

Patient Name: _____ Age: _____
Last First M.I. Suffix

Date of Birth: ____/____/____ Sex: M F Marital Status: Single Married Divorced Widowed Separated

Address: _____
Street City State Zip

Telephone : (____) _____ (____) _____ (____) _____
Home Mobile Work ext

Social Security Number: _____ - _____ - _____ Patient Email Address: _____

(we do not need minors SS#)

Responsible Party: Self Other: _____ Relationship: _____
(i.e., person who pays bill for any patient portion)

INSURANCE SUBSCRIBER INFORMATION:

Employer Name: _____ *Policy Holder Name: _____

*Date of Birth: _____ *Social Security number: _____ * (if insurance requires as policy number)

Emergency Contact Name: _____ Relationship: _____

Emergency Contact Telephone: (____) _____ (____) _____
Home Other

How did you find us? Family or Friend Phone Book Insurance Co Internet Advertising _____

Referring Physician/PCP: _____ Telephone: (____) _____

Pharmacy Name & Location: _____ Pharmacy telephone: (____) _____

Patient Consent for Use and Disclosure of Protected Health Information (PHI) and the HIPAA patient consent

I give permission to allow Dermatology and Skin Surgery to leave messages regarding my medical care which may include lab and pathology results on my:

_____ Home answering machine _____ Cell Phone _____ Work voicemail _____ Email _____ Other (_____)

Permission to speak with: _____ **Relationship:** _____

I do not give permission to allow Dermatology and Skin Surgery to leave messages regarding my medical care which may include lab and pathology results on my:

_____ Home answering machine _____ Cell Phone _____ Work voicemail _____ Email _____ Other (_____)

With this consent, Dermatology and Skin Surgery may mail to my home or other alternative location any items that assist the practice in carrying out such as appointment reminder cards and patient statements. By signing this form, I am consenting to Dermatology and Skin Surgery use and disclosure of my medical records to carry out insurance payment. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Dermatology and Skin Surgery may decline to provide me treatment.

The patient also understands that:

1. Protected health information may be disclosed or used for treatment, payment or health care operations.
2. The practice has a Notice of Privacy Practices and that the patient has the right to ask for this notice.
3. The practice reserves the right to change the Notice of Privacy Practices at any time.
4. The patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions.
5. The patient may revoke this consent in writing at any time and all future disclosed will then cease.
6. The practice may condition receipt of treatment upon the execution of this consent.

This consent was signed by: _____
Printed name-patient or patient representative Signature Date

The following is a statement of our Financial Policy which we require you to read and sign prior to any treatment. **Payment for services rendered is due in full at the time they are provided.** For your convenience, we accept cash, checks, VISA, Mastercard, Discover Card, and American Express. Any appointment not cancelled or rescheduled prior to 24 hours is subject to a \$50 service fee.

INSURANCE

We cannot file your insurance unless all of your insurance information is given at the time of your visit. It is imperative that a current copy of your insurance card is provided for accurate billing. If your insurance company has not paid within 90 days, you may receive notification in the mail requesting assistance by you in determining if there is a problem, or if additional information is required in processing the claim. Insurance benefits will be obtained by our verification clerk. All patients will be responsible for their portion due at the time of service. Example: If your insurance pays at 80%, you must pay 20% at the time of service.

Copays and deductibles are required at the time of service with no exceptions.

***It is extremely important for you to educate yourself about your individual insurance benefits. If you are scheduled for a procedure that could be considered a surgery, like a biopsy, cryotherapy, excision, etc, you could be responsible for these charges. To protect yourself, contact your insurance company prior to any procedure to be certain of your benefits and coverage.**

REFERRALS

If your insurance requires a referral, it is solely your responsibility to obtain a current referral for office visits. Please do not ask our receptionists to call your primary care physician to obtain the referral for you. You must bring a referral to our office on the day of your appointment.

NON-COVERED SERVICES

All cosmetic services are not covered by insurance and these services must be paid in full at the time of the visit.

LABS

If you are aware that your insurance carrier requires you to utilize certain labs for blood work or biopsies, it is your responsibility to inform our office prior to the lab being performed. Lab charges are separate charges from our office charges. I have read the financial policy, and I understand and agree to this financial policy.

Signature of patient or responsible party

Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

I hereby assign all medical and/or surgical benefits to include Medicare, private insurance and any other health plans to: Dermatology and Skin Surgery. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all services not paid for by my insurance company; including co-payments, deductible amounts, or services that are not a covered benefit by my plan. I hereby authorize said assignee to release all information necessary to secure the payment.

I authorize Dermatology & Skin Surgery to release any information acquired in the course of my exam or treatment to my insurance company, primary care physician, pediatrician or another physician. I recognize that I am responsible for all charges incurred whether or not paid by my insurance company. I also recognize and agree that I will pay any amount not paid by my insurance company within 30 days. In the event I fail to comply with this financial policy, I understand that my account will be turned over to a collection agency which charges a collection fee, accrual of interest, and credit reporting.

I UNDERSTAND and agree that, (REGARDLESS OF MY INSURANCE STATUS), I am ultimately responsible for the balance on my account for any professional services rendered. I will notify you of any changes in my health status or health insurance. If I am a member of an HMO or PPO group and the insurance company has not paid the claim within 90 days of the visit, I understand I am responsible for the balance due. I hereby give consent for treatment by Dr. Gina Harney and Leslie Hornberg, PA-C. A photo static copy hereof is as valid as the original. I hereby state that all information provided is true and correct to the best of my knowledge.

Signature

Date

CONSENT TO TREAT

I voluntarily consent to surgical, medical, and/or diagnostic treatment by my provider, physician assistant or medical assistant as deemed necessary to treat my condition(s). I release the provider from any responsibility which takes place as a natural complication of the procedure. I also realize that it is my responsibility to keep post-operative appointments and follow post-operative directions and instructions for wound care. If any problem exists such as bleeding, infection or if I have any doubts, I am to contact the doctor immediately.

Signature

Date

MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card _____ Date: _____

Patient: _____ DOB (____) Date: _____

Reason for today's visit: _____

Medication Allergies: _____

Are you allergic to local anesthesia like novocaine or lidocaine? Yes No
Do you develop skin rashes in reaction to (Please circle all that apply):
Bandages/adhesives, Latex, Neosporin/Polysporin, environment, other _____

Do you take aspirin or blood thinners? Yes No Do you smoke? Yes No Do you drink alcohol? Yes No

List medications you currently take (include prescriptions, over-the-counter, vitamins, herbs & supplements):

- 1. _____ 4. _____ 7. _____
- 2. _____ 5. _____ 8. _____
- 3. _____ 6. _____ 9. _____

FAMILY HISTORY (Please circle all that apply)

Skin Cancer: Basal cell carcinoma/ Squamous cell carcinoma/ Melanoma Other: _____
Psoriasis Hayfever Arthritis Diabetes Asthma Cancer Eczema
Multiple Sclerosis OTHER: _____

PAST MEDICAL HISTORY (Please circle all that apply to you personally)

General Health: Excellent/ Good/ Poor Lupus/ Rheumatoid arthritis/ Other _____
Multiple Sclerosis/ Fibromyalgia/ Chronic Fatigue **Artificial joint replacement** _____
Eczema/ Psoriasis, _____ Herpes/ Cold Sores/ Keloids/ Hives
Ear/ nose/ throat/ or mouth disease **Organ transplantation** _____
Stroke/ TIA's/ Seizures/ Headaches Menstrual irregularities _____
Diabetes/ Thyroid disease **Pregnant Yes No Due Date:** _____
Heart disease/ Heart attack Depression/ BiPolar/ Anxiety _____
Mitral valve prolapse/ Heart murmur Cancer type _____
Pacemaker/ Defibrillator Radiation therapy/ Chemotherapy
Heart valve replacement Bleeding disorder/ Anemia
Asthma/ Tuberculosis **Hepatitis/ AIDS/ HIV positive**
Allergies/ Hay fever High Blood Pressure

List any other diseases or conditions: _____

Have you been told to take oral antibiotics before dental or other procedures? Yes No

Past Surgeries: _____

SKIN CANCER HISTORY: (Please circle all that apply)

- Melanoma Basal Cell Carcinoma Squamous cell carcinoma other _____
- Location of the skin cancer and date treated: _____

When exposed to the sunlight, do you Burn Burn-then tan Tan

Do you use sunscreen Daily Seldom Never only when I am outside sports/fun/etc

Do you have problems with healing? (Please explain) _____

Do you develop keloids (raised bumpy scars) after surgery? Yes No

What is your occupation? _____ Hobbies: _____

Physician's Signature: _____ Date: _____
Gina G. Harney, MD

Physician's Signature: _____ Date: _____
Leslie Hornberger, PA