Corederm Dermatology & Cosmetic Center

Please present ALL Insurance cards and Drivers License to the receptionist at every visit.

Patient Information: **Please Complete All Fields Using Legal Names of the Parties Involved.**
First name:____________________________ **Last name:** _________________________
Home address: ____
City: _________________ **State:** ______________ **Zip:** ___________
Email: ____________________ **SSN:** ___________________
Date of birth: ____________ **Age:** _____ **Gender:** Female ❑ Male ❑
Home phone: _____________________ **Cell phone:** ______________________
Is it Okay to leave a detailed message on your home phone? Yes ❑ No ❑ **Cell phone?** Yes ❑ No ❑
Marital status: Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other ❑
Preferred Language: ________________________
Race: White ❑ American Indian or Alaska Native ❑ Asian ❑ Black or African American ❑
Native Hawaiian or other Pacific Islander ❑ Other ❑
Ethnic group: Hispanic or Latino ❑ Not Hispanic or Latino ❑ Unknown ❑
Emergency contact: _________________________ **Contact #** ____________________________
Employer's name: __________________ **Occupation**: _______________ **Work #** ______________
Primary doctor (name, location, phone): ____
Referring doctor (name, location, phone): ____
New patients: How did you hear about Corederm? ____

INSURANCE INFORMATION

Primary Insurance Plan: ___________________________ **ID #** _______________________
Plan Holder's Name: __________________ DOB: ___________ Relationship to patient: ______________
Mailing address of Plan Holder if different from patient: ____
Home # of Plan Holder: ________________________ Cell # of Plan Holder: ________________________

Secondary Insurance Plan: _______________________ ID # ____________________________
Plan Holder's Name: _________________ DOB: __________ Relationship to patient: _______________

Patient Release: MUST BE SIGNED BY PATIENT OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I understand I am responsible for co-insurances, co-payments and deductibles. If I am not insured or Corederm Dermatology & Cosmetic Center does not participate in my plan I am responsible for payment in full at the time of service. I further understand that full payment of cosmetic services is due at the time services are rendered.

I certify that I hereby authorize Corederm Dermatology & Cosmetic Center , its providers and staff to provide my minor child in my absence with examinations and basic treatments following the initial visit for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

PATIENT OR LEGAL GUARDIAN SIGNATURE: ______________________________ Date: _________________

Corederm Dermatology & Cosmetic Center

Patient Name: ____________________________________ Date: ____________________

APPOINTMENT CANCELLATIONS

If I am unable to keep my scheduled appointment, I will call Corederm Dermatology & Cosmetic Center to cancel or re-schedule my appointment. Medical appointments require a 24-business-hour cancellation notice. Cosmetic and surgical appointments require 48 business- hour notice and Mohs surgery requires 72 business-hour notice. If I do not call Corederm Dermatology & Cosmetic Center to cancel my appointment, I may be charged the no show fees listed below.

NO SHOWS/ Failure to cancel within time frame outlined above.

Failure to arrive for my scheduled appointment may result in a $25.00 fee for regular appointments and a $100 fee for all surgical appointments (Mohs/ excisions) and loss of my deposit for cosmetic appointments. I understand I will forfeit one treatment if I am in a pre-paid cosmetic package with multiple treatments.

LATE ARRIVALS

Corederm Dermatology & Cosmetic Center strives to stay on time as often as possible. There are times surgeries run long or patients present with complicated medical needs which causes providers to run behind. Patients arriving past their scheduled appointment time and being added into the schedule causes significant issues for the practice and other patients. Therefore, I understand should I arrive 10 minutes past my scheduled time will essentially cancel my appointment. Should the provider or their associate have an opening the same day, I may ask to be seen in that time slot and know there may be a wait in doing so. Should the provider or their associate not have any openings for the day, I understand I will have to reschedule my appointment.

INSURANCE/ REFERRAL POLICY

I understand that I must provide a copy of my insurance card along with a photo ID or drivers license at every visit.
It is my responsibility to know if my insurance plan requires a referral to see a specialist. If my insurance plan requires a referral, it is my responsibility to obtain an updated referral from my Primary Care Physician and to make sure Corederm Dermatology & Cosmetic Center has the referral before my visit. I further understand that it is my responsibility to keep track of the number of visits I have used on my referral and the expiration dates of referrals and will obtain new ones as needed. I understand that should I fail to have a valid referral for my visit, Corederm Dermatology & Cosmetic Center is not authorized to see me. I will need to reschedule my appointment. If I fail to reschedule my appointment and chose to be a self-pay patient in lieu of rescheduling and obtaining a referral, I am completely responsible for all charges incurred and must pay at the time of service in full. I understand my insurance company will not reimburse me for this visit.

INSURANCE POLICIES

I will confirm my insurance is current at each visit. If there is a change to my insurance I will provide a valid insurance card or temporary print out at the time of my visit. If I am unable to produce this documentation I will pay in full at the time of the visit and submit my claim to the insurance company for reimbursement or will need to reschedule my appointment. My insurance carrier may consider certain routine services in dermatology to be surgical in nature and separate co-insurances, deductibles or co-payments may apply. Each insurance plan is different and I understand it is my responsibility to understand my policy and what will be covered. I understand in signing below that I am responsible for notifying Corederm Dermatology & Cosmetic Center of any changes to my insurance or contact information. If insurance or referral information I present at the time of my visit is not correct, I will be responsible for all charges incurred.

ACCOUNT BALANCES

All balances are due in full within 30 days of my first billing. If my balance is unpaid after 60 days, I understand I will incur a $25.00 administrative billing fee. Any balance left unpaid after 90 days will be considered for collections. It is my responsibility to contact the office to arrange for an acceptable payment plan should I be unable to pay my balance in full. Should my account be sent to collections, I understand I will be responsible for an additional 15% administrative collection fee plus any attorney / court fees which may be added to my account during efforts to obtain payment. I am responsible for any bank fees associated with returned check fees plus a $25.00 administrative processing fee. Any returned check must be paid in full via credit card or cash within 15 days of notice or legal efforts to collect balance will be instituted.

MINOR PATIENTS

Patients under the age of 18 must be accompanied by an adult or legal guardian for their initial visit. The adult that accompanies the minor to the initial visit is held responsible to pay any co-pays or balances due. Minor patients being accompanied by a non-family member should provide a note of permission from the parent/guardian of the patient for the initial visit.

INSURANCE INQUIRIES

From time to time I may receive a letter from my insurance company requesting information about my coverage. I understand that claims will not be paid without my providing this information. I will reply to all insurance inquiries within 30 days of receipt or the balance will become my responsibility to pay.

Patient or Guardian Signature: _______________________________________ Date: ______________________

Corederm Dermatology & Cosmetic Center

Patient Name: ___________________________________ **Date:** ____________________

HIPAA POLICY

Patients 18 years of age or older are protected under the Federal **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct. This federal law prohibits any staff member of **COREDERM** from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or care takers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition / obtain results for you, please list their name(s) below. Only individuals names listed will be provided with information. Should you wish to update the names provided, please ask the receptionist at the front desk for a HIPPA form.

Name of Individual ____________________________________Relationship_______________________

Name of Individual ____________________________________Relationship_______________________

Name of Individual ____________________________________Relationship_______________________

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge and understand the above HIPAA policy and understand I was given the opportunity to review the Notice of Privacy Practices that is displayed in the waiting area. I understand a copy of the Privacy Practices is available upon my request (please ask our front desk staff).

Patient Signature: ____ Date: ___________________

Must be signed by patient 18 years or older. Patients under 18, must be signed by a parent or guardian.

Corederm Dermatology & Cosmetic Center

Name ____ Date_________________________

Past Medical History: (please circle all that apply

Anxiety
Arthritis
Asthma
Atrial Fibrillation (irregular Heartbeat)
BPH (enlarged prostate)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD

None
Hearing Loss
Hepatitis
Hypertension (high blood pressure)
HIV / AIDS
Hypercholesterolemia (high cholesterol)
Hyperthyroidism (overactive)
Hypothyroidism (underactive)
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

Other Important Medical History: ____

____

Past Surgical History: (please circle all that apply)

Appendix
Bladder
Breast
Colon
Gallbladder
Heart
Valve replacement
Stent
Other: _____________

None
Joint
Which joint? _____________
When? ________________
Kidney
Ovaries
Prostate
Skin
Spleen
Testicles
Uterus

Other Surgeries: ____
Please explain surgeries circled above: ____

____

Skin Disease History: (please circle all that apply) None

Acne
Actinic Keratosis (pre-cancer)
Asthma
Basal Cell Skin Cancer
Blistering Sunburns

Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma

Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

Other Important Skin Disease History: ____
Do you wear Sunscreen? Yes No What SPF? ______
Do you tan in a tanning salon? Yes No

Family History: Do you have a family history of skin cancer? Yes No
If yes, which relative(s)? _________________ Which type? Squamous cell carcinoma, Basal cell carcinoma, Melanoma
Do you have a family history of any of the following? (please circle all that apply)
Please note: dad, mom, brother, sister, son, daughter

Arthritis
Breast Cancer
Cholesterol

Colon Cancer
Depression
Diabetes

Heart Disease
High Blood Pressure
Thyroid disease

Other family History: ____

____

____

(see reverse side)

Corederm Dermatology & Cosmetic Center

Please list primary Local Pharmacy (name, city, zip and phone)

____

Please list Mail Order Pharmacy (name) ____

Medications/Supplements: (please list all current medications)

1.	____________________	6.	____________________
2.	____________________	7.	____________________
3.	____________________	8.	____________________
4.	____________________	9.	____________________
5.	____________________	10.	____________________

Allergies to Medications: (Please enter all medication allergies and reactions)

____

Social History: (please circle all that apply)

Smoking Use:

Currently Smokes – daily
Currently Smokes – not daily
Has never smoked
Has smoked in the past

Alcohol Use: None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

IV Drug Use:

Other: ____

Do you have a healthcare proxy, power of attorney and/or a living will? Yes ❑ No ❑

Are you currently experiencing any of the following?: (please circle all that apply)

Changing mole
Rash
Problems with scarring (hypertrophic or keloid)
Problems with healing
Problems with bleeding
Yeast infections with antibiotics
GI upset with antibiotics
Pregnancy or planning pregnancy
Thyroid problems
Hepatitis
HIV/AIDS
Abdominal pain
Anxiety
Bloody stool
Bloody urine
Blurry vision
Chest pain
Cough
Depression
Fever or chills
Headaches
Hay fever
Immunosuppression
Joint aches
Muscle weakness
Neck stiffness
Night sweats
Seizures
Shortness of breath
Sore throat
Unintentional weight loss
Wheezing

Other: ____

Alerts: (please circle all that apply)

Allergy to adhesive
Allergy to latex
Allergy to lidocaine
Allergy to medication
Allergy to topical antibiotic ointments
Artificial heart valve
Artificial joints in the last two years
Blood thinners
Defibrillator
MRSA
Pacemaker
Personal history of atypical moles
Personal history of dysplastic nevi
Personal history of Melanoma
Premedication prior to procedures
Rapid heartbeat with epinephrine