Demographics

Last Name: _________________________________ First: ________________________ Middle:______________DOB: __________

Driver's License # _________________ Address: ___________________________ City: ____________State: ____ Zip: _________

Phone: Home# ______________________________ Work # __________________________ Cell # _________________________

Preferred Phone: Home Cell Work Text Appt. Reminders: YES NO Email Appt. Reminders: YES NO

Marital Status : Single Married Divorced Widowed Partnered Sex: Male Female Transgender

Email ____ Occupation: ______________________________________

Employer Name: ____ Address: ____

Emergency Contact

Name: ____ Relationship: ___________________ Phone :___________________

Do you have an Advance Care Plan or Medical Decision Maker if you are not able to make decisions for yourself?

YES NO Name: ______________________________________ Phone :__________________________

Primary Care Physician

Doctor's Name: ____ Did this doctor refer you to us? YES NO

Can we communicate your lab / pathology results back to your PCP/ referring physician: YES NO

How did you hear about us? Insurance Internet Friend Advertisement Radio Other: _____________

Preferred Pharmacy: ______________________________ Address:________________________________

Person Responsible for Bill

(Complete only if different from patient)

Name: ____ Relationship: ___________________________________

Address : ____City: _________________ State: ______ Zip: __________

Date Of Birth: _________________ Phone: Home #________________________ Cell # _________________________

Are you Self Pay?: Yes NO

Primary Insurance

Insurance Company: _____________________________

Address: ____

Policy Number: ___________________________________

Group Number: ___________________________________

Policy Holder: ____________________________________

DOB:_____________Relationship to Patient:___________

Secondary Insurance

Insurance Company: _____________________________

Address: ____

Policy Number: ___________________________________

Group Number: ___________________________________

Policy Holder: ____________________________________

DOB:_____________Relationship to Patient:___________

Treatment to Minors

Many times parents are unable to accompany their teen or child under age 18 to appointments. In such an event, I herby grant Tru-Skin Dermatology permission to treat my child when they arrive at the office unaccompanied.

Parent or Guardian Signature ____ Date ____________________

Name:______________________

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ OTHER: ___________________________
- ☐ NONE
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

Select any of the following surgeries you have had:

- ☐ Appendix
- ☐ Bladder
- ☐ Gallbladder
- ☐ Coronary Artery Bypass Surgery
- ☐ Mechanical Valve Replacement
- ☐ Joint Replacement: Hip L R B
- ☐ Joint Replacement: Knee L R B
- ☐ OTHER ______________________________________
- ☐ Tubal Ligation
- ☐ Prostatectomy: Prostate Cancer
- ☐ Skin: Skin Biopsy
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ Neck / Spine / Back
- ☐ Sinus
- ☐ Pacemaker
- ☐ Tonsils / Adenoids
- ☐ Ear Tubes
- ☐ Hernia
- ☐ Shoulder / Rotator Cuff
- ☐ NONE

Have you had any of the following Skin Diseases?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Have Fever / Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ OTHER _________________

Do you have a family history of Melanoma? YES NO **If Yes, Which Relative?** ________________________________

Do you or have you used tanning salons? YES NO **If Yes, How often?** ________________

Medication: List all current medications/Dosage/Frequency: (Prescription, OTC, as well as vitamins / supplements)

☐ **NONE** ☐ **See Attached List** ***(Example: Aspirin 81mg 1 daily)***

Name	Strength (mg/ml)	Dose (#)	Frequency (daily)	Name	Strength (mg/ml)	Dose (#)	Frequency (daily)

Can we import your medications electronically from your Pharmacies? YES NO

Allergies: List all allergies and reactions: ____ ☐ **NONE**

Tobacco Status (Please choose one):

- ☐ Current everyday smoker / Tobacco
- ☐ Current someday smoker / Tobacco
- ☐ Former smoker / Tobacco
- ☐ Never smoker / Tobacco

Alcohol Intake (Please choose one)

- ☐ NONE
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Immunization: (recent)

Flu (Month/year) _______________

Pneumonia (Month/Year)___________

Family History: (first-degree relatives) Are there any Serious health conditions any of your family members have had?

IF Yes Please Explain:____

Cosmetic Concerns (Optional)

Are you interested in getting more information on the cosmetic options that are available for the treatment for sun-damage and aging skin? YES NO If yes, check below:

- ☐ Botox / Dysport
- ☐ Skin Bleaching
- ☐ Chemical Peels
- ☐ Fillers
- ☐ Lip Fillers
- ☐ Radiesse
- ☐ Leg Veins
- ☐ Microdermabrasion
- ☐ Laser Hair Removal
- ☐ Photofacial / IPL
- ☐ Fraxel Laser Resurfacing
- ☐ Micropen

Tru-Skin Dermatology Financial Policy

We would like to Thank You for choosing Tru-Skin Dermatology as your healthcare provider. We are committed to providing you with the best possible medical care. We are sure you understand that payment for this healthcare is your responsibility. The following information outlines your financial responsibilities related to payment for professional services.

For our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many HMO, PPO, EPO insurance companies and government agencies including Medicare. Our billing office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way we reasonably can to help get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. If your insurance requires a referral it is your responsibility to get with your PCP to obtain a referral. Please bring your insurance card(s) with you at the time of your appointment.

If you are insured by a plan we do business with but don't have an insurance card with you, payment in full for each visit is required until we can verify your coverage.

Co-Payments and Deductible:

Your insurance company requires us to collect co-payments at the time of service. Waiver of co-payments may constitute fraud under state and federal law. Please help us in upholding the law by paying your co-payment at each visit. If you are unable to pay your co-payment your appointment may be rescheduled.

Additionally, you may have coinsurance and/or deductible amounts required by your insurance carrier. These amounts are due at the time of service. Any outstanding balance on your account, after adjusting for all of your insurance's responsibilities, will be billed to you.

Waiver of Patient Responsibility:

It is the policy of the practice to treat all patients in an equitable fashion related to account balances. The practice will not waive, fail to collect, or discount co-payments, co-insurance, deductibles, or other patient financial responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Charity/Free Care Policy.

Cosmetic Services:

Payment for all cosmetic services is due at the time of service. We will not take a partial payment for cosmetic services unless it is approved by a provider and management.

Coverage Changes:

If your insurance changes, please notify us at least 24 hours before your next visit so we can make the appropriate changes to help you receive your maximum benefits. Any charges incurred by you because of failure to provide any necessary information with be your responsibility.

For our Patients with No Medical Insurance:

If you do not have group or individual medical insurance, payment for all professional services is expected at the time of your visit. Please note, we do offer discounted fees for patients without health insurance.

Late Arrivals:

A patient who arrives more than 15 minutes after his/her appointment is considered a late arrival. A late arrival, not considered to be the responsibility of the Practice, will be registered and worked into the schedule as soon as possible.

Appointment No-Shows:

______ (initial) Any patient who fails to arrive for a scheduled appointment without cancelling the appointment at least 24 hours prior to the scheduled time is considered a "no-show". A no-show patient may be charged **$40.00**, as set by the Practice, for failure to show. A patient who fails to present themselves two times for scheduled appointments is considered a chronic no-show. A patient who is a no-show four times may be dismissed from the Practice.

Divorced Parents of Patients:

By signing below, the adult who signs a minor child into our practice on the day of service accepts responsibility for payment. This office does not promise to send bills or records to the other parent/guardian for issues of payment or communication. We will communicate about treatment and payment with the parent who signs in that day. Parents are responsible between themselves to communicate with each other about the treatment and payment issues.

Name:______________________

Laboratory Fees:

______ (initial) Tru-Skin uses third-pathology and diagnostic labs. Pathology services are performed on every biopsy and excision. Tru-Skin cannot guarantee your insurance carrier will cover any labs or pathology performed or ordered by a physician. If your insurance company requires use of a specific lab it will be your responsibility to inform your physician for proper handling. You will be billed separately by the laboratory. By initialing, I acknowledge and agree to these terms and responsibilities.

Delinquent Balance Appointment:

Patients with a delinquent balances are required to make payment in full at time of service . A delinquent account is defined as a patient balance in excess of 90 days where the patient has not made any payments or sought assistance via financial hardship during this time. If such payment is not made, services may be refused. I agree to pay any costs incurred by Tru-Skin Dermatology in collecting any amount due including, without limitations collection agency fees and attorney's fees.

Payment Plan:

Please let us know if you are having difficulty paying your account. We may be able to help you by setting up a payment plan based on your financial hardship. All payments plans that are approved must be on an automatic draft payment arrangement.

By signing below, I acknowledge and agree to the terms and responsibilities laid out in this document.

Patient Signature____ **Date:**______________

Guarantor Signature____ **Date:**______________

HIPAA Acknowledgement and Consent:

Notice of Privacy Practices. I acknowledge that I have received the practice's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my health information for its treatment, payment, healthcare operations, and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer on the notice if I have a question or complaint. To the extent permitted by law, I consent to the use and discloser of my information for the purposes described in the practice's Notice of Privacy Practices.

Release of information. I hereby permit the practice and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for the purpose of treatment, payment, and healthcare operations. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or other purpose related to benefit payment. Healthcare information may also be released to my employer's designed when services delivered are related to a claim under worker's compensation. If I am covered by Medicare or Medicaid claim, I authorize the release of healthcare information to the Social Security Administration or this intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and /or psychiatric reports, drug and alcohol treatment and discharge summary. Federal and State laws may permit this facility to participate in organizations with other healthcare providers, insures and / or health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposed; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/ or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

Patient Signature____ **Date**:______________

Guarantor Signature____ **Date**:______________

Disclosure of Medical Information friends/or family members:

I ____, give permission for my protected health information to be disclosed for purpose of communicating results, findings and care decisions to the family members and others listed below:

Name ____________________________ Relationship ____________________ Contact Number ________________

Name ____________________________ Relationship ____________________ Contact Number ________________

Email Communication

It is the policy of Tru-Skin Dermatology to not share your contact or email info with any third parties. Our newsletter is available to you, but only with your permission:

☐ Yes, I want you to email me a newsletter with discounts on cosmetic services/products. You may use this email address:
____

☐ No, I do not wish to receive emails at this time.