

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 Medicare authorization 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 supplemental authorization 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.

Please present Medicare and secondary insurance card(s) and photo ID to the receptionist so copies may be made.

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Professional Association

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

Lehman Dermatology Clinic Professional Association

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	Other Systemic:		Yes	No
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>		Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>		Excessive Thirst/Hunger	<input type="checkbox"/>	<input type="checkbox"/>	
Asthma	<input type="checkbox"/>	<input type="checkbox"/>		Amputation	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>		Kidney	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>		Dialysis	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>		Bladder	<input type="checkbox"/>	<input type="checkbox"/>	
				Frequency/Burning	<input type="checkbox"/>	<input type="checkbox"/>	
				Gastrointestinal			
				Stomach Absorptive Disorder	<input type="checkbox"/>	<input type="checkbox"/>	
				Nausea, vomiting, diarrhea			
				when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	
				Yeast infection when			
				taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	
				Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>	
				Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>	
				Limited Motion	<input type="checkbox"/>	<input type="checkbox"/>	
				Artificial Joint	<input type="checkbox"/>	<input type="checkbox"/>	
				Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
				Fainting	<input type="checkbox"/>	<input type="checkbox"/>	

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 _____ Signed by Patient _____ Date ____/____/____
Initials _____

Reviewed by _____ Date ____/____/____