

Patient Name _____ Date of Birth ____/____/____ Age ____ M ____ F ____

Address _____ City _____ State ____ Zip ____

Home Phone (____) _____ Cell (____) _____ Work (____) _____

Employer _____ SS # ____ - ____ - ____ E mail Address _____

Were you referred by another physician? ____ Whom? _____ Phone (____) _____

Primary Care Physician? Dr. _____ Phone (____) _____

Pharmacy _____ Phone (____) _____

In case of emergency, who should be notified? _____ Phone (____) _____

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name _____ Date of Birth ____/____/____

Address _____ City _____ State ____ Zip ____

SS # ____ - ____ - ____ Home Phone (____) _____ Work (____) _____

INSURANCE INFORMATION (Please present insurance card at time of check-in)

Primary Insurance _____ Secondary Insurance _____

Name of Insured _____ Name of Insured _____

ID # _____ Group # _____ ID # _____ Group # _____

Insured Date of Birth ____/____/____ Insured Date of Birth ____/____/____

Relationship to Patient _____ Relationship to Patient _____

- Payment is due at the time of service, as are co-payments and deductibles, unless prior arrangements are made.
- How are you paying today? ____ Check ____ Cash ____ Credit Card (VISA, Master Card) ____ Debit Card
- If we do not receive payment from your insurance carrier within 30 days, we will ask that you contact them to get your bill paid.
- All charges will become **patient's financial responsibility** if your insurance carrier has not paid within 60 days.
- All COSMETIC PROCEDURES are paid at time of service. We do not bill these to insurance companies.

I agree to the following:

1. Permission for treatment is granted for such medical and surgical treatment as deemed necessary.
2. I authorize the release of any medical information necessary to process my insurance claims and obtain reimbursement.
3. I authorize and request payment of medical benefits directly to my physician.
4. I accept full financial responsibility for this account in accordance with policies of this practice.
5. I agree to pay for all costs of collection, attorney fees and court costs should this account be referred for collection.

Signed _____ Date _____

Name: _____

Dermatology and Mohs Surgery Center
Medical History

Date of Birth: _____

OFFICE USE

Today's Date: _____

Reviewed By: _____ Date: _____

Reason for your visit: _____

Are you allergic to any medication? Yes No If YES, please list _____

List all medications you are currently taking. Include all prescriptions, over the counter medicines, vitamins & herbals:

Do you have now, or have you ever had the following diseases or conditions?

- | | | |
|---|--|--|
| Y N | Y N | Y N |
| <input type="checkbox"/> <input type="checkbox"/> Taking Coumadin or | <input type="checkbox"/> <input type="checkbox"/> Require antibiotics prior | <input type="checkbox"/> <input type="checkbox"/> Aspirin use on a regular basis |
| <input type="checkbox"/> <input type="checkbox"/> Other blood thinners | <input type="checkbox"/> <input type="checkbox"/> to Surgery/dental procedures | <input type="checkbox"/> <input type="checkbox"/> Blood Transfusions |
| <input type="checkbox"/> <input type="checkbox"/> Pacemaker/Defibrillator | <input type="checkbox"/> <input type="checkbox"/> Eczema | <input type="checkbox"/> <input type="checkbox"/> Fever Blister |
| <input type="checkbox"/> <input type="checkbox"/> Chest Pain | <input type="checkbox"/> <input type="checkbox"/> Psoriasis | <input type="checkbox"/> <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> <input type="checkbox"/> Heart Problems (Angina) | <input type="checkbox"/> <input type="checkbox"/> Allergies | <input type="checkbox"/> <input type="checkbox"/> Dialysis |
| <input type="checkbox"/> <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> <input type="checkbox"/> Hepatitis/Type ____ | <input type="checkbox"/> <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> <input type="checkbox"/> Prosthesis |
| <input type="checkbox"/> <input type="checkbox"/> Heart Attack | <input type="checkbox"/> <input type="checkbox"/> Keloids | <input type="checkbox"/> <input type="checkbox"/> Artificial Joint |
| <input type="checkbox"/> <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> <input type="checkbox"/> Cancer | <input type="checkbox"/> <input type="checkbox"/> Seizures |
| <input type="checkbox"/> <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> <input type="checkbox"/> Fainting |
| | <input type="checkbox"/> <input type="checkbox"/> Diabetes | <input type="checkbox"/> <input type="checkbox"/> Liver Problems |

Any other serious illness? Yes No Specify _____

Is your present health good? Yes No Specify _____

Y N <input type="checkbox"/> <input type="checkbox"/> Has anyone in your family had skin cancer? What type and where? _____ <input type="checkbox"/> <input type="checkbox"/> Have you ever had skin cancer? What type and where? _____ <input type="checkbox"/> <input type="checkbox"/> Do you have problems with healing? <input type="checkbox"/> <input type="checkbox"/> Do you have a history of any specific skin diseases? Explain: _____ <input type="checkbox"/> <input type="checkbox"/> Do you bleed easily?	(WOMEN) Y N <input type="checkbox"/> <input type="checkbox"/> Are you taking Birth Control Pills? <input type="checkbox"/> <input type="checkbox"/> Are you pregnant? Due Date: _____ <input type="checkbox"/> <input type="checkbox"/> Are you nursing? <input type="checkbox"/> <input type="checkbox"/> Do you plan to become pregnant in the next year?
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Do you develop skin rashes in reaction to:

- Medications Antibiotic Cream Environment Bandages Food
 Other _____

List other significant health problems including prior surgeries. Include dates of surgeries.

- Do you drink alcohol? Yes No How much? How often? _____
- Do you use tobacco? Yes No How much? How often? _____
- Do you use narcotics? Yes No How much? How often? _____
- Do you use IV drugs? Yes No How much? How often? _____
- Do you have, or have you been exposed to Hepatitis or HIV (AIDS)? Yes No Explain _____

What is your occupation? _____ Hobbies? _____

Patient's Signature _____ Completed by: Patient Other _____

Today's date _____

Consent for Phone Messages

I, (**print your name**) _____ give Dr. Willard and his staff my permission to leave all test results:

check one or more

_____ on answering machine / voice mail.

_____ with _____ my _____
(Relationship to patient)

(Patient's signature)

Acknowledgement of Receipt of Notice of HIPAA Privacy Practices

I, (**print your name**) _____ acknowledge that I have received *The Notice of Privacy Practices for Dermatology and Mohs Surgery Center, PC* (available at receptionists desk).

(Patient's signature)

Signature of patient's personal representative

Name of personal representative (please print)

Relationship to patient

DERMATOLOGY AND MOHS SURGERY CENTER
FINANCIAL POLICY

Thank you for choosing *Dermatology and Mohs Surgery Center* for your care. We are providing you with the following information to help you to understand our insurance and billing policies.

Your insurance policy is a contract between you and your insurance company. We will submit claims for care you have received to your insurance carrier if you have given us all of the required information needed to do so. Please be aware that some and perhaps all of the services provided may be “non-covered” services according to your insurance policy. However, you are still responsible for payment of these services.

If you are covered by an insurance plan that we do not participate with, we will request payment at the time of service for all office visits. We will assist you with providing the necessary information needed to file your claim with your insurance company, however.

We accept assignment for most major insurance companies. However, you may be responsible for payment of the office visit, deductible, co-pays, coinsurance, or non-covered services at the time of service.

Unfortunately, timely payments from insurance companies can be a major problem for medical practices. Therefore, our office follows the billing procedures listed below:

- We file an insurance claim within five business days of your date of service.
- If we do not receive a response from your insurance carrier within 30 days, we will submit a second claim.
- If we do not receive a response from your insurance carrier within 45 days, you will receive a statement and will need to contact your insurance carrier regarding payment. After 60 days the balance due for medical services rendered will be your responsibility.
- A billing statement covering medical services rendered will be mailed to you on a monthly basis.
- After 150 days from the original date a claim has been filed, we reserve the right to place your account with a collection agency. You are then responsible for any collection cost.

We accept cash and checks as payment. In the event that a personal check is returned unpaid from your bank, your account will be charged a \$25 returned check fee.

Minor Patients (Under 18 Years of Age)

The parent/guardian/adult accompanying a minor child is responsible for payment. The practice requires pre-approval from a parent/guardian for an unaccompanied minor. Any child 18 or over is legally an adult and responsible for his/her bill. We therefore cannot release financial or medical information to a parent/guardian of a patient over the age of 18 without the patient’s written permission. If both parents have insurance, the parent with the first birthday in the year is usually the primary insurer. Please check your insurance policy to determine which company is primary before the appointment.

(Continued on next page)

Collection Balances

If you had a previous balance or are presently in collection, Dr. Willard may use his discretion as to providing you with further treatment. You will be required to pay your previous balance in full prior to being seen. You will be responsible for payment of the office visits, copayments, deductible, etc., on the day of the visit.

Cancellation Policy

Please assist us with servicing you better by keeping your scheduled appointment. If you are unable to do so, please notify us at least 24 hours in advance. Repeated missed appointments with no notification of cancellation will result in a \$40 charge that will require payment prior to scheduling any future appointments.

I understand and agree to this policy.

Signature of Patient or Responsible Party

Date