Patient Medical History

Patient Name: ____ DOB: ______ / ______ / ________

Reason for today's visit: ____

____

Is this a new or chronic condition: ____

List of Medical Health Problems (including those for which you are not taking medication)

Condition	Medication

List all significant hospitalization(s) and/or surgical procedure(s):

Description	Month/Year

Do you have a history of skin cancer? □ No □ Yes
Type and location:
____
Are you currently **PREGNANT** or breastfeeding? □ No □ YES
Do you have **DRUG ALLERGIES**? □ No □ YES
If yes, please specify type and reaction:
____
____

Family Medical History
Mother: Alive Deceased Father: Alive Deceased
Family history of skin cancer: □ No □ Yes

Personal/Social Habits and History:
Do you use tobacco products? □ No □ Yes
Do you drink alcohol? □ No □ Yes
Do you use recreational drugs? □ No □ Yes
Have you been exposed to HIV? □ No □ Yes
Have you been exposed to Hepatitis? □ No □ Yes
Amount of daily sun exposure: □ Low □ Med □ High
Do you use sunscreen? □ No □ Yes
Do you use tanning beds? □ No □ Yes

Other Medical Information:
Do you have dry or sensitive skin? □ No □ Yes
Do you have a pacemaker or defibrillator? □ No □ Yes
Do you have a tendency to develop keloids? □ No □ Yes
Are you allergic to tape or bandages? □ No □ Yes
Are you allergic to topical antibiotics? □ No □ Yes
Do you take aspirin or meds to thin your blood? □ No □ Yes
Do you have problems with your immune system? □ No □ Yes
Do you experience excessive sweating? □ No □ Yes
Do you have bleeding problems? □ No □ Yes
Do you have problems with your finger/toe nails? □ No □ Yes

Please circle any areas of concern:

Facial lines/wrinkles
Scars/Acne Scars
Acne/Breakouts
Skin redness/irritation
Brown spots/discoloration
Length/Fullness of eyelashes
Unwanted/excess hair
Stretch marks
Spider Veins
Pore size
Hair loss/thinning
Eyelid drooping
Sensitive skin
Thin Eyebrows
Dull skin texture
Excessive sweating
Double chin
Body Fat

PATIENT INFORMATION

____ ☐ M ☐ F__

LAST NAME FIRST NAME MIDDLE INITIAL GENDER

____

HOME ADDRESS: NUMBER AND STREET NAME APT/UNIT #

____

CITY STATE ZIP CODE

____

PRIMARY PHONE NUMBER DATE OF BIRTH **SSN #**

______________________________________ Brilliant Distinctions or Aspire Member? ☐ YES ☐ NO

EMAIL ADDRESS

RESPONSIBLE PARTY: ______________________________ IF SAME AS ABOVE PLEASE INITIAL: ________

ADDRESS: ____ RELATIONSHIP: ________________________

SSN: ______________________________ **DOB**: ________________________ PHONE #: ______________________________

PHARMACY INFORMATION

PHARMACY NAME PHARMACY ADDRESS PHARMACY PHONE NUMBER

PRIMARY INSURANCE INFORMATION

COPY OF INSURANCE CARDS ARE REQUIRED ARE YOU THE INSURED OR A DEPENDENT? ☐ INSURED ☐ DEPENDENT

____

PRIMARY INSURANCE: CLAIMS PHONE #:

____

PRIMARY INSURANCE ID #: GROUP #:

____

POLICY-HOLDER NAME POLICY-HOLDER DATE OF BIRTH

____

RELATIONSHIP TO PATIENT: POLICY-HOLDER PHONE #:

____

POLICY-HOLDER ADDRESS:

SECONDARY INSURANCE INFORMATION

SECONDARDY INSURANCE: CLAIMS PHONE #:

____

SECONDARY INSURANCE ID #: GROUP #:

____

POLICY-HOLDER NAME POLICY-HOLDER DATE OF BIRTH

____

RELATIONSHIP TO PATIENT: POLICY-HOLDER PHONE #:

EMERGENCY CONTACT INFORMATION

IS CASE OF EMERGENCY WHO SHOULD WE CONTACT?

NAME: ______________________________ PHONE #: ______________________________ RELATIONSHIP: ________________

SIGNATURE

____

PATIENT/GUARDIAN SIGNATURE **DATE:**

I HEREBY AFFIRM THAT I AM THE PATIENT OR LEGAL GUARDIAN OF THE PATIENT AND HAVE AUTHORITY TO MAKE DECISIONS REGARDING MEDICAL TREATMENTS.

DERMATOLOGY & COSMETIC CENTER

FINANCIAL POLICY

Thank you for choosing Mays Dermatology & Cosmetic Center. We are committed to providing you with the highest quality care and pleased to discuss our financial policy with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please read the entire agreement and ask if you need any clarification.

A CURRENT GOVERNMENT ISSUED PHOTO ID AND INSURANCE CARD (IF YOU ARE REQUESTING US TO BILL YOUR INSURANCE COMPANY) **MUST** BE PRESENTED AT EVERY VISIT.

APPOINTMENTS

A 24-hour notice must be provided in the event that you cannot keep an appointment. Should you not provide this notice, a $25 no show fee for medical and $85 fee for surgery appointments will be charged. Please understand that you are personally responsible for this fee. If you arrive after your scheduled appointment time you may be rescheduled.

EXPECTED AMOUNT DUE

FULL PAYMENT IS DUE AT TIME OF SERVICE for all patients with no insurance coverage or proof of insurance. Prior to your appointment your insurance benefits/eligibility will be checked. Based on your specific benefits, your insurance may apply all or part of your visit and/or procedures to your responsibility. In this case, payment for visit and all other rendered applicable services are collected at time of service. After your claim is processed, you may owe additional fees based on your coverage and in/out of network status. Please note only after a claim is fully processed can the practice provide exact fees/coverage numbers. Mays Dermatology & Cosmetic Center does not guarantee benefits, coverage, and/or fees as these are based on your insurance plan and allowed amounts.

1. Insurance: We participate in most insurance plans. If you are not insured by a plan we are contracted with, estimated payment in full is expected at time of service. If you are insured by a plan we are contracted with, but don't have an up-to-date insurance card or cards (for multiple plans), payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits and whether our physician is in network with your plan is the patient's responsibility. It is the responsibility of the patient/ guardian to provide correct insurance information, notify the practice of any changes to your insurance coverage and to provide a current referral when/if required. Should your insurance require further paperwork for approval of certain procedures/services, a documentation processing fee may be applied.

2. Co-payments and deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Due to increased high deductible plans we now require a form of payment on file for all patients. This information is secured in our HIPPA compliant system and is only used during denials.

3. Non-covered services: Some procedures and services may not be covered or considered reasonable or medically necessary by your insurance. All non-covered services are due and payable at the time of visit. If your insurance requires a referral/PA for coverage of any services, you may be responsible for up-front fees until proper needed documentation is received.

4. Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. All of our billing is handled by an independent billing company. All questions or concerns regarding your bill is directed to the billing company for resolution.

5. Nonpayment: Please understand that payment is an integral part of your treatment. If your account is over 30 days past invoice date, interest will incur (1.5%) minimum $2 daily. If a balance remains unpaid more than 45 days, your account will be sent to a collection agency and you may be discharged from the practice. In the event that Mays Dermatology & Cosmetic Center refers your account to a collection agency, you understand that you are responsible for and agree to pay all fees, collection fees and legal fees, incurred with settlement of your delinquent account.

6. Minor patients: Minor patients MUST be accompanied by a parent or legal guardian. The parent/legal guardian accompanying the minor during the first visit will be considered guarantor of the account and therefore accepts full financial responsibility of all services rendered on the minor's behalf to be charged to their account.

7. COSMETIC and CASH pay patients: Full payment for all cosmetic procedures, products, and/or cash pay services is due at time of service. For procedures that require blocking of staff time and disposable/supply purchase, payment is required at time of scheduling the treatment or procedure. Please make sure you understand your entire fee prior to having any services performed. All cosmetic procedures and product sales are FINAL. Our practice only accepts cash, money order, or CC for cosmetic procedures, products, and/or cash pay services. For your convenience we offer CareCredit.
Our practice is committed to providing the best treatment to our patients. **Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.**
*In the event of a returned check for any reason, a fee of $30.00 will be charged to your account.
* All product and cosmetic sales are final. No refunds or exchanges.

I have read and understand the payment policy fully. I agree to abide by its guidelines:

____ ____________________

Signature of patient or responsible party **Date**

HIPAA

I have read and understood the Notice of Privacy Practices. (full detailed version is found on website www.maysderm.com) and consent to our use and disclosure of protected health information about you for the purpose of treatment, coverage, and payment from your health insurance company.

Please list names and relationships of persons with whom we may discuss your medical care (if any) and whether messages can be left on your phone.

SELF ONLY : Can Leave Message: Y N

Name:________________________________ Relationship____________ Phone#______________ Message: Y N

Name:________________________________ Relationship____________ Phone#________________ Message: Y N

ASSIGNMENT OF BENEFITS

ASSIGNMENT OF BENEFITS, ASSIGNMENT OF RIGHTS TO PURSUE ERISA AND OTHER LEGAL AND ADMINISTRATIVE CLAIMS ASSOCIATED WITH MY HEALTH INSURANCE AND /OR HEALTH BENEFIT PLAN (INCLUDING BREACH OF FIDUCIARY DUTY) AND DESIGNATION OF AUTHORIZED REPRESENTATIVE
I hereby assign and convey directly to the above-named health care provider, as my designated authorized representative, all medical benefits and/or insurance reimbursement, if any, otherwise payable to me for services, treatments, therapies, and/or medications rendered or provided by the above-named health care provider, regardless of its managed care network participation status. I understand that I am financially responsible for all charges regardless of any applicable insurance or benefit payments. I hereby authorize the above-named health care provider to release all medical information necessary to process my claims.

Further, I hereby authorize my plan administrator fiduciary, insurer, and/or attorney to release to the above-named health care provider any and all plan documents, summary benefit description, insurance policy, and/or settlement information upon written request from the above-named health care provider or its attorneys in order to claim such medical benefits. In addition to the assignment of the medical benefits and/or insurance reimbursement above, I also assign and/or convey to the above named health care provider any legal or administrative claim or chose an action arising under any group health plan, employee benefits plan, health insurance or tort feasor insurance concerning medical expenses incurred as a result of the medical services, treatments, therapies, and/or medications I receive from the above-named health care provider (including any right to pursue those legal or administrative claims or chose an action). This constitutes an express and knowing assignment of ERISA breach or fiduciary duty claims and other legal and/or administrative claims.

I intend by this assignment and designation of authorized representative to convey to the above-named provider all of my rights to claim (or place a lien on) the medical benefits related to the services, treatments, therapies, and/or mediations provided by the above-named health care provider, including rights to any settlement, insurance or applicable legal or administrative remedies (including damages arising from ERISA breach of fiduciary duty claims). The assignee and/or designated representative (above-named provider) is given the right by me to (1) obtain information regarding the claim to the same extent as me; (2) submit evidence; (3) make statements about facts or law; (4) make any request including providing or receiving notice of appeal proceedings; (5) participate in any administrative and judicial actions and pursue claims or chose in action or right against any liable party, insurance company, employee benefit plan, health care benefit plan, or plan administrator. The above-named provider as my assignee and my designated authorized representative may bring suit against any such health care benefit plan, employee benefit plan, plan administrator or insurance company in my name with derivative standing at provider's expense.

Unless revoked, this assignment is valid for all administrative and judicial reviews under PPACA (health care reform legislation), ERISA, Medicare and applicable federal and state laws. A photocopy of this assignment is to be considered valid, the same as if it was the original.

AUTHORIZATION FOR TREATMENT

I authorize examination, diagnosis, and general treatment (including, but not limited to, the use of skin biopsies, labs and other non-invasive procedures such as diagnostic tests) to be performed by physicians and staff of Mays Dermatology & Cosmetic Center, PSC. I understand that any treatment/procedure other than an Office Visit (such as Liquid Nitrogen and biopsy) may not be covered under my co-pay but might be applied to my deductible**. I realize that if a medical procedure such as a biopsy or surgery is required, I will be given additional information. <u>IN THE EVENT THAT A BIOPSY IS PERFORMED</u> I understand and consent to the following:**
I may be responsible for a separate fee related to processing and examination of my tissue specimen(s).
Tissue specimen(s) will be sent to a laboratory for analysis to confirm a diagnosis. Furthermore, additional costs may be incurred for consultation fees and from additional special studies if indicated. Any additional questions or issues must be addressed with my insurance carrier. I am responsible for all costs which are not covered by my insurance plan. if I do not have insurance coverage, I assume all financial responsibility with laboratory fees.

ADDITIONAL AUTHORIZATION FOR THE MEDICAL TREAMTENT OF A MINOR/CHILD
I hereby authorize Mays Dermatology & Cosmetic Center to treat me or my dependent. All minors seeking medical treatment must be accompanied by a parent/legal guardian during the first office visit. After the initial appointment, a minor may be seen for treatment only with written and signed authorization from the parent/guardian which must be presented by the time of the appointment. This authorization will be valid for sevens year from the date it was signed. If you choose to send your child as an unaccompanied minor to an appointment, you must agree to all of the following:

I authorize Mays Dermatology& Cosmetic Center to write new prescriptions as deemed necessary for treatment. I authorize Mays Dermatology& Cosmetic Center to refill medications as deemed necessary for treatment. I authorize Mays Dermatology& Cosmetic Center to treat a new diagnosis as deemed necessary. I authorize my minor child to give verbal consent for minor procedures such as freezing/injecting/topically treating warts, injecting cysts, lancing boils. I agree that, should my child need any other procedures, including biopsies or excisions, these will have to be rescheduled for a time when he or she may be accompanied by a parent, legal guardian, or other person authorized to give consent.
I have read, fully understand and agree with the above.

Patient Name : ________________________________ DOB_____________________

X____

PATIENT/GUARDIAN SIGNATURE DATE