



PATIENT INFORMATION

First _____ Middle _____ Last _____

DOB _____ Age _____ Male Female SSN# _____

Status: Minor Single Married Divorced Widowed Other

Mailing Address _____

City _____ State _____ Zip _____

Home # _____ Cell# _____ Work# _____

Email Address _____

May we have your consent to use this email address to send you appointment reminders and general information about our practice? Yes No

Employer/School _____ Full-Time/ Part-Time _____

In case of emergency, contact _____ Phone _____ Relation _____

Preferred Pharmacy _____ Location _____ Phone _____

INSURANCE INFORMATION

Insurance Company Name _____

Subscriber/Member ID# _____ Group # _____

Subscriber Name _____ Patient's Relation: Self Spouse Dependent Other: _____

DOB _____ SSN _____ Phone _____

Mailing Address (if different from patient) _____

City _____ State _____ Zip _____

Employed by _____ Occupation _____

Do you have a secondary insurance? Yes No **If yes, please complete:**

Insurance Company Name _____

Subscriber/Member ID# _____ Group ID# _____

Subscriber Name _____ Patient's Relation: Self Spouse Dependent Other: _____

DOB _____ SSN _____ Phone _____

HOW DID YOU HEAR ABOUT FOUR POINTS DERMATOLOGY?

- | | | |
|--|--|---------------------------------------|
| <input type="checkbox"/> Doctor: _____ | <input type="checkbox"/> Insurance | <input type="checkbox"/> Newspaper |
| <input type="checkbox"/> Friend/Family: _____ | <input type="checkbox"/> Internet/Website: _____ | <input type="checkbox"/> Yellow Pages |
| <input type="checkbox"/> Community Newsletter:
(which one? _____) | <input type="checkbox"/> Billboard | <input type="checkbox"/> Yellow Book |
| | <input type="checkbox"/> Car Magnet | <input type="checkbox"/> Other: _____ |

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FINANCIAL INFORMATION



We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Financial Policy is important to our professional relationship; please understand that payment for services is a part of that relationship. Do not hesitate to ask a member of our staff for clarification regarding payment, fees, benefits and eligibility, deductible status, etc; we are more than happy to help in any way we can. *Please initial next to each paragraph as well as sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies.*

____(initial) Insurance Claims

Please remember that your insurance policy is a contract between you and your insurance company. Our staff makes a point to call ahead and get each patient's benefits and eligibility; however, it is the patient's responsibility to know how their benefits work. Prior to your appointment, it is suggested you contact your insurance company to verify coverage, your co-pay/deductible/co-insurance amounts met to date, and any restrictions your insurance company may have. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits.

____(initial) Patients Without Insurance Coverage or Out-of-Network Coverage

Payment is due for all services on the day they are rendered. Our office accepts cash, check, and credit/debit cards for your convenience. For all surgical/medical procedures, full payment is due on the day the procedure is performed unless arrangements have been made with our office *prior* to the scheduled surgery/procedure.

____(initial) Labs/Outside Testing

In the event that your visit includes biopsies, lab tests, or cultures, the specimen(s) will be sent out for processing and/or testing. Note to the patient: You will receive *separate billings* from the laboratory performing the service; any questions regarding this bill should be directed to the billing department at the lab where services were rendered.

____(initial) Outstanding Balance

It is our office policy that all past due accounts be sent two statements. If payment is not made on the account, a single phone call will be made to try to make payment arrangements. If no resolution can be made, the account will be sent to the collection agency, and the collection agency's fee may be added to patient's balance. Patients whose accounts are sent to collections may be discharged from the practice. All checks returned for insufficient funds will be subject to a \$30 additional fee.

____(initial) Medical Records

For the protection of our patients, our office does not release any medical information without the written authorization from the patient, parent or legal guardian, except when requested by law. No fee is required if records are sent directly from physician to physician. If you would like for us to release information directly to you there is a \$25.00 charge.

____(initial) No Show Policy

We understand that at times it is necessary to change an appointment; please give our office as much advanced notice as possible so we may change our schedule accordingly. It is our office policy that a patient who "no shows" their appointment, that is does not call to cancel or reschedule **24 hours prior** (*48 hours prior for procedures*) to their appointment, be charged a \$50 fee for a New Patient appointment and \$25 for an established patient appointment. If the appointment scheduled is for a procedure, the fee is \$75 for a 45 minute procedure and \$100 for an hour long procedure. For a subsequent "no show," a \$75 fee will be charged to the account. For a third consecutive "no show," patient may be discharged from the practice. (These fees are not covered by insurance, if applicable)

____(initial) Minors and Adult Students Covered by Parent's Insurance

A parent or legal guardian must accompany all children under the age of 18. In the case of divorced parents, the parent bringing the child in for service is responsible for the bill. However, if the patient is over the age of 18, you are responsible for your bill unless other arrangements were made *prior* to the appointment.

____(initial) Authorization/Assignment/Financial Responsibility

I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and that I am responsible for obtaining referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Four Points Dermatology for services rendered to me. As a courtesy, my charges will be filed with my insurance carrier; however, I will be billed if the claim is denied or is not paid in a timely manner.

Signature of Patient/Responsible Party

Date Signed



ACKNOWLEDGEMENT/CONSENT

_____ **Initials** **RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)**

I have acknowledged that I am entitled to receive a copy of Four Points Dermatology's Notice of Privacy Practices, which explains how my medical information will be used and disclosed.

_____ **Initials** **CONTACT PERMISSION**

In the event that Four Points Dermatology needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

- Leave a message on an answering machine or voice mail. Phone # _____
- Speak with spouse/significant other. Name: _____
- Speak with other family members. Name: _____

_____ **Initials** **CONSENT TO TELEPHONE/EMAIL COMMUNICATION**

I understand that any phone or email communication will be part of my medical record. I also understand that all email communication is **not** secure, **not** to be used for any emergent matters, and response will be given back within three to five business days.

CONSENT TO TREATMENT

I consent to the performance of those examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I consent to treatment in the event the physician finds routine dermatologic treatment necessary (i.e. skin biopsy, destruction, scissor clipping, injection, etc.). As with any treatment, I am aware that complications and side effects can occur (i.e. bleeding, infections, scarring, pain, recurrence, etc.). I authorize Four Points Dermatology to take photographs/videos of myself; I understand that the photograph/video will *only be used in my medical record and will not be released without my prior authorization*. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

Patient Printed Name _____

Signature _____ **Date Signed** _____

-----*ONLY COMPLETE BELOW IF PATIENT IS A MINOR*-----

CONSENT TO TREATMENT OF MINORS

I, the undersigned parent/legal guardian, of _____ (patient name) listed above do authorize the physician and assistants of Four Points Dermatology to provide health services to this minor in the absence of a parent or legal guardian. This health service may include, but is not limited to examination, preventative and/or curative treatment, laboratory examination, anesthetic, medical or surgical diagnosis, and any consultation deemed necessary at the physician's discretion. It is understood that this consent is given in advance of any specific diagnosis or treatment being required and is given to encourage and allow the physician to exercise her best judgment as to the requirements of such diagnosis or medical treatment in my absence. I authorize Four Points Dermatology to take photographs/video of my child (or person for whom I am legal guardian); I understand that the photograph/video will *only be used in the medical record and will not be released without my prior authorization*. This consent shall remain in effect until revoked, in writing, by parent or legal guardian or until child may legally consent for him or herself.

Parent/Guardian Printed Name _____

Signature of Parent/Guardian _____ **Date Signed** _____

(CONTINUED ON BACK →)

GENERAL HEALTH PROFILE

FOUR POINTS



DERMATOLOGY

Patient _____ DOB _____ Primary Care Dr. _____ (Office Use)

NP EST NO

Reason(s) for today's visit _____

Have you had a full body skin exam in the past year? YES NO Would you like to schedule one in the future? YES NO

MEDICATIONS (include all prescriptions, over the counter, herbal/supplements, birth control , etc.): _____

PATIENT MEDICAL HISTORY

Do you have now, or have you ever had diseases or conditions of (please check yes or no; if yes, please explain):

- Skin Cancer YES NO _____ Heart Attack YES NO _____
- Problems with Skin Healing YES NO _____ Irregular Heartbeat YES NO _____
- Keloid(s) after Surgery YES NO _____ Pacemaker or Defibrillator YES NO _____
- Skin Rash from Bandages YES NO _____ Heart Murmur YES NO _____
- Skin Rash from Neosporin/Bacitracin YES NO _____ High Blood Pressure YES NO _____
- Skin Rash from Environment/Food YES NO _____ Bleeding Problems/Anemia YES NO _____
- Sun Sensitivity YES NO _____ Blood Clots/Phlebitis YES NO _____
- Asthma/Seasonal allergies/Sinusitis YES NO _____ Artificial joints/heart valve YES NO _____
- Eczema YES NO _____ High Cholesterol YES NO _____
- Fainting/Dizzy Spells YES NO _____ Kidney Disease YES NO _____
- Cancer (non-skin) YES NO _____ Liver Disease/Hepatitis YES NO _____
- Lung Disease YES NO _____ HIV/AIDS YES NO _____
- Diabetes YES NO _____ Herpes/Cold Sores YES NO _____
- Gastrointestinal Disorder YES NO _____ Other STD's YES NO _____
- Urologic/Gynecologic Disorder YES NO _____ Swelling of Hands/Feet YES NO _____
- Neurologic(seizure, stroke, migraine, etc) YES NO _____ Eye Disease YES NO _____

Psychiatric Disorder (depression, anxiety, bipolar, etc.) YES NO If yes, explain: _____

Arthritis/Joint Pain (rheumatoid, osteoarthritis, congenital, etc.) YES NO If yes, explain: _____

Autoimmune Disease (rheumatoid arthritis, lupus, vitiligo, thyroid disorders, etc.) YES NO If yes, explain: _____

History of chronic infections (staph, pneumonia, tuberculosis, osteomyelitis, etc.) YES NO If yes, explain: _____

Any other medical condition(s) OR skin disease(s): _____

ALLERGIES to medications/topicals/food: _____

SURGERY/HOSPITALIZATIONS (and date): _____

Have you ever had dental anesthesia (Novocaine)? YES NO If yes, any bad reactions? YES NO

When taking antibiotics, do you experience any of the following: Nausea, vomiting, or diarrhea? YES NO Yeast infection? YES NO

Need for antibiotics prior to procedures (i.e. dental procedures) in the past? YES NO

FEMALE PATIENTS ONLY

Currently pregnant? YES NO Regular menses? YES NO Date of last period: _____

Breastfeeding? YES NO Trying to conceive? YES NO Using contraceptives? YES NO If yes, which one? _____

FAMILY MEDICAL HISTORY

If yes....

Skin Cancer YES NO Relation: _____ Type of Cancer: _____

Other Medical Problems YES NO Relation: _____ Type of Problem: _____

SOCIAL HISTORY

Do you....

Smoke/use smokeless tobacco? YES NO If yes, how much? _____

Drink alcohol? YES NO If yes, how much? _____

Use sunscreen? YES NO If yes, how much? _____

Utilize a tanning bed? YES NO If yes, how much? _____

The above information is accurate and complete to the best of my knowledge.

Occupation :
Height : Weight :
Race : Ethnicity :
<i>Are you interested in learning more about cosmetic dermatology?</i> <input type="checkbox"/> YES <input type="checkbox"/> NO

Signature of Patient/Responsible Party

Date Signed