SILLS DERMATOLOGY

NAME _____ DOB ____/____/____SEX: M / F
(Last) (First) (MI)

ADDRESS _____
(City) (State) (Zip Code)

HOME PHONE_____CELL_____EMAIL _____

SOCIAL SECURITY #_____ RACE_____ETHNICITY Hispanic / Non-Hispanic

EMPLOYER/OCCUPATION: _____WORK PH#_____

MARITAL STATUS_____ SPOUSE'S NAME_____ PH#_____

IF PATIENT IS A MINOR:

GUARDIANS NAME_____ DOB: _____/_____/_____PH#:_____

ADDRESS:_____

INSURANCE INFORMATION:

PRIMARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID #_____POLICY/GROUP #_____POLICY HOLDER _____

Policy Holder Date of Birth _____/_____/_____ Policy Holder Social Security Number: _____

SECONDARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID #_____POLICY/GROUP #_____POLICY HOLDER _____

Policy Holder Date of Birth _____/_____/_____ Policy Holder Social Security Number: _____

PREFERRED PHARMACY:_____PH#:_____

PRIMARY CARE PROVIDER:_____

REFERRING PROVIDER:_____

We need the name of someone we can contact in the event of an emergency as well as release medical information about your condition. Please list below. PLEASE NOTE: If you are the PARENT OF A MINOR CHILD, you should be listed here as well as anyone else we may contact.

Name:	Relationship:	Phone:

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RECEIPT OF NOTICE OF PRIVACY PRACTICES:

I acknowledge that a copy of my physicians Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices) has been made available to me.

AUTHORIZATION TO OBTAIN/RELEASE MEDICAL RECORDS

I authorize Sills Dermatology to obtain/release copies of my medical records to/from any physician or institution for the purpose of continuity of care for me and/or my dependents.

NO SHOW/CANCELLATION POLICY:

I understand that if I fail to reschedule or cancel an appointment 24 hours prior to the appointment then a $25 no-show fee will be applied to my account. For procedure appointments, a $100 fee will be applied. I understand that the no-show fee must be paid prior to rescheduling my appointment and that it is not reimbursable by my insurance company or able to be paid with my health savings card.

MEDICARE PATIENTS ONLY:

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.

I request authorized SECONDARY benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the SECONDARY carrier any information needed to determine these benefits or the benefits payable to related services.

Signature/Legal Guardian:_____

Date:_____

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FINANCIAL & ADMINSTRATIVE POLICIES

Name: _____Date of birth: _____/_____/_____

CONSENT TO TREAT

• I hereby give my permission to Sills Dermatology for medical treatment including but not limited to examinations, laboratory procedures, injections, local anesthesia, surgery, diagnostic testing, or medical procedures deemed necessary and appropriate for diagnosis and treatment. I further understand that state law requires this practice to report any communicable diseases to the health department.

CONSENT FOR PHOTOGRAPHY

• I hereby give my permission to Sills Dermatology to take photographs of my skin as part of the medical record and clinical documentation only. Any other use of my photographs will require additional consent.

DISCLOSURE OF INSURANCE COVERAGE

• I certify that I have provided **ALL INSURANCE INFORMATION** to the practice and it is my responsibility to notify the practice of any changes.

PATIENT PAYMENT POLICY AND COVERED SERVICES

• I understand that I am responsible for all charges associated with my care. All patient balances, co-pays, and deposits are due at the time of service.

• Health insurance plans **may not** provide coverage for all medical services, tests, and/or procedures that our providers may offer or recommend for treatment. It is my responsibility to know and understand the services covered by my insurance. If insurance does not cover services, I will be responsible for payment.

• Our office may contact your insurance carrier to verify your insurance coverage and benefits. An **estimate** of your financial responsibility will be determined according to the contractual agreement between the practice and your insurance company. We may review your benefits with you to explain your financial obligations and you may be required to pay a deposit prior to services being rendered.

• If an insurance claim is denied due to incorrect personal information or incorrect insurance information that you have provided, you will be billed for any unpaid claims for services, and payment in full will be due immediately.

• If an account is sent to a collection agency due to non-payment, you may be dismissed from the practice and denied future care and services by all providers within the practice. A collection fee of 33% will be added to your account balance. I understand I am responsible for the collection fees and/or attorney fees incurred in the collection of this account.

• If your provider is not in network with your insurance plan, you must pay in full at the time of service.

• If you cannot supply a valid insurance card and/or coverage cannot be determined, you must pay in full at the time of service.

• Some specimens collected in this office may be sent to an outside pathology lab for testing. As such, you may be billed by an outside reference lab. You may also have pathology lab charges if your biopsy was read in-house by Dr. Sills.

• It is your responsibility to obtain any referrals or prior authorizations for medical services if required.

RETURNED CHECK CHARGE

• A $25.00 administrative charge will be assessed for any returned checks.

CANCELLATION POLICY

• **A minimum 24-hour advance notice is required to cancel an appointment or surgery/procedure.**

• **No shows or cancellations without a 24-hour notice may receive a $25.00 charge for missed office visits and $100.00 for missed procedures. This charge will be the patient's responsibility and will not be billed to or reimbursed by your insurance.**

• **If a patient repeatedly misses or cancels appointments, the patient may be dismissed from the practice.**

FORMS AND PAPERWORK

• A minimum fee of $20.00 will be billed to the patient for the release of medical records. Records that exceed twenty (20) pages, may be charged $0.50 for each additional page.

• A $25.00 fee will be charged to complete FMLA or disability forms. An additional fee of $25.00 will be charged for completing subsequent forms.

PRACTICE GUIDELINES

• Routine medication refills are handled during office hours only. We do not refill any prescriptions (including narcotics) after hours or on weekends. When calling for prescriptions, please have your pharmacy phone number available.

• Physician excuses for days missed from work or school are written only for the days you are seen in our office and additional days needed for recovery. We are unable to write excuses for illnesses not evaluated in our office. We also do not backdate excuses.

A photocopy of this statement is considered to be as valid as the original.

Signature/Legal Guardian:_____Date:_____

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Name: _____ **Date of Birth**:_____/_____/_____

Email: _____May we contact you by email? **YES/NO**

Weight: _____ lbs. **Height**: _____ ft. _____ in.

Reason for Visit:

_____

Please circle all that **CURRENTLY** apply(ROS):

Problems with Bleeding
Problems with Healing
Problems with Scarring
Rash
Immunosuppression
Allergies/Hay Fever
Chest Pain
Fever/Chills
Night Sweats
Unintentional Weight Loss
Sore Throat
Blurry Vision
Abdominal Pain
Joint Aches
Muscle Weakness
Itching
Numbness/Tingling
Cough
Anxiety/Depression

Past Medical History: (please circle all that apply)

Arthritis
Asthma
Atrial fibrillation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Seizures
Stroke
Heart Valve Replacement
Other_____

Past Surgical History: (please circle all that apply)

Coronary Artery Bypass
Basal Cell Carcinoma
Biological Valve Replacement
Heart Transplant
Knee Replacement (R/L/B)
Hip Replacement (R/L/B)
Joint Replacement past 2yrs
Kidney Transplant
Melanoma Surgery
Mechanical Heart Valve
Squamous Cell Carcinoma
Spleen Removed
Hysterectomy:Fibroids
Hysterectomy:Uterine Cancer
Other_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Abnormal/Dysplastic Moles
Psoriasis
Squamous Cell Skin Cancer
Other:_____

Do you wear Sunscreen? YES NO
If yes, what SPF? _____

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Do you tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO
If yes, which relative(s)?
_____

Current Medications: ☐ Check if you brought a list

_____
_____
_____
_____

Allergies: ☐ Check if you brought a list ☐ Latex Allergy?

_____
_____

Social History: (please circle all that apply)

Tobacco	Smokeless Tobacco	Alcohol Use
Never Smoked	YES	YES
Quit: Former Smoker	NO	NO
Smokes less than daily	VAPOR or "Vaping"	If yes, how many drinks?
Smokes Daily		_____drinks per
		▪ DAY
		▪ WEEK
		▪ MONTH
		▪ YEAR

How often do you exercise?	What is your caffeine use?
Once a day	A few times a day
A few times a week	Once a day
A few times a month	A few times a week
Never	A few times a month
	Never

Occupation: _____

Pharmacy: Name: _____
Street: _____ City/State: _____

Have you had a **pneumonia vaccine since turning 60?** YES NO
Do you have a health care proxy in the event you are not able to make medical decisions?
YES NO If so, please provide name:_____
Do you have a living will? YES NO
Is there a possibility you could be pregnant: YES NO