INTEGRATED
DERMATOLOGY
OF CHESTERFIELD

Patient name: _____ Today's Date: _____
Date of Birth: _____ Sex: _M/F___
Home# _____ Cell# _____ Other#_____
Home Address:

_____

Responsible Party (if other than self) Name: _____
Date of Birth_____ Address: _____
Phone#_____
Employer:_____ Relationship to Responsible Party: _____
Pharmacy: _____ Address/City: _____
Phone: _____
Emergency Contact: _____Relationship: _____
Phone: _____
Address: _____
Insurance: Primary company: _____
Secondary company: _____
Cardholder: _____ Date of Birth: _____
HOW DID YOU HEAR ABOUT US?

_____

Who is your primary care provider (PCP)?

_____

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans to Integrated Dermatology of Chesterfield of any medical benefits payable to me for the services provided at Integrated Dermatology of Chesterfield. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claims processing or as long as dictated by payor. I understand it is my responsibility to pay any deductible amount, co-insurance or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or otherwise ineffective. I also understand that if my insurance plan requires a referral authorization for my appointments, it is my responsibility to obtain a referral prior to appointment. I will be responsible for the unpaid balance due any bills if this is not done. If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorney's fees and cost of collection.

X_____

Patient signature or Signature of Guardian or Parent Date

MEDICARE!PATIENTS! ONLY – Lifetime Signature on File and Lifetime Consent:
I request that payment of authorized Medicare benefits be made on my behalf to Integrated Dermatology of Chesterfield. 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 those benefits or the benefits payable related services. I request that payment of authorized Medigap or secondary insurance benefits be made on my behalf to Westminster Dermatology. 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 Beneficiary Date

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HIPAA PATIENT CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- ☐ Protected health information may be disclosed or used for treatment, payment, or health care operations
- ☐ The Practice has a Notice of Privacy Practice and that the patient has the opportunity to review this Notice
- ☐ The Practice reserves the right to change the Notice of Privacy Practices
- ☐ The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- ☐ The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- ☐ The Practice may condition receipt of treatment upon the execution of this Consent.

I give consent to the Practice to release and discuss my medical records, including but not limited to information regarding appointments, diagnosis, test results, and treatment plans to the following individuals:

_____

_____

Signed by: _____X

_____

Printed Name – Patient or Representative Signature Date

Relationship to Patient (if representative): _____

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Medical History Form

Patient Name: _____ Today's Date: _____

Date of Birth: _____

Who is your PCP (family doctor)? _____

Do you personally have a history of: (circle any that apply)

- Skin Cancer
  - Melanoma
  - Squamous Cell Carcinoma
  - Basal Cell Carcinoma
- Abnormal Moles
- Diabetes
- High Blood Pressure
- Bleeding Disorder
- Allergies or Asthma
- Thyroid Disease
- Anemia
- Liver Disease
- Kidney Disease
- Please list other medical conditions:

  _____
  _____
  _____

Do you have a family history of: (Please list details)

- Skin Cancer_____
- Abnormal Moles_____
- Any Cancer_____
- Psoriasis_____
- Eczema_____
- Other Skin Concern _____
- Auto-immune Disease _____

Please list all of your current medications below:

_____
_____
_____
_____
_____
_____
_____

Do you have a pacemaker? Y/N

Please list all allergies to drugs, medications, latex, adhesive tape, other:

_____
_____
_____
_____
_____

Do you wear Sunscreen?

- Never
- Occasionally
- Every Day

Have you used tanning beds?

- In the past
- Currently
- Never

In the sun do you:

- Burn only
- Tan and Burn
- Tan only

Do you smoke or chew tobacco?_____

How many alcoholic drinks do you have in one week?

_____

Have you had a flu shot this year? Yes / no

Have you ever received a Pneumonia vaccine? Yes / no

Do you have an Advanced Care Plan (a written plan of who would make medical decisions for you if you are not able to? Yes / no

Sign and Date: _____

Integrated Dermatology of Chesterfield Billing Information

Dear Patients:

Every insurance plan is different. We strongly recommend that you check with your insurance carrier regarding your plan's benefits and coverage. You may also want to check with your insurance company prior to consenting to laboratory / pathology testing or in-office procedures in order to determine what will be covered.

In-Office Procedures:

Routine in-office procedures include but are not limited to biopsies, injections, destruction of precancerous and non-cancerous growths and surgical removal and repair of cancerous and non-cancerous growths. These are billed separately from your office visit and may or may not be covered by your insurance or be applied toward your deductible.

Do we have permission to leave a message regarding your medical conditions and/or test results on an answering machine? Yes_____ No_____

Do we have your permission to discuss your medical condition with and/or give test results to a family member? Yes_____ No_____

Name(s) of designated family member(s)_____

_____ _____

Laboratory/Pathology Services:

Your provider will order the laboratory tests that are necessary to provide the best plan of care to you. Routine laboratory services include pathologic evaluation of skin biopsy or excision specimens and scrapings are billed separately by that facility.

Initial: _____

Cancellation Policy:

Our office strives to provide you with exceptional medical care provided in a warm, professional environment. In order to ensure timely scheduling for all patients, we reserve the right to charge a $30.00 cancellation fee if a patient fails to cancel a scheduled appointment in a timely manner. Family emergencies or weather-related delays will be handled on a case by case basis.

Initial: _____

Acknowledgement:

Signature of this form indicates that you understand that you are responsible for payment of your account at the time of service for deductibles, non-covered services, medically unnecessary services, co-payments and insurance balances, should your primary insurance be with a company with which the providers are contracted. If your insurance company is not one with which the provider is contracted, you are responsible for the entire amount at the time of service.

If your account becomes delinquent, it may be forwarded to an outside collection agency without notice. If this happens, you will be responsible for all costs of collection, including but not limited to interest, re-billing fees, court costs, attorney fees and collection agency costs.

Signature of Responsible Party _____Date:_____

Print Patient's Name _____DOB:_____