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 | Ethnicity

Referring Physician | Primary Care Physician

Preferred Pharmacy

May we import your medication list from your pharmacy? ☐ Yes ☐ No

If you are 65 or older, do you have an Advanced Care Plan or Health Care Proxy? ☐ Yes ☐ No

If Yes: Name _____ Phone Number _____

If you are unable to make or communicate medical decisions, is there someone you want us to contact? If Yes:

Name | Relation | Contact

Insurance Policy Holder Name _____ Relation _____ DOB _____

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

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 may send a report of your visit to your referring doctor and primary care physician listed by you above unless you check here to opt out. ☐

Other physicians to receive information _____

Patient signature _____ Date _____

How did you hear about our practice? _____

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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)**

- ☐ Acne
- ☐ Allergic contact dermatitis
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atopic dermatitis/eczema
- ☐ Basal cell carcinoma
- ☐ Depression
- ☐ Diabetes
- ☐ End-stage kidney disease
- ☐ Hay fever
- ☐ Heart valve replacement
- ☐ HIV
- ☐ History of hepatitis C
- ☐ History of radiation therapy
- ☐ Hypertension
- ☐ Joint replacement (specify) _____
- ☐ Leukemia/Lymphoma
- ☐ Liver disease
- ☐ Lupus
- ☐ Melanoma
- ☐ Organ transplant (specify) _____
- ☐ Pacemaker/Defibrillator
- ☐ Psoriasis
- ☐ Rheumatic heart disease
- ☐ Squamous cell carcinoma
- ☐ Thyroid disease
- ☐ Other _____

History of neurosurgery or major ENT surgery involving the head or neck, including radiation? (If yes, please give details)

_____

Are you currently pregnant, breastfeeding, or planning to be within the next 6-10 months? ☐ Yes ☐ No

Have any first-degree relatives had melanoma? ☐ Yes ☐ No

Do you currently use tobacco? ☐ Yes ☐ No

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_____

Medication_____Dosage_____ Frequency_____

Medication_____Dosage_____ Frequency_____

Medication_____Dosage_____ Frequency_____

Are you allergic to any medications? ☐ Yes (please list below **or** attach a separate list) ☐ No

_____

HUDSON DERMATOLOGY

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_____

PRIMARY CARE REFERRALS

If your plan requires it, you must obtain a valid referral from your primary care physician before your appointment. If you are a returning patient, ask at booking whether your previous referral is still valid; we will confirm if a new referral is needed. Our office cannot obtain referrals for you,you must arrange it directly with your primary care physician. If you do not have a valid referral on file, you are responsible for payment for services.

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_____

NON-COVERED EXPENSES

I understand that I am responsible for payment for services that are considered non-covered expenses by my insurer.

Signature_____ Date_____

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. We accept all major credit cards, Apple Pay and Samsung Pay. 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.

CANCELLATIONS

If you need to cancel an appointment, you must do so at least 24 hours in advance. There will be a $45 fee for general dermatologic appointments, a $90 fee for surgical appointments, and a $150 fee for Mohs surgery appointments that are not kept or are canceled without at least 24-hour notice.

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_____