrhea (when taking antibiotics)	____other_____________
___Acne			
___other_________			

Cardiovascular	**Respiratory**	**Gastrointestinal**	**Musculoskeletal**
__angina, heart attacks	__asthma	__stomach ulcers	__arthritis
__heart valve problems	__emphysema	__other GI problems______	__artificial joints
__high blood pressure	__other lung problems		__aching joints
	__allergies		__other_____________

Neurological	**Psychiatric**	**Endocrine**	**Infections**
__Stroke	__depression	__diabetes	__hepatitis____type/treatment
__seizures	__anxiety attacks	__thyroid problems	__urinary tract
__other_______________	__other_____________	__other_______________	__HIV/AIDS
			__Staph
			__TB

Please check if **family member** has had any of these diseases and list family member.

__ Melanoma (skin cancer)	Family member____________	__ Psoriasis	Family member____________
__ Other Skin cancer	Family member____________	__ Eczema	Family member____________
__ Seasonal Allergies	Family member____________	__Acne	Family member____________
		__other____________________________________	

Have you had extensive sun exposure? (Even as a child) __Yes __No
Have you had blistering sunburns? (Even as a child) __Yes __No
Do you have a history of Skin Cancer? __Yes __No Type____
If yes, please list ***site, date, treatment and Doctor***: ____
Please list any other cancers or malignancies____

*** *PRIMARY CARE PHYSICIAN**____

*** *PREFERRED PHARMACY**____

Patient Signature____

Signed by Physician___________________________ **Reviewed by** _____________________

Chart #____________________________

the
Dermatology
Clinic PLLC

Financial Policy

Patient Name: ______________________________________ **DOB:** __________________________

Your clear understanding of our financial policy is important to our professional relationship. In an effort to increase our office efficiency and to keep your health care costs lower, our financial policy requires that payment in full be collected on the day that services are rendered unless the service is covered by insurance.

If you have valid health insurance coverage with one of the insurance carriers that we contract with, we will collect co-pays at the time of service(s) being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. You are also responsible for any co-insurance, deductibles or non-covered services as required by your insurance.

As a courtesy, we will file a claim with your primary and secondary insurance that we contract with. After payment is received from your insurance carrier(s), any balance that remains on the account will be deemed your responsibility including balances of insurance responsibilities not paid within 60 days from the date of service. You will be notified on your first statement from our billing office of the balance which is due and payable upon receipt of the statement. **If payment is not received after the first statement is issued, there will be an additional $5.00 fee added on each statement that is required to be sent until the balance is paid in full.**

Additionally, if you do not wish to receive statements in the mail, you can fill out and sign our credit card authorization to ensure that the balance will be paid in a timely fashion and avoid any additional statement charges.

I have read and acknowledge the Financial Policy of The Dermatology Clinic, PLLC

X____

Signature of Patient (or parent if minor) **Date**

(if you are signing for a Patient or minor, you are accepting financial responsibility for any services that are rendered on their behalf).

I authorize The Dermatology Clinic, PLLC to charge remaining balances on my account after insurance has paid to the following credit card:

Visa **MasterCard** **American Express** **Care Credit** **Discover**

Account number: ______________________________**Expiration Date:** ___________ **CVV:**___________

Name as it appears on the card (please print) ____

Signature: ____________________________________**Date:**________________________

Please note:

- A receipt will be kept in your chart, and you can request a copy at any time.
- We will NOT call you prior to charging your card, so consider this if you give us your debit card number. You may incur overdraft charges at your bank.
- You have the right to dispute any charges which you feel may be incorrect. You still have the right to question your insurance company's determination of payment.

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the
Dermatology
Clinic PLLC

PATIENT **Notice of Privacy Policy** ACKNOWLEDGEMENT

Patient Name: ____ DOB: ___________________________

I acknowledge that I have been given an opportunity to review The Dermatology Clinic, PLLC's Notice of Privacy Practices, which is displayed in the lobby and will be provided a copy if I desire one. In order to assist The Dermatology Clinic, PLLC in protecting my privacy, I have answered the following questions on how the clinic may disclose my medical information.

___ Yes ___ No You may call me on these numbers:

Home:________________ Cell:_________________ Work:__________ ____________

Leave messages on my answering machine/voicemail:

____Home ____Cell ____Work

Send appointment reminders to: ____Home ____Cell

___Yes ___ No Text Message Reminders (if reminders are sent to a cell phone)

___ Yes ___ No You may leave messages regarding my care with the following persons:

Name ____________________________________ Relationship _____________

Phone # _____________________

Name ____________________________________ Relationship _____________

Phone # _____________________

___ Yes ___ No You may photograph my skin for documentation purposes.

____

Signature of Patient (or Legal Guardian) **Date**

____

Legal Guardian's Name (Please Print)