

DERMATOLOGY & SKIN SURGERY

Patient Consent for Use and Disclosure of Protected Health Information/ Consent to Treat

I give permission to Dermatology & Skin Surgery to leave messages regarding my medical care, including lab results at: __phone __email __both (place an X before the preferred method)

I give permission to Dermatology & Skin Surgery to discuss my medical care with:

Permission to speak with:_____ Relationship:_____

I authorize Dermatology & Skin Surgery to contact me by mail. __Yes __No

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, or another physician. I authorize Dermatology & Skin Surgery to take medical photographs of myself as part of my medical record. I agree that Dermatology & Skin Surgery may access my medication history from other healthcare providers and/or pharmacies for treatment purposes.

I acknowledge that I have been given the Dermatology & Skin Surgery Notice of Privacy Practices.

I consent to surgical, medical, and/or diagnostic treatment by the staff of Dermatology & Skin Surgery as deemed necessary to treat my condition(s).

Patient Signature (or responsible party)

Date

ASSIGNMENT OF BENEFITS AND FINANCIAL RESPONSIBILITY

Payment is due at time service is provided.

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 assign all medical and/or surgical benefits to Dermatology & Skin Surgery. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is to be considered as valid as an original. I hereby authorize said assignee to release all information necessary to secure the payment.

NO-SHOW POLICY

Any unattended appointment not canceled or rescheduled 24 hours prior is subject to a \$50 service fee.

A \$50 **appointment holding fee** will be collected with the scheduling of new patient appointments.

The fee will be refunded after the appointment is kept if not applied to a copay or deductible.

REFERRALS

If your insurance requires a referral from your primary physician, this referral must be in place before your appointment. If you arrive without the referral required by your insurance company, you may be seen as a non-insured/cash patient or reschedule to allow time for you to obtain the needed referral.

LABS

If your insurance carrier requires the use of a specific laboratory, the staff must be informed before the specimen is taken.

MEDICARE PATIENTS

I authorize release of my medical information to Social Security Administration or its intermediaries for my Medicare claims. I assign the benefits payable for services to Dermatology & Skin Surgery. I permit a copy of this authorization to be used in place of the original.

I have read, understand, and agree to this financial policy.

Patient Signature (or responsible party)

Date

DERMATOLOGY & SKIN SURGERY

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:

Bandages/adhesives Latex Neosporin/Polysporin Other _____

Do you take aspirin or blood thinners? Yes No **Smoke?** Yes No **Drink alcohol?** Yes No

HEIGHT: _____ ft _____ in **WEIGHT:** _____ lbs

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

_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICAL HISTORY

List any diseases or conditions:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Surgeries: _____

Pregnant: Yes No Due Date: _____

Breastfeeding: Yes No

SKIN CANCER HISTORY:

Melanoma Basal Cell Carcinoma Squamous cell carcinoma Other _____

Location of the skin cancer and date treated: _____

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

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

FAMILY HISTORY OF MELANOMA: Yes No If yes, which relative: _____

What is your occupation? _____

How did you hear about us? _____

Provider Signature: _____ Date: _____