Patient Name: ___________________________________ DOB: __________________________

WHY ARE YOU BEING SEEN TODAY?

____

____

Are you in any pain related to your visit today? (o is no pain, 10 is horrible pain)___________________

REVIEW OF SYSTEMS (Please select any of the following that apply to you.)

__fever
__chills
__fatigue
__weakness
__night sweats
__weight loss
__recent visual problem
__dysphagia (difficulty swallowing)
__sore throat
__shortness of breath
__peripheral edema (leg swelling)
__nausea
__vomiting
__diarrhea
__abdominal pain
__dysuria (difficulty urinating)
__anxiety
__depression
__bleeding tendency
__swollen lymph glands
__change in hair texture
__flushing (redness)
__high dose steroid use
__immunocompromised
__joint pain
__muscle weakness
__rash
__pruritus (itching)
__dryness
__skin lesion
__altered sensations
__dizziness
__headache

List names and dosages of all medications you are taking including over the counter medications. If you are a return patient, please provide any updates to your medications since your last visit. You may use the back of the page for additional space.

____
____
____
____
____
____

Are you allergic to any medications? __yes __no (If yes, please list medication names.)

____

SOCIAL HISTORY

Occupation:________________
Marital Status:______________

Tobacco use __yes __no If yes, what kind and how much?______________________________
Alcohol use___yes __no If yes, how much?____

PAST MEDICAL HISTORY (Please select if you have any of the following.)

__Basal Cell Skin Cancer
__Blood Clots
__High Blood Pressure
__HIV
__Squamous Cell Skin Cancer
__Melanoma (If so, where? __________)
__Organ Transplant
__Diabetes
__Hepatitis
__Thyroid disease

FAMILY HISTORY (Please select if any of your blood kin relatives have any of the following.) If yes, who?

__Melanoma

__Skin Cancer

__Psoriasis

Are there any cultural and/or spiritual practices that may affect your care? If yes, please explain:
____
____

Preferred Pharmacy: ____

Patient/Legal Guardian Signature:_______________________________ Date:_____________

Patient Name: ____ Sex: M F

Mailing Address: ____

City: ____________________ State: ______________________ Zip: _______________________

Home Phone# (____) ______________ Work# (____) _____________ Cell# (____) ____________

Date of Birth _____/_____/_____ Age____ Social Security #______________________________

Marital Status: Single___ Married___ Widowed___ Divorced___ Other______________________

Primary Insurance Coverage_________________________ Deductible or Co-Payment Amount: _____

Policy Holder/Name on Card: ____________________ Group#___________ Policy #_____________

Secondary Insurance Coverage: ____

Policy Holder/Name on Card: ___________________Group#____________Policy#_____________

Patient's Employer (if not applicable, insert N/A):____

Spouse or Parent's Name: ____________________________________ Date of Birth: ___/___/____

Spouse or Parent's Employer: ___________________________ Social Security#_________________

Nearest Relative/Friend NOT living with you: _______________________ Phone# (___) ____________

Patient's E-mail Address: ____

Do you approve of healthcare provider's sending appointment reminders, lab results, etc. to this e-mail address?
___yes ___no

Were you referred to our practice by another physician? ___yes ___no If yes, who? __________________

Primary Care Physician: ____

ASSIGNMENT OF BENEFITS

I request payments by Medicare, Medicaid, medical insurance companies and other third party payers be made payable to my healthcare providers. I authorize my physicians and healthcare providers to release my Protected Health Information (PHI) to the Healthcare Financing Administration, insurance companies, and other providers of medical services as may be necessary to provide for my clinical care and/or to determine my financial benefits or coverages in compliance with HIPAA and other applicable laws. I hereby acknowledge I have received a Notice of Privacy Practices. I understand and agree I am responsible for any charges not paid by my insurance.

Name of Patient/Legal Guardian: ____

Signature of Patient/Legal Guardian: ____

THIRD PARTY ACCESS FORM

Patient Name: ____Date of Birth: _____/_____/______

Patient Address: ____

Chart #_________________________________Social Security#_____________________________

I AUTHORIZE THE RELEASE OF MY PROTECTED HEALTH INFORMATION (PHI) TO THE FOLLOWING:

Spouse: ____Phone:_______________________

Children: ____Phone:_______________________

Family Member: _____________________________________Phone:_______________________

Employer: ____Phone:_______________________

If any of these individuals contact us, they will be asked to provide your social security number. Please make sure they know this information. Anyone who is not named above or who cannot provide your social security number will be denied access to your Protected Health Information

- I understand information disclosed pursuant to this authorization may be re-disclosed to additional parties is no longer protected.
- I understand I may revoke this authorization at any time by signing the revocation section of this form and returning it to the address above. I further understand any such revocation does not apply to the extent that person authorized to use or disclose my health information have already acted in reliance on this authorization.
- I understand I am under no obligation to sign this authorization. I further understand my ability to obtain treatment will no depend in any way on whether or not I sign this authorization.
- I understand I have a right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.
- I understand the clinic named above will not receive compensation for the used and disclosures I have authorized.

Note: After the initial completion of this form, any additions or deletions must be given to the healthcare provider in writing.

Name of Patient/Legal Guardian (Please Print):____

Signature of Patient/Legal Guardian: ___________________________________Date:_______________

****

REVOCATION SECTION

I hereby revoke this authorization: ____Date:_____________

Revocation received by the clinic: ____Date:_____________

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGMENT FORM

I, ________________________________, have received a copy of the clinic's Notice of Privacy Practices.

(Patient Name-Please Print)

____ ____________________

Signature of Patient or Legal Guardian Date

If not signed by patient please indicate relationship:

- ___Parent or Guardian of minor patient
- ___Guardian or conservator of an incompetent patient
- ___Beneficiary of personal representative of deceased patient

I would like to receive a copy of any amended Notice of Privacy Practices. ___yes ___no

****

For Office Use Only:

Signed for received by: ___________________________________

Acknowledgment refused:

Efforts to obtain:

Reason for refusal:

Patient's Date of Birth: ____/____/_____ Patient's Chart Number: _________________

PAYMENT POLICY

Thank you for choosing St. Bernard's Dermatology Clinic. We are committed to providing you with quality and affordable healthcare. We have developed this policy to answer your questions regarding patient and insurance responsibilities for services rendered. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. We accept personal checks, cash, MasterCard, Visa, and Discover. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company/ Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may not be covered or not considered reasonable or necessary by Medicare or other insurers. Also, please be aware that if Medicare does not cover a service, it may not be covered by your secondary insurance. You must pay for these services at the time of visit.

4. Proof of Insurance. All patients must complete our patient information form before seeing the physician. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information, you will be responsible for the balance of the claim.

5. Claims Submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company.

6. Coverage Changes. If your insurance changes, please notify us prior to seeing the doctor so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does no pay your claim in 60 days, the balance may be billed to you.

7. Nonpayment. If your account is 90 days past due, you will receive a letter stating that you have 10 days to pay your account in full. Partial payments will not be accepted unless arrangements have been made with our Business Office. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by certified mail that you have 30 days to find an alternative medical care. During that 30-day period, our physician will only be able to treat you on an emergency basis.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area.

Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines:

____ _____________________

Signature of patient or responsible party Date