

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** _____

Primary Emergency Contact: _____ **Phone #** _____ **Relationship:** _____

Secondary Emergency Contact (*not in your household-if different from above*): _____

Phone # _____ **Relationship:** _____

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: _____ **Phone #** _____ **Relationship:** _____

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:

<p>Name _____ First Middle Last</p> <p>Birthdate _____ Social Security # _____</p> <p>Relationship to Patient _____ Employer _____</p>

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

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 \$35 no show/cancellation fee will be applied for all office appointments.
The \$35 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 and aesthetician.
- A \$100 no show/cancellation fee will be applied for all Mohs surgery appointments.
- A \$100 fee will be applied to all patch testing appointments not cancelled prior to 5pm on Friday before the first appointment.
- All accounts which acquire no show/cancellation fees authorizes SD to retain any credit/debit card used on the account for payment of fee which will be charged on the missed appointment date.

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 to agree upon terms prior to your appointment time.
- A \$10 late fee will be applied for all balances after 30 and 60 days past due.
- A \$35 fee will be applied for all returned checks.

COLLECTIONS/PENDING COLLECTIONS

- Accounts with a remaining balance will be considered pending collections 90 days from the first statement date.
- All balances pending collections authorize SD to retain any credit/debit card used on the account for payment of overdue balances to prevent account from being sent to collections and to avoid collection fees mentioned below.
- All accounts sent to collections will be charged a \$30 collection fee for balances under \$200, or a \$50 collection fee for balances over \$200.
- I consent to Signature Dermatology contacting me at any telephone number or email address I provide. I consent to communications from Signature Dermatology's staff or third parties working on behalf of Signature Dermatology. I consent to communications originating from automatic dialing devices and/or automated messages. I consent to receiving text messages to the mobile telephone numbers I provide. I acknowledge text messages may be for appointment reminders, education, account balance(s), survey participation, other healthcare services or related to any lawful purpose. I know that none of my Protected Health Information will be sent. I understand that data usage and other charges from my mobile service provider may apply. I may stop all text messages by replying STOP. If I do not agree to receive text messages, I know I can still get care from Signature Dermatology if I am in good standing.

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

Signature of Patient or Representative

Print Name

Date

Signature Dermatology

Medical History Form

Name: _____ Preferred Pharmacy: _____

Primary Care Physician: _____ Height (inches): _____ Weight (pounds): _____

Current Medications (dosage NOT necessary): _____

Allergies: _____

PERSONAL HISTORY

Asthma	NO	YES	
Artificial Valve/Joint	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

<input type="checkbox"/>	NO
<input type="checkbox"/>	YES – Daily
<input type="checkbox"/>	YES – Socially

TOBACCO

<input type="checkbox"/>	NO
<input type="checkbox"/>	YES - Smoking
<input type="checkbox"/>	YES – Chewing

TANNING

<input type="checkbox"/>	NO
<input type="checkbox"/>	YES - Tanning Beds
<input type="checkbox"/>	YES - Sunbathing

Signature Dermatology

Please Circle All Concerns/Treatments That You Would Like to Discuss

This form is optional. Your provider will try their best to discuss these items during today's visit but may recommend a separate cosmetic consultation to discuss treatment options in full detail.

Prevention and Correction of Fine Lines

Crow's Feet

Lines of Forehead

Lines Around Mouth

Microneedling

Facial Vessels

Broad Band Light (BBL)

Brown Spots

Skin Discoloration

Hyaluronic Acid Fillers – Juvéderm,

Vollure, Volbella, Voluma, Volux

Volume Loss of Face

Volume Loss of Mid-Face

Volume Loss of Chin

Volume Loss of Lips

Volume Loss Under Eye

Please List the Current Products You Are Using or Leave Blank If None

Facial Cleanser: _____

Sunblock: _____

Moisturizer: _____

Eye Cream: _____

Morning Cream: _____

Night Cream: _____