

New Patient Information

LAST NAME	FIRST NAME	M.I.	
DATE OF BIRTH	SOC. SEC.	SEX	MARITAL STATUS
ADDRESS	PRIMARY PHONE		<input type="checkbox"/> CELL
CITY	STATE	ZIP	CELL PHONE
EMPLOYER	WORK PHONE		
PRIMARY PHYSICIAN	LAST SEEN	YOUR E-MAIL	
PHARMACY	LOCATION		PHARMACY PHONE
PREFERRED CONTACT METHOD	<input type="checkbox"/> PHONE	<input type="checkbox"/> PATIENT PORTAL	
PREFERRED REMINDER METHOD	<input type="checkbox"/> PHONE	<input type="checkbox"/> PATIENT PORTAL	<input type="checkbox"/> TEXT

INSURANCE INFORMATION

PRIMARY INSURANCE	ID NO.	GROUP NO.	
NAME OF SUBSCRIBER OR GUARDIAN IF MINOR	RELATIONSHIP		
ADDRESS	SUBSCRIBER SEX		
CITY	STATE	ZIP	SUBSCRIBER PHONE
SUBSCRIBER'S EMPLOYER	SUBSCRIBER SOC. SEC.	SUBSCRIBER DATE OF BIRTH	

PATIENT AUTHORIZATION

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to the physician for services.

Signature _____ Date _____

MANAGED CARE PATIENTS

I understand that it is my responsibility to obtain a valid referral from my primary care physician. I understand that if I do not obtain or do not have a referral on file I am responsible for payment for services. I further understand that I am responsible for payment for services that are considered non-covered expenses by my insurer.

Signature _____ Date _____

MEDICARE PATIENT AUTHORIZATION

I request the payment of authorized Medicare benefits be made on my behalf to Hudson Dermatology P.C. for services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature _____ Date _____

Medical History

Patient name _____ Date of birth _____

Have you ever been diagnosed with or treated for the following? (If yes, please check and give details)

- | | |
|--|--|
| <input type="checkbox"/> Anxiety _____ | <input type="checkbox"/> Hearing loss _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Hepatitis _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> High blood pressure _____ |
| <input type="checkbox"/> Atrial fibrillation _____ | <input type="checkbox"/> High cholesterol _____ |
| <input type="checkbox"/> Bone marrow transplant _____ | <input type="checkbox"/> HIV/AIDS _____ |
| <input type="checkbox"/> Breast cancer _____ | <input type="checkbox"/> Leukemia _____ |
| <input type="checkbox"/> Colon cancer _____ | <input type="checkbox"/> Lung cancer _____ |
| <input type="checkbox"/> COPD _____ | <input type="checkbox"/> Lymphoma _____ |
| <input type="checkbox"/> Coronary artery disease _____ | <input type="checkbox"/> Prostate cancer _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Radiation treatment _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Seizures _____ |
| <input type="checkbox"/> End stage renal disease _____ | <input type="checkbox"/> Stroke _____ |
| <input type="checkbox"/> GERD (reflux disease) _____ | <input type="checkbox"/> Other _____ |

Have you had major surgery? (If yes, please give details)

Yes No _____

Do you have a history of any of these skin conditions?

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Acne | <input type="checkbox"/> Yes <input type="checkbox"/> No Flaking or itchy scalp |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Actinic keratosis | <input type="checkbox"/> Yes <input type="checkbox"/> No Hay fever/allergies |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Melanoma |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Basal cell skin cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Poison ivy |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Blistering sunburns | <input type="checkbox"/> Yes <input type="checkbox"/> No Precancerous moles |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Dry skin | <input type="checkbox"/> Yes <input type="checkbox"/> No Psoriasis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eczema | <input type="checkbox"/> Yes <input type="checkbox"/> No Squamous cell skin cancer |
- Yes No Do you wear sunscreen regularly? If so, what SPF? _____
- Yes No Do you tan in a tanning salon?
- Yes No Have any of these members of your family had melanoma?
 Mother Father Sister Brother Unknown

Is there a family history of (mother, father, sister, brother only)

- | | |
|--|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Asthma | <input type="checkbox"/> Yes <input type="checkbox"/> No Psoriasis |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hay fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Eczema |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Hives | <input type="checkbox"/> Yes <input type="checkbox"/> No Skin cancer (non-melanoma) |



Do you take any prescription or non-prescription medications or supplements?

Yes (please list below) No

_____ Dosage_____ _____ Dosage_____
_____ Dosage_____ _____ Dosage_____
_____ Dosage_____ _____ Dosage_____
_____ Dosage_____ _____ Dosage_____

Please verify my prescription medications with my pharmacy

Are you allergic to any medications?

Yes (please list below) No

_____ Reaction_____ LOCATION Skin Local Abdominal Systemic
SEVERITY V Mild Mild Moderate Severe
ONSET Child Adult Unknown
_____ Reaction_____ LOCATION Skin Local Abdominal Systemic
SEVERITY V Mild Mild Moderate Severe
ONSET Child Adult Unknown
_____ Reaction_____ LOCATION Skin Local Abdominal Systemic
SEVERITY V Mild Mild Moderate Severe
ONSET Child Adult Unknown

Do you or did you smoke?

- Current every day smoker Smoker, current status unknown
 Current some day smoker Unknown if ever smoked
 Former smoker Heavy tobacco smoker
 Never smoked Light tobacco smoker

Do you sometimes drink beer, wine or other alcoholic beverages?

- No, don't drink Average 1 to 2 a day
 Average less than 1 a day Average 3 or more a day

Preferred language English Spanish Other_____

Race

- American Indian Native Hawaiian or other Pacific Islander
 Asian Native American or Native Alaskan
 Black or African-American White

Ethnicity Non-Hispanic Hispanic Not specified

Signature_____ Date_____
(parent or guardian if patient is a minor)

Payment Policies

IF YOU ARE COVERED BY AN INSURANCE PLAN WE ACCEPT

If we participate in your insurance plan, we will gladly submit your claim and wait for your insurer's payment. Your copayment is expected when you visit, so please be prepared with check, cash or credit card: MasterCard or Visa. There is a \$5 handling charge if we have to send you a bill for the copayment.

If your insurance requires an additional copayment for surgery or payment of a deductible, we will bill you when we receive payment from your insurance company. Please be familiar with your insurance coverage so that you are not surprised if your insurance requires an additional bill from us. You are responsible for paying claims denied by your insurance company. Patients who have not yet met their insurance deductible must prepay \$75 for the first visit and \$50 for subsequent visits.

IF YOU ARE COVERED BY AN INSURANCE PLAN WE DO NOT ACCEPT

We do not participate with Medicaid or with every insurance company. If you have insurance that we do not accept, you can still be seen as a private pay patient. Full payment will be due at the time of your appointment unless other arrangements have been made in advance.

INSURANCE ELIGIBILITY

We make every effort to determine your insurance eligibility at the time of your visit. If you provide an insurance card or ID number to us and it is later determined that your coverage had terminated before the date of your appointment, or if you change coverage and we do not participate with your new insurance plan (including Medicaid), you will be considered a private pay patient and will be responsible for the full balance due.

IF YOU ARE COVERED BY MORE THAN ONE INSURER

Your claim must go to your primary insurer first, even if it is not one we accept. It is likely that we will not receive payment from that insurer or a copy of the explanation of benefits, because of privacy rules. When you receive your payment, if any, or your rejection and explanation of benefits, you must forward them to us so that we can submit a claim to your secondary or tertiary insurer.

If your secondary or tertiary insurance is one in which we do not participate (including Medicaid), you will be considered a private pay patient and will be responsible for the full balance.

IF YOU ARE COVERED BY A MANAGED CARE PLAN REQUIRING A REFERRAL

You must get a valid referral from your primary care provider before your appointment. If you are a returning patient, please ask when you book your appointment whether your previous referral will still be valid. We will let you know if you need a new referral, but our office cannot get it for you; you must arrange that directly with your primary care physician.

CANCELLATIONS

If you need to cancel an appointment, you must do so at least 24 hours in advance. It is important to give us notice so that we may accommodate other patients. We will call you 48 hours before an appointment, and our automated reminder system lets you push a phone key to cancel. There will be a \$45 fee for appointments that are not kept or are canceled without at least 24-hour notice.

CONTINUED ►



LATE PAYMENTS AND COLLECTION FEES

Payment is due within 30 days of the billing date. If you do not pay promptly and your bill goes to a collection agency, you will be responsible for the collection agency fees, which may be as high as 35% of the outstanding amount.

RETURNED CHECKS

If a check is returned as not payable, the patient will be responsible for the amount of the check plus a \$25 bank fee, which we incur when a check is returned. This must be paid in cash or by money order, bank check or credit card.

I have read and understand both pages of Hudson Dermatology's payment policies and agree to abide by them.

Signature_____ Date_____



Privacy Consent

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my Protected Health Information. I understand that the information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

You have informed me of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my health information. I have been given the right to read and review your Notice of Privacy Practices before signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact the organization’s Privacy Officer to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations and I also understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient name (please print)_____

Signature_____ Date_____

Relationship to patient_____

Contact Information

May we leave a message about your appointment . . . ?

- On your answering machine Yes No
 With another person Yes No

May we leave a message concerning your test results . . . ?

- On your answering machine Yes No
 On your office voicemail Yes No
 On your cell phone Yes No
 With another person Yes No

Who is authorized to receive the information above? (Name and relationship)

Patient signature _____ Date _____

We will send a report on your visits to your referring doctor and your primary care physician unless you check here to instruct us not to.

Referring doctor _____

Other physicians to receive information _____

Patient signature _____ Date _____

How did you hear about our practice?

- Referred by the doctor above or another doctor _____
- Recommended by a Hudson Dermatology patient, friend or family member
- Insurance plan directory
- Google search Facebook Other web site _____
- Received a postcard from Hudson Dermatology
- In the yellow pages
- Saw your sign on the building or door
- Magazine or newspaper advertisement in _____
- Other _____