Joe M. Lehman, M.D.
Michael Lehman, M.D.

David Long, M.D.
Bryan D. Harris, M.D.

Lehman Dermatology Clinic Professional Association

MEDICARE PATIENT INFORMATION

Patient:

Name ____
Last First M.I.

Date of Birth ____/____/____ Sex: ❑Male ❑Female SS# _____-____-_____

Mailing Address ____
City State Zip

Home Phone (____)________________ Cell Phone (____)________________

Employer ________________ Work Phone (____)________________

Referring Physician:

Name ________________ Specialty ________________

Emergency Contact:

Name of Spouse/Close Relative/Friend ________________
(In Case of Emergency)

Relationship ________________ Phone # (____) ________________

Please sign so we may have your <u>Medicare authorization</u> on file:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date ____/____/____ Signature ________________

Please sign so we may have your <u>supplemental authorization</u> on file:
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date ____/____/____ Signature ________________

Payment Policy
Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

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MEDICAL HISTORY

Patient ______________________________ **Patient's Date of Birth** ____/____/____

Reason for today's visit ______________________________ Referring Doctor ______________________________

Are you allergic to any medications? ❑Yes ❑No If yes, list below:

____

Have you ever had dental anesthesia (Novocaine)? ❑Yes ❑No Any bad reactions? ❑Yes ❑No
List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals):

1.____________________ 3.____________________ 5.____________________

2.____________________ 4.____________________ 6.____________________

Do you have now, or have you ever had diseases or conditions of: (Please check yes or no)

Lungs:	**Yes**	**No**
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	**Yes**	**No**
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of Vein	❑	❑
Blood Clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	**Yes**	**No**
Diabetes	❑	❑
Excessive Thirst/Hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/Burning	❑	❑
Gastrointestinal		
Stomach Absorptive Disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited Motion	❑	❑
Artificial Joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

List any other diseases or conditions ______________________________

List surgical procedures you have had in the last 6 months ______________________________

Skin:
- Have you ever had skin cancer? ❑Yes ❑No
- Has anyone in you family had skin cancer? ❑Yes ❑No
- Do you have a history of any specific skin diseases? ❑Yes ❑No If yes, ____________________
- Do you have problems with healing? ❑Yes ❑No
- Do you develop keloids (scars) after surgery? ❑Yes ❑No
- Do you bleed easily? ❑Yes ❑No
- Do you develop skin rashes in reaction to ❑Medications ❑Food ❑Environment ❑Bandages ❑Topical Neosporin ❑Other ____________________

Social History:
- Do you drink alcohol? ❑Yes ❑No If yes, __________ drinks per day
- Do you use IV drugs? ❑Yes ❑No If yes, what? ______________ How often? __________
- Do you smoke? ❑Yes ❑No If yes, how much? ____________________
- Have you had or have you been exposed to HIV (AIDS) ? ❑Yes ❑No

Please answer the following questions

(Women) Are you pregnant? ❑Yes ❑No Due Date ____/____/____

What is your occupation? ____________________ Hobbies? ____________________

Do we have permission to discuss your medical condition with family members? ❑ Yes ❑ No

If so, name ____________________ Relationship ____________________

Completed by ❑Patient
❑Medical Assistant ________ Initials

____________________ Signed by Patient

____/____/____ Date

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INFORMATION REGARDING YOUR FINANCIAL RESPONSIBILITY

PATIENTS WITH INSURANCE
Please read, sign and date at the bottom of the page

IF PRIVATE PAY/NO INSURANCE
Please check the box, read, sign and date at the bottom of the page

☐ **PRIVATE PAY/NO INSURANCE**

The total patient balance is required to be paid at the time services are provided. We accept cash, checks, VISA, MasterCard and Discover. ***WE DO NOT ACCEPT CARE CREDIT!!!***

Our office participates in various insurance plans. It is your responsibility to:

- Bring your insurance card to every visit.
- Be prepared to pay your copay, deductible and out of pocket at time of service.
- For medical care NOT COVERED under your insurance, 100% of payment is due at time of service.
- Any outstanding balances (owed by you or any family members you are responsible for) are to be paid at time of service.
- If we file a claim to an out-of-network plan as a courtesy, you will still be responsible to pay in full at time services are rendered.
- Payments for any unaccompanied minors (17 years or younger) are due at time of service.

If your insurance requires a referral, it is your responsibility to get that referral from your PCP prior to your appointment. If you do not have a referral, you may want to reschedule your appointment, or you will have to pay 100% of your visit.

Individual insurance companies determine in what situations deductibles will apply. In-office surgeries, procedures, biopsies, pathology fees, removal of pre-cancerous lesions and some injections may fall under your deductible and/or out of pocket. If you have questions as to what part of your visit falls under the deductible, please contact your insurance company prior to your visit.

I HAVE READ THE ABOVE INFORMATION AND UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR MY COPAY, DEDUCTIBLE AND/OR OUT OF POCKET AT THE TIME OF SERVICE. IF NO REFERRAL IS OBTAINED, I WILL PAY 100% OF MY VISIT.

SIGNATURE OF PATIENT OR RESPONSIBLE PARTY
(MUST BE 18 YEARS OR OLDER)

DATE

*****PLEASE TURN OVER*****

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this 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.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above 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 health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name (please print)____

Relationship to Patient____

Signature____

Date____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

PLEASE TURN OVER