skinfocused dermatology

patient information

first name: _____last name:_____

address: _____
street address city state zip

email: _____ date of birth: _____ gender: M F

cell telephone: _____ land line home number: _____

let us know if you were referred by a friend! if so, who?_____

past medical history: _____

past surgical history: _____

skin cancer history (please note type and location):_____

medications: please list all current medications

_____

medication allergies:_____

are you allergic to latex or adhesives? yes no

are you pregnant,currently trying to get pregnant, or nursing? yes no

family history of melanoma (if yes, which relative): _____

preferred pharmacy: _____
name city/state zip code

privacy notice written acknowledgement

All healthcare providers are now required to have a formal privacy policy to protect your personal healthcare information. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires our practice to make these regulations accessible to our patients, and please know you have an opportunity to review our privacy notice. Please feel free to request a current copy that describes how your information is used and disclosed. In addition, your signature acknowledges that Skinfocused Dermatology has the right to change this notice at any time.

_____ _____
signature (and relationship, if other than patient) date

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certification of active and valid insurance and assignment of benefits

patient name: _____
last first
primary insurance carrier: _____ ID number:_____
subscriber/name of insured: _____ subscriber DOB: _____
relationship to subscriber: self spouse parent child

secondary insurance carrier (if you have one): _____
subscriber/name of insured: _____ relationship to subscriber: _____
ID number: _____subscriber DOB: _____

- I hereby authorize Skinfocused Dermatology to release any of my medical information necessary to process this claim and also authorize payments directly to Skinfocused Dermatology.
- I hereby voluntarily consent for examination and treatment by the physicians of Skinfocused Dermatology LLC.
- I voluntarily declare that I have **valid and active health insurance** as detailed above for the doctor visit and am responsible for payment if my health plan is not one that Skinfocused Dermatology participates with.
- I fully understand that I will be responsible for payment of the services rendered by Skinfocused Dermatology if my insurance is not valid and active at the time of service and/or if my health plan determines that the services I receive at this facility are, in their opinion, not medically necessary.
- I also understand that I am responsible for all deductible, co-payment, and co-insurance amounts as indicated by my health plan and agree to pay in a current manner, any balance of said professional service charges over and above this insurance payment.
- A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.
- IF a referral letter or authorized referral number is REQUIRED by my insurance carrier in order to assure that it is a covered benefit to see the specialist physicians of Skinfocused Dermatology, I acknowledge that I elect to receive care if that referral letter or authorization has not been obtained by me. The full cost for the visit will be considered the patient's responsibility. If you are able to obtain a referral after the fact for the visit, your paid fee will be refunded to you after your insurance processes the claim (minus any deductible, copayments, or patient responsibility).
- ***Please keep in mind*** – if you are here for a **cosmetic** service and a medical opinion is sought and documented – we will be required to submit a claim to your insurance which may result in a copayment as well as additional financial patient responsibility (dependent upon your plan).

_____ _____
signature (and relationship, if other than patient) date