HUDSON DERMATOLOGY

Patient Information

(To be completed every 3 years)

LAST NAME	FIRST NAME		M.I.	
DATE OF BIRTH			SEX	MARITAL STATUS
ADDRESS			PRIMARY PHONE	☐ CELL
CITY	STATE	ZIP	ALT PHONE	☐ CELL
EMPLOYER			WORK PHONE	

YOUR E-MAIL

REFERRING PHYSICIAN		LAST SEEN	
PRIMARY PHYSICIAN (if different)		LAST SEEN	
PHARMACY	LOCATION	PHARMACY PHONE	

IMPORT MEDICATIONS FROM PHARMACY ☐ Yes ☐ No

Health Care Proxy ☐ Yes ☐ No

NAME	RELATION	CONTACT

Preferred language ☐ English ☐ Spanish ☐ Other_____

Race

☐ American Indian
☐ Asian
☐ Black or African-American
☐ Native American or Native Alaskan
☐ White
☐ Other_____

Ethnicity ☐ Non-Hispanic ☐ Hispanic ☐ Not specified

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

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_____

PATIENT AUTHORIZATION

I authorize the release of any medical information necessary to process any claim. I authorize payment of medical benefits to Hudson Dermatology, P.C., 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 that payment of authorized Medicare benefits be made directly to Hudson Dermatology P.C. for services furnished to me. I authorize any holder of my medical information to release to the Health Care Financing Administration and its agents any information needed determine these benefits and benefits for related services.

Signature_____ Date_____

HUDSON DERMATOLOGY

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)

- ☐ Anxiety_____
- ☐ Arthritis_____
- ☐ Chronic obstructive lung disease_____
- ☐ Depressive disorder_____
- ☐ Diabetes mellitus_____
- ☐ Disease caused by 2019-nCoV_____
- ☐ Disorder of thyroid gland_____
- ☐ End-stage renal disease_____
- ☐ H/O: hypertension_____
- ☐ H/O: liver disease_____
- ☐ Disease from Covid-19_____
- ☐ HIV positive_____
- ☐ History of hepatitis C_____
- ☐ History of radiation therapy_____
- ☐ Human immunodeficiency virus_____
- ☐ Hypercholesterolemia_____
- ☐ Leukemia_____
- ☐ Malignant lymphoma_____
- ☐ Malignant tumor of colon_____
- ☐ Rheumatic disease of heart valve_____
- ☐ Transplantation of bone marrow_____
- ☐ Other_____

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

☐ Yes ☐ No _____

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

- ☐ Yes ☐ No Acne
- ☐ Yes ☐ No Actinic keratosis
- ☐ Yes ☐ No Allergic contact dermatitis
- ☐ Yes ☐ No Basal cell carcinoma
- ☐ Yes ☐ No Dysplastic nevus of skin
- ☐ Yes ☐ No Eczema
- ☐ Yes ☐ No H/O Malignant melanoma
- ☐ Yes ☐ No H/O asthma
- ☐ Yes ☐ No H/O hay fever
- ☐ Yes ☐ No H/O squamous cell carcinoma
- ☐ Yes ☐ No Lupus erythematosus
- ☐ Yes ☐ No Psoriasis
- ☐ Yes ☐ No Other

☐ 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)

- ☐ Yes ☐ No Asthma
- ☐ Yes ☐ No Hay fever
- ☐ Yes ☐ No Hives
- ☐ Yes ☐ No Psoriasis
- ☐ Yes ☐ No Eczema
- ☐ Yes ☐ No Skin cancer (non-melanoma)

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

(Please list or attach)

Medication____________________ Dosage__________ Frequency__________

Medication____________________ Dosage__________ Frequency__________

Medication____________________ Dosage__________ Frequency__________

Medication____________________ Dosage__________ Frequency__________

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__________
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Do you or did you smoke?

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

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

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

Signature______________________________ Date________________
(parent or guardian if patient is a minor)

HUDSON
DERMATOLOGY

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 $35 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_____

HUDSON DERMATOLOGY

Contact Information

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

On your voicemail or answering machine ☐ Yes ☐ No
With another person ☐ Yes ☐ No

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

On your voicemail or answering machine ☐ Yes ☐ No
On your office voicemail ☐ Yes ☐ No
On your cell phone ☐ Yes ☐ No
In your email ☐ Yes ☐ No
With another person ☐ Yes ☐ No

Who is the other person 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 ☐ Google review
☐ Facebook
☐ Yelp
☐ Other web site _____
☐ Saw your sign on the building or door
☐ Received a postcard from Hudson Dermatology
☐ Magazine or newspaper advertisement in _____
☐ Other _____