Patient Information

Prefix: _____

Last Name: _____ First Name: _____Middle: _____

Nickname: _____ Suffix: _____ SSN: _____ Date of Birth: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Driver's License #: _____ Sex: □Male □Female

What is your preferred method of Appointment Reminders? □ Telephone call to primary number □ Text

Patient Home Number: _____ Patient Work Number: _____ Patient Mobile Number: _____

Emergency Contact: _____ Phone Number _____ Relationship: _____

Preferred phone number to be contacted on: □Home □Work □Mobile Is it ok to leave detailed message: □Yes □No

Email Address: _____ Would you like to opt in email notifications? □Yes □No

Marital Status: □ Single □ Married □ Separated □ Widow Ethnicity: □ Hispanic □ Non-Hispanic □ Unknown

Race: □White □Black or African American □Asian American □Indian/Alaska Native □ Native Hawaiian/Other Pacific Islander □ Hispanic □ Declined

Guarantor Information/Responsible Party

Guarantor Contact Information: Check if Same as Patient □

Patients Relationship to Guarantor: (please check) □Self □Spouse □Child □Other_____

Guarantor Last Name: _____ Guarantor First Name: _____

DOB: _____ Social Security Number: _____ Phone: _____

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Consent for Release of Medical Information to Family Members or Personal Representative

□ Yes, The Practice May Discuss:

□ Medical Condition/Treatment □ Appointments □ Prescriptions □ Financial □ Pathology and/or Lab Results with the following person(s)

I understand this authorization may include information related to HIV, AIDS, and Psychiatric Care, Treatment for Alcohol and/or Drug Abuse or Genetic Testing. Initial: _____

<u>Please list Authorized Person(s) Below:</u>

Name: _____Relationship: _____ Phone Number: _____

Name: _____Relationship: _____ Phone Number: _____

SIGNATURE: _____ DATE: _____

Patient Acknowledgement

PATIENT RESPONSIBILITY. I understand that I am financially responsible for all services rendered. I understand that my insurance coverage is a contract between myself and my insurance company. Therefore, I am financially responsible for any unpaid balance not covered by my insurance. All copays, deductibles, and coinsurances not covered by my insurance carrier are my responsibility and will be due at the time of service.

PAYMENT ASSIGNMENT. I authorize and assign directly to DeSilva Dermatology, all insurance benefits, if any, payable for any services rendered otherwise payable to me. I understand that this office will prepare all necessary claim forms to assist me in making collection from the insurance company.

INFORMATION RELEASE. I authorize DeSilva Dermatology to release all protected health information to my insurance carrier(s) (including Medicare, if appropriate) and third-party collection agencies in order to secure payment for services rendered. I also authorize DeSilva Dermatology to release my medical information to my Primary Care Provider or Referring Provider for continuity of my care.

REFERRALS. I understand that it is my responsibility to obtain any referrals required by my insurance company from my primary care physician. It is my responsibility to make sure that my referral is accurate and denial of payment because of my failure to do this will result in me being personally responsible for the charges incurred.

RETURN POLICY. I understand that skin care product sales are final.

TREATMENT GUARANTEE. Although good results are anticipated, I understand that there can be no guarantee or warranty, expressed or implied, by anyone as to the actual results I may get. I also understand that additional charges, in which I will be responsible, will be applied for the management of problems and/or complications

GENERAL CONSENT. I consent to treatment rendered from the provider and his/her directed medical support staff at DeSilva Dermatology.

MEDICATION CONSENT. I consent for DeSilva Dermatology to access and obtain a history of my medications purchased at pharmacies.

PHOTOGRAPHY CONSENT. I hereby authorize DeSilva Dermatology to photograph me or my dependent while I (he/she) am (is) a patient. I understand the photograph(s) or videotape(s), will be used for documentation of my (his/her) medical condition. For example, my clinical team will take pictures of my skin condition, biopsy site, or surgical site. My team will also take before and after pictures to monitor the progression of my condition.

NOTICE OF PRIVACY PRACTICES. I acknowledge that I have been provided a copy of the Notice of Privacy Practices from DeSilva Dermatology for me to keep and that I have read (or had the opportunity to read if I so chose) the Notice.

APPOINTMENT NO-SHOWS: Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A no-show patient may be charged $40.00, as set by the Practice, for failure to show. A patient who is a no-show three times may be dismissed from the Practice.

LABORATORY FEES: We use third party pathology and diagnostic labs. Pathology services are performed on every biopsy and excision. DeSilva Dermatology cannot guarantee your insurance carrier will cover any labs or pathology performed or ordered by a physician. If your insurance company requires use of a specific lab it will be your responsibility to inform your physician for proper handling. You will be billed separately by the laboratory. I acknowledge and agree to these terms and responsibilities.

PATIENT SIGNATURE **DATE**

Name: Last, First, MI: _____ Date of Birth: _____

Pharmacy Name: _____ Pharmacy Number: _____

How did you hear about us? _____ Primary Care Physician: _____

Skin History

Do you sunbathe? ◯ Yes ◯ No Have you used tanning beds? ◯ Yes ◯ No History of Skin Cancer: ◯ Yes ◯ No

Date of last skin cancer: _____ Flu shot: ◯ Yes ◯ No Pneumococcal shot: ◯ Yes ◯ No

Please mark the skin condition that you or your family / blood relatives have OR have had

Condition	Self	Family	Relation	Condition	Self	Family	Relation
Actinic Keratosis				Psoriasis			
Basal Cell Carcinoma				Difficulty with wound healing			
Squamous Cell Carcinoma				Difficult with skin infections			
Melanoma				Hives			
Atypical / Dysplastic Mole				Eczema / Rashes			
Keloid / Scars				Rosacea			
Acne / Accutane				Other Skin Conditions			

MEDICAL CONDITIONS

Please mark the condition that you or your family / blood relatives have OR have had

Condition	Self	Family	Relation	Condition	Self	Family	Relation
Arthritis				Congestive Heart Failure			
Asthma / Hay fever				Mitral Valve Prolapse			
Autoimmune Disease				Hyperlipidemia			
Atrial Fibrillation				Kidney Disease			
Depression / Psychiatric				Multiple Sclerosis			
Diabetes				Thyroid Disease			
Tuberculosis				Hepatitis C			
Liver Disease				HIV / AIDS			
Gastrointestinal Disease				Bleeding Disorder			
High Blood Pressure				Cancer / Lymphoma			

Females only: Are you pregnant? ◯ Yes ◯ No Are you nursing? ◯ Yes ◯ No Do you take birth control? ◯ Yes ◯ No

Do you smoke? ◯ Never ◯ Current ◯ Former, Total years smoking _____

Do you drink alcohol? ◯ None ◯ Less than 1 drink per day ◯ 1-2 drinks per day ◯ 3 or more drinks per day

List Current Medications: ◯ None ◯ See attached list

_____

_____

_____

Patient MEDICATION Allergies: ◯ No Known Drug Allergies

_____

_____

PATIENT SIGNATURE: _____ **DATE:** _____

We would like to thank you for choosing DeSilva Dermatology as your healthcare provider. We are committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many PPO, HMO insurance companies and government agencies including Medicare. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance requires a referral, it is your responsibility to get with your PCP to obtain a referral. Please bring your insurance card(s) with you at the time of your appointment. If you are insured by a plan, we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

Your insurance company required us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. If you are unable to pay your co-payment your appointment may be rescheduled. Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. These amounts are due at the time of service. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.

If your insurance changes, please notify us at least 24 hours before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Any changes incurred by you because of failure to provide any necessary information will be your responsibility.

For Our Patients with No Medical Insurance:

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit.

Cosmetic Services:

Payment for all cosmetic services is due at the time of service. We will not take a partial payment for cosmetic services unless it is approved by a provider and management.

Late Arrivals:

A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule if possible or patient may need to reschedule appointment.

Divorced Parents of Patients:

By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

Delinquent Balance Appointment:

Patients with a delinquent balance are required to make payment in full at time of service. A delinquent account is defined as a patient balance in excess of 90 days where the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused. I agree to pay any costs incurred by DeSilva Dermatology in collecting any amount due including, without limitations collection agency fees and attorney's fees.

PATIENT SIGNATURE: _____Date: _____

Guarantor Signature: _____Date: _____