

New Patient Information

LAST NAME	FIRST NAME	M.I.	
DATE OF BIRTH	SOC. SEC.	SEX	MARITAL STATUS
ADDRESS		HOME PHONE	
CITY	STATE	ZIP	CELL PHONE
EMPLOYER		WORK PHONE	
REFERRING/ PRIMARY PHYSICIAN			

INSURANCE INFORMATION

PRIMARY INSURANCE	ID NO.	GROUP NO.	
NAME OF SUBSCRIBER			
ADDRESS		SEX	
CITY	STATE	ZIP	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 give details):

- Yes No Heart disease _____
- Yes No High blood pressure _____
- Yes No Cancer _____
- Yes No Stroke, thrombosis or blood clots _____
- Yes No Diabetes / thyroid disease _____
- Yes No Kidney disease _____
- Yes No Gastrointestinal disease (stomach, colon, liver, etc.) _____
- Yes No Infectious disease (Hepatitis, TB, AIDS, Lyme) _____
- Yes No Major surgery _____
- Yes No Difficulty with healing of wounds, keloids or bad scars _____
- Yes No Excessive bleeding or easy bruising _____
- Yes No Other skin disorders _____

Do you have a history of

- Asthma Yes No
- Hay fever Yes No
- Hives Yes No
- Eczema Yes No
- Psoriasis Yes No
- Skin cancer Yes No

Is there a family history of

- Asthma Yes No
- Hay fever Yes No
- Hives Yes No
- Eczema Yes No
- Psoriasis Yes No
- Skin cancer Yes No

Do you

- Smoke Yes No
- Burn easily Yes No
- Use sunscreen Yes No
- Have anemia Yes No

- Yes No Are you taking any medications (please list) _____
- Yes No Are you allergic to any medications (please list) _____
- Yes No Are you pregnant or nursing?
- Yes No Do you need antibiotics prior to surgery (even dental)?
- Yes No Do you have an implanted pacemaker or defibrillator?

Signature _____ Date _____

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 insurer requires you to pay surgical coinsurance, we will bill you when we receive your insurance payment. Please be familiar with your insurance coverage so any additional billing from us that your insurance requires does not come as a surprise.

Your insurer may send you a questionnaire about student status or other insurance coverage you may have. If you receive such a questionnaire, be sure to fill it out and return it to your insurer immediately. If the insurer does not receive a response, it may not pay your claim and you will have to pay out of pocket.

IF YOU ARE COVERED BY MORE THAN ONE INSURER

Your claim must go to the 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, and your explanation of benefits, you must forward them to us so that we can submit a claim to your secondary insurer.

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.

RETURNED CHECKS

If a check is returned as unpayable, the patient will be responsible for the amount of the check plus a \$15 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.

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 _____

How did you hear about our practice?

Referred by a doctor, Dr. _____

Recommended by a patient

In the yellow pages

On the Web

Magazine or newspaper advertisement in _____

Other _____