

# SIGNATURE DERMATOLOGY

(614) 777-

1200

**Patient's Name** \_\_\_\_\_

First

Middle

Last

**Address** \_\_\_\_\_

Street

Apt #

City

State

Zip

**Birthdate** \_\_\_\_\_ **Social Security #** \_\_\_\_\_ ☐ Female ☐ Male

**Home #** \_\_\_\_\_ **Cell #** \_\_\_\_\_ **Email:** \_\_\_\_\_

**Marital Status:** ☐ Single ☐ Married to \_\_\_\_\_ ☐ Other \_\_\_\_\_

**Patient's Employer** \_\_\_\_\_ **Occupation** \_\_\_\_\_

**Primary Care Physician** \_\_\_\_\_ **Practice Name** \_\_\_\_\_ **Phone** \_\_\_\_\_

**Emergency Contact** (*not in your household*): \_\_\_\_\_

**Phone #** \_\_\_\_\_ **Relationship to Patient:** \_\_\_\_\_

**Do you give our office permission to discuss your medical information with family members?**

☐ Yes ☐ No If yes, please provide their names and phone numbers below.

**Name:** \_\_\_\_\_ **Relationship:** \_\_\_\_\_

**Phone # (day)** \_\_\_\_\_ **Phone # (evening)** \_\_\_\_\_

**Please list any other contact persons that we may discuss results or answer questions:**

**Name** \_\_\_\_\_ **Phone #** \_\_\_\_\_

**May we leave personal medical information on your answering machine or cell phone?** ☐ Yes ☐ No

**May we email you personal medical information?** ☐ Yes ☐ No

**Please include PRIMARY INSURED PERSON, Guardian or Parent Information Here:**

**Name** \_\_\_\_\_

First

Middle

Last

**Birthdate** \_\_\_\_\_ **Social Security #** \_\_\_\_\_

**Relationship to Patient** \_\_\_\_\_ **Employer** \_\_\_\_\_

I understand that office visit charges are payable on the day the service is rendered. I authorize Signature Dermatology, LLC to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that my contract is between Signature Dermatology and myself.

**Signature** \_\_\_\_\_

**Date** \_\_\_\_\_



## HIPAA Notice

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. We are also required to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Please sign the accompanying "Acknowledgment" form. Please note that by signing the Acknowledgment form you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Acknowledgment of Receipt of the Notice of Privacy Practices

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Signature of Patient or Representative

Print Name

Date



## FINANCIAL POLICY

### INSURANCE AND SELF PAY GUIDELINES

Upon receiving insurance details, we will make our best effort to verify coverage and determine in-network or out-of-network status. We will collect your office visit co-pay based on our insurance verification systems. We may provide estimates on patient responsibility and discuss payment options. After verification, we will file your claims with your insurance company after every date of service. It is ultimately your responsibility to pay any deductible, co-insurance, or any balance not paid by your insurance company due to non-covered benefits or out-of-network status. Self-pay patients are responsible for payment at time of service.

### NO SHOWS/CANCELLATIONS WITHIN 24 HOURS

- A \$25 no show/cancellation fee will be applied for all office and aesthetician appointments. The \$25 fee will be required to be paid BEFORE scheduling another appointment for you or immediate family members.
- A \$50 no show/cancellation fee will be applied for all surgery and cosmetic appointments with our physicians.
- A \$100 fee will be applied to all patch testing appointments not cancelled prior to 5pm on Friday before the first appointment.

### PAYMENT DETAILS

All patient balances are due immediately upon receipt. All dependents and spouses in the same household will be responsible for outstanding balances. Patients with upcoming appointments must pay their balance(s) in full prior to their next appointment. Payment plans are available, but must be discussed with our billing department in order to agree upon terms.

- A \$10 late fee will be applied for all balances under \$100 after 30 days.
- A \$15 late fee will be applied for all balances \$100 and over after 30 days.
- A \$25 fee will be applied for all returned checks.

### COLLECTIONS/PENDING COLLECTIONS

- All balances sent to collections will be charged a \$20 collection fee.
- All balances pending collections or balances with a history of collections authorizes SD to retain any credit/debit card used on the account for payment of overdue balances.

I have read the above financial information and understand my responsibilities as a patient.

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Signature of Patient or Representative

Print Name

Date

## SIGNATURE DERMATOLOGY

## Medical History Form

Name: \_\_\_\_\_

Current Medications (dosage NOT necessary): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_

## PERSONAL HISTORY

Asthma	NO	YES	
Cancer (non-skin related)	NO	YES	Type of Cancer :
Diabetes	NO	YES	
Eczema	NO	YES	
Hepatitis	NO	YES	Type of Hepatitis :
High Blood Pressure	NO	YES	
HIV	NO	YES	
Hives	NO	YES	
Lupus/Connective Tissue Disease	NO	YES	
Pacemaker/Defibrillator	NO	YES	
Psoriasis	NO	YES	
Skin Cancer	NO	YES	Type of SKIN cancer :
Stroke	NO	YES	
Thyroid Disorder	NO	YES	
Tuberculosis	NO	YES	
Other Medical Problems	NO	YES	List:

FAMILY HISTORY	Family Member(s)	Details
Skin Cancer		
Skin Disease		

FEMALE PATIENTS: Are you pregnant or breastfeeding? YES NO

Social History (please check):

## ALCOHOL

	NO
	YES – Daily
	YES – Socially

## TOBACCO

	NO
	YES - Smoking
	YES – Chewing

## TANNING

	NO
	YES - Tanning Beds
	YES - Sunbathing