Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

FINANCIAL POLICY

Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. It is our policy to expect payment from the patient or responsible party for services rendered. If we are billing a contracted insurance company, we are obligated to collect all co-payments up-front at check-in.

Please review and sign on the next page in regards to the policy listed below:

Private Pay (Self Pay): Payment is due at the time of service and will be collected up-front at check-in. Self Pay patients will be given a 15% discount on all services, if paid at time of service; full price will apply if payment is not made at time of service.

Policy Benefits/Non-Covered Charges: I understand that it is my responsibility to know my insurance policy coverage and benefits. It is my responsibility to notify The Clinic for Dermatology and Wellness, LLC ("The Clinic") of any insurance changes in a timely manner. I understand that many insurance companies have additional stipulations that may affect my coverage. I am responsible for any amounts not covered by my insurer. Services rendered may be considered non-covered by insurance and/or may be subject to deductible in addition to a co-pay. I understand that I have the right to refuse any services before they are rendered if I think that they are non- covered services or not payable by my insurance.

I understand that my insurance card and photo ID will be required to be presented at check-in for my appointment. I understand that these cards will be scanned into the Clinic's system and used for all healthcare claim submissions on my behalf.

Out-of-Network Insurance Plans: I understand that full payment may be required if I choose to be seen using an out-of-network insurance plan.

In-Network Insurance Plans: I understand that I must provide a copy of my current insurance card in order to file an insurance claim. If I do not have my insurance card, self-payment guidelines will apply and payment in full will be collected up-front at time of service. If I produce my insurance card at a later time, the Clinic will attempt to bill my insurance on my behalf and will reimburse any insurance overpayment due to me. I authorize the release of my medical information necessary to process an insurance claim on my behalf. I understand and agree to this financial policy. I request that my medical insurance carrier make any payments to The Clinic for Dermatology and Wellness, LLC for services rendered to me.

Co-payments: I understand that The Clinic may be contracted with my insurance company and the contract likely requires that The Clinic collect all co-pays up-front at check-in. I understand that The Clinic for Dermatology and Wellness, LLC has providers that are considered specialists; higher co-pays may be required.

No-Shows: Two missed appointments will result in a $100 deposit before any further appointments are scheduled. Three missed appointments will result in dismissal from The Clinic's practice.

Account Balances: If I have a balance on my account I will receive monthly statements until the account is paid in full. Bills are due and payable upon receipt of these monthly statements. The Clinic will bill my insurance, if I provide the appropriate billing information. My insurance will make payment directly to The Clinic for Dermatology and Wellness, LLC and I will be responsible for any deductible, co-payment, patient balance or co-insurance amounts.

Managed Care (Medicaid): I understand that my insurance coverage is based on funding levels. There are some diagnoses that are considered non-covered and my insurance will not pay for these services or conditions. The Clinic for Dermatology and Wellness, LLC will not bill any managed care plan for these non-covered services rendered at the office. A waiver must be signed prior to services rendered; I will need to pay cash for services not covered by Medicaid.

Medicare Patients: The Clinic for Dermatology and Wellness, LLC is a participating provider with Medicare. Medicare will pay 80% of allowed services, minus my annual deductible. If my annual deductible has not been met, I will be responsible for my deductible and 20% of the allowed charges at each visit. Also, by signing this agreement, I authorize any holder of medical or other information regarding me to release such information to the Social Security Administration effective from this date.

Procedures: The Clinic will attempt to request Prior Authorization for all procedures prior to my arrival, however it is my responsibility to confirm approval status with my insurance prior to arrival for my procedure. If I choose to undergo a procedure without Prior Authorization approval, I will owe 50% up-front at check-in. The Clinic will attempt to bill my insurance on my behalf and will reimburse any insurance overpayment due to me.

Cosmetic and Aesthetic Services: The Clinic for Dermatology and Wellness, LLC requires payment in full up-front, at check-in, for any cosmetic or aesthetic services. Insurance companies rarely cover these procedures. In the event that a treatment can be covered by insurance, The Clinic will attempt to bill my insurance on my behalf and will reimburse any insurance overpayment due to me. Non-refundable deposits are required for many aesthetic services at time of scheduling.

Ancillary Services: I understand that it is my responsibility to know from whom my insurance company requires me to obtain any labs, x-rays, or any other ancillary services. I agree to let my providers' medical staff know so that they may schedule these services accordingly. These charges are billed separately and are no relation to The Clinic for Dermatology and Wellness, LLC.

Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

FINANCIAL POLICY (continued)

Worker's Compensation / Motor Vehicle Accident (MVA): I understand that The Clinic for Dermatology and Wellness, LLC does not participate with worker's compensation claims nor motor vehicle accident claims. Full payment is due at the time of service.

Returned Checks: I understand that personal checks returned for non-sufficient funds will be charged a fee of $35; balances must be handled by cash, credit card, or money order.

Past Due Accounts: I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter mailed. I agree to contact The Clinic before this if I would like to set up payment arrangements.

Authorization for Disclosure of Information for Purposes of Service Reimbursement: I hereby authorize The Clinic for Dermatology and Wellness, LLC to disclose all or part of the medical record of the above patient to any company that may be responsible for payment of all or part of that patient's medical charges. Disclosure of the medical record may be necessary to determine eligibility for benefits and to obtain reimbursement for health care services. I hereby release The Clinic for Dermatology and Wellness, LLC from all legal responsibility or liability that may arise from disclosure of these records. I understand that I may revoke this authorization at any time in writing except to the extent that The Clinic for Dermatology and Wellness, LLC has already taken action on my claim(s).

Assignment of Benefits: I give lifetime authorization for payment of insurance benefits to The Clinic for Dermatology and Wellness, LLC for any services rendered. I understand that I am financially responsible for all charges whether or not they are covered by insurance. I further expressly agree and acknowledge that my signature on this document authorizes my provider to submit claims for services rendered. I hereby authorize this health care provider to release all information necessary to secure payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

By signing this Financial Policy, I, the guarantor, acknowledge that I have read, understand and accept all of the above policies. I further attest that my insurance information provided (if any) at check-in, is true and accurate.

Signature of Patient or Guardian _____ Date _____

Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

Health Information Portability and Accountability Act (HIPAA) Disclosure Form

I understand that *The Clinic for Dermatology & Wellness, LLC* (referred to below as "*The Clinic*") will use and disclose health information about me, as detailed below.

I understand that my health information may include information both created and received by *The Clinic*, may be in the form of written or electronic records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health-related information.

I understand and agree that *The Clinic* may use and disclose my health information in order to:

1. Make decisions about a plan for my care and treatment.
2. Refer to, consult with, coordinate among, and manage along with other healthcare providers for my treatment.
3. Determine my eligibility for health plan or insurance coverage, and submit bills, claims, and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
4. Perform various office, administrative and business functions that support my provider's efforts to provide me with, arrange, and be reimbursed for quality, cost-effective healthcare.

I also understand that I have the right to receive and renew a written description of how *The Clinic* will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information made and the information practices followed by the employees, staff and other office personnel of *The Clinic*, and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of *The Clinic*'s Notice of Privacy Practices in effect is available on The Clinic's website and at the front desk upon request.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in this Notice of Privacy Practices, and I understand that *The Clinic* is not required by law to agree to such requests.

BY SIGNING BELOW, I AGREE THAT I HAVE REVIEWED AND UNDERSTAND THE INFORMATION ABOVE AND THAT I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES.

By: _____ Date: _____
(Patient)

– OR –

By: _____ Date: _____
(Patient's Representative)

Description of Representative's Authority:

_____

*** CONTINUED ON NEXT PAGE ***

Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

PATIENT HEALTH QUESTIONNAIRE

PRIMARY CARE PROVIDER: _____

PHARMACY: _____

PAST MEDICAL HISTORY

Have you had any of the following conditions?

- ☐ anxiety
- ☐ arthritis
- ☐ asthma
- ☐ BPH
- ☐ breast cancer
- ☐ colon cancer
- ☐ COPD
- ☐ coronary artery disease
- ☐ depression
- ☐ diabetes
- ☐ end stage renal disease
- ☐ hepatitis
- ☐ HIV/AIDS
- ☐ hypercholesterolemia
- ☐ hypertension
- ☐ hyperthyroidism
- ☐ hypothyroidism
- ☐ leukemia
- ☐ lung cancer
- ☐ lymphoma
- ☐ prostate cancer
- ☐ radiation treatment
- ☐ seizures
- ☐ stroke

PAST SURGERIES

Have you had any previous surgeries? If so, what and when? _____

_____

SKIN DISEASE HISTORY

Do you wear sunscreen? ☐ Yes ☐ No - If yes, what SPF? _____

Have you ever used a tanning salon? ☐ Yes ☐ No

Have you had any of the following?

- ☐ acne
- ☐ actinic keratoses
- ☐ asthma
- ☐ blistering sunburns
- ☐ dry skin
- ☐ eczema
- ☐ flaking or itchy scalp
- ☐ hay fever/allergies
- ☐ melanoma
- ☐ precancerous mole
- ☐ psoriasis
- ☐ skin cancer - type if known: _____

MEDICATIONS / SUPPLEMENTS

Are you currently on prescription medication? ☐ Yes ☐ No - If yes, please list **with dosage**:

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

ALLERGIES

Do you have any allergies (including medications)? ☐ Yes ☐ No – If yes, type of reaction: _____

If yes, what? _____ Are you allergic to shellfish? ☐ Yes ☐ No

Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

PATIENT HEALTH QUESTIONNAIRE (CONTINUED)

SOCIAL HISTORY

Occupation + Workplace: _____

Please check all that apply:

- ☐ Currently smokes
- ☐ Never smoked
- ☐ Previous Smoker – Date quit _____
- ☐ Drug use
- ☐ Alcohol use – How many drinks per day? _____

VACCINATIONS / QUALITY MEASURES

For patients 65 and older: Have you received a pneumonia vaccination? ☐ Yes ☐ No

REVIEW OF SYSTEMS

Do you have any of the following currently?

- ☐ **pregnancy or planning a pregnancy**
- ☐ problems with bleeding
- ☐ problems with scarring (hypertrophic or keloid)
- ☐ rash
- ☐ fever or chills
- ☐ thyroid problems
- ☐ abdominal pain
- ☐ joint aches/muscle aches
- ☐ headaches
- ☐ cough
- ☐ depression
- ☐ other _____

ALERTS

Do you have any of the following?

- ☐ allergy to adhesive
- ☐ allergy to lidocaine
- ☐ allergy to topical antibiotic ointments
- ☐ artificial heart valve
- ☐ artificial joints (within past 2 years)
- ☐ blood thinners
- ☐ defibrillator
- ☐ pacemaker
- ☐ premedication prior to procedures
- ☐ rapid heartbeat with epinephrine
- ☐ dizziness
- ☐ breastfeeding

FAMILY HISTORY

Relative	Age at Death	Disease	Age when diagnosed
Father	_____	_____	_____
Mother	_____	_____	_____
Sibling	_____	_____	_____
Sibling	_____	_____	_____

Patient Signature: _____ Date: _____

Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

PATIENT DEMOGRAPHIC FORM

PATIENT INFORMATION

Gender: ☐ Male ☐ Female

Race: ☐ White / Caucasian ☐ Native American ☐ Asian ☐ Black / African American ☐ Hispanic / Latino
☐ Native Hawaiian / Pacific Islander ☐ Other_____ ☐ I decline to provide this

Mailing Address: _____
City: _____ State: _____ Zip: _____

Marital Status: ☐ Married ☐ Single / Never Married ☐ Divorced / Annulled / Separated ☐ Widowed

PATIENT CONTACT INFORMATION

Preferred #? (choose one)

☐ Mobile Phone #: (_____)_____-_____ Is it okay to leave a detailed message? ☐ Yes ☐ No

☐ Home Phone #: (_____)_____-_____ Is it okay to leave a detailed message? ☐ Yes ☐ No

☐ Work Phone #: (_____)_____-_____ Is it okay to leave a detailed message? ☐ Yes ☐ No

Email: _____

PATIENT EMPLOYMENT INFORMATION

Employer: _____ Occupation: _____
Street Address: _____
City: _____ State: _____ Zip: _____

EMERGENCY CONTACT INFORMATION

First Name: _____ MI: _____ Last Name: _____
Emergency Phone #: (_____)_____-_____

Relationship to Patient: _____

Emergency Street Address: _____
City: _____ State: _____ Zip: _____

GUARANTOR (if applicable)

Relationship to Patient: _____
Guarantor Last Name: _____ First Name: _____ Middle Initial: ____
Guarantor Date of Birth: _____/_____/_____ Guarantor Gender: ☐ Female ☐ Male
Guarantor Street Address: _____
City: _____ State: _____ Zip: _____
Guarantor Employer: _____ Guarantor Employer Phone: _____

*** OPTIONAL ***

Patient Name (Last, First MI): _____

Date of Birth: _____ /_____ /_____

Authorization to Disclose Health Information to Family or Other Designated Persons

I, _____, direct my health care and medical services providers and payers to
(Name of the Individual Giving this Authorization)
disclose and release my protected health information described below to:

Designated Person Information:

First Name: _____ **MI:** _____ **Last Name:** _____

Phone #: (_____) _____ - _____ **Relationship to Patient:** _____

Street Address: _____

City: _____ **State:** _____ **Zip:** _____

Health Information to be disclosed upon the request of the person named above (choose either A or B below):

☐ **A.** Disclose my complete health record (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing, for all conditions) **OR**

☐ **B.** Disclose my health record, as above, BUT do not disclose the following (check as appropriate):
- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS) Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

Form of Disclosure: An electronic record or access through an online portal Hard copy (unless another format is mutually agreed upon between my provider and designee)

This authorization shall be effective until (Check one):

- ☐ All past, present, and future periods, OR
- ☐ Date or event: _____ unless I revoke it.

(NOTE: You may revoke this authorization in writing at any time by providing written notice to your health care provider(s).)

Signature: _____ **Date:** _____

Note: HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

*** OPTIONAL ***