CEDAR DERMATOLOGY
PATIENT INFORMATION SHEET

PATIENT INFORMATION:

LAST _____ FIRST _____ MIDDLE _____ PREFERRED NAME _____

MAILING ADDRESS _____ CITY _____ ST ____ ZIP _____

BIRTHDATE _____ SEX M / F _____ SOCIAL SECURITY # _____

PHONE # _____ CELL # _____ WORK # _____

OCCUPATION _____ EMAIL _____

RELATIVE/FRIEND (NOT LIVING AT SAME ADDRESS)

NAME _____ ADDRESS _____ PHONE# _____

INSURED OR RESPONSIBLE PARTY INFORMATION:

NAME _____ ADDRESS _____ CITY _____ ST ____ ZIP _____

PHONE # _____ CELL# _____ RELATIONSHIP TO PATIENT _____

SOCIAL SECURITY # _____ BIRTHDATE _____

SPOUSE'S NAME _____ SOCIAL SECURITY # _____ BIRTHDATE _____

REFERRING DOCTOR: _____

INSURANCE INFORMATION:

PRIMARY INSURANCE _____ ID# _____ GROUP # _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE _____ ID# _____ GROUP# _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

POLICYHOLDER _____ RELATIONSHIP TO PATIENT _____

INSURANCE AND FINANCIAL POLICY

We are committed to provide you with the best possible care and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibility.

For your convenience, we accept cash, check, and/or Visa, Mastercard, American Express or Discover as well as Health Flex Cards. If you have health insurance, please be advised that you are responsible for your deductible, co-insurance and co-pay. Dermatologists are specialists and co-pay may be higher than what is listed on your insurance card. It is your responsibility to know what is required.

Insurance is a contract between you and your insurance company. We are not a party to this contract. We will assist you as much as possible in obtaining prior authorization, referrals, or answers to your questions, but it is ultimately your responsibility to check with your insurance company to determine eligibility, co-payment amounts, deductibles, covered services, referrals, etc. Disagreements and misunderstandings with your insurance carriers are not between this office and the insurance, but rather between you and the insurance company. This can be avoided when you are personally involved and your carrier is far more likely to respond to requests or complaints directly from you since you pay the premiums. **Remember, you are responsible for the timely payment of your account.**

MEDICAID RECIPIENTS: Medicaid cards for the current month, a referral and co-payment if required, must be presented at the time of your visit.

AUTHORIZATION TO RELEASE INFORMATION AND CONTRACT TO PAY

In consideration of professional services rendered to the patient (whose name follows), I/we agree to pay co-pay at time of service. I understand that I am financially responsible for all charges whether they are eligible for payment by my insurance carrier or not. I/we authorize the doctor to receive assignment of insurance payments. If the customary charges are more than the benefits allowed under my insurance plan, I/we agree to pay the difference. Your account will be turned over to an outside agency if no real attempt of payment has been made in a reasonable amount of time.

Should the balance due be left unpaid after 90 days, and it becomes necessary to refer your account to a collection agency, the undersigned agrees to pay 33 1/3% collection charges. This includes, but is not limited to 18% per annum on unpaid balance, court costs and reasonable attorney fees as charged by outside agency.

I/we hereby authorize **Cedar Dermatology** to administer such medications, immunizations and to perform such diagnostic/medical/surgical procedures as may be necessary for proper health care. I am aware that any major lab work may be sent to an outside lab and I will receive an additional bill from that facility. I authorize use of any photographs taken during my care for medical education purposes.

My/our signature below signifies my/our understanding of the terms and conditions of this Financial Policy, contract to pay for medical services and Release of Medical Information.

Dermatology is a specialist visit and is usually not considered preventative.

I ACKNOWLEDGE THAT A NOTICE OF PRIVACY PRACTICES HAS BEEN PROVIDED FOR MY/OUR INFORMATION AND REVIEW. **( ) YES ( ) NO**

Signature of Responsible Party _____ Date _____

Please Print Responsible Party Name _____ Relationship to patient _____

My pathology results and/or medical records may be discussed or given to someone other than myself as listed below.
( ) YES ( ) NO

Name _____ Relationship _____

Name _____ Date of Birth _____ Date _____

Purpose of today's visit: 1)_____ 2)_____ 3)_____

Present Medications:_____

Medical allergies:_____

Social History (please circle): married, single, student, child, retired, tanning bed use, tobacco use, alcohol use

Do you have any of the following (circle Y or N)?

Fever	Y / N	Night Sweats	Y / N	Vision changes	Y / N
Rash	Y / N	Itching	Y / N	Gastric reflux/heartburn	Y / N
Anxiety	Y / N	Depression	Y / N	Pass out easily	Y / N
Hair/nail changes	Y / N	Heat/cold intolerance	Y / N	Varicose veins	Y / N
Joint/muscle pain	Y / N	Fatigue	Y / N	Leg swelling	Y / N
Nasal/oral sores	Y / N	Tanning bed use	Y / N	Blood clots	Y / N
Recent viral cold	Y / N	Yeast infections	Y / N	Breathing requiring oxygen use	Y / N

Medical History (circle Y or N and check appropriate spaces) Other: _____

Skin cancer __ basal cell or squamous cell carcinoma __ melanoma ___ unknown type	Y / N	Hepatitis C Tuberculosis HIV/AIDS	Y / N Y / N Y / N
Asthma	Y / N	Eczema	Y / N
Diabetes	Y / N	Hayfever (seasonal allergies)	Y / N
High blood pressure	Y / N	High Cholesterol	Y / N
Currently pregnant ____ weeks	Y / N	Psoriasis	Y / N
Breastfeeding	Y / N	Hypothyroid (low thyroid)	Y / N
Heart disease	Y / N	Hysterectomy	Y / N

Past surgeries: _____

Family History: (please circle Y or N or check appropriate conditions)

basal cell or squamous cell carcinoma melanoma unknown type	Y / N Y / N Y / N	__ Asthma / __eczema / __hayfever __ Psoriasis __ Acne __ Blood Clots

IMPORTANT INFORMATION REGARDING CERTAIN PROCEDURES AND TREATMENT

Dermatology is a specialty and visits are usually **not considered preventative.** Please note that all dermatology procedures are considered to be "surgery" codes; this can result in additional patient responsibility (deductible/co-ins).

_____
Initial/date

Your insurance coverage is a contract between you and the insurance company. We will be happy to bill your insurance, but it is your responsibility to make sure that we are providers and to know your co pay/deductible amounts.

_____
Initial/date

***Warts*:** Warts are viral and often require multiple visits for treatment. Please be aware that each visit will be billed separately.

_____
Initial/date

***Alopecia (hairloss) & Hypertrophic scars (keloids)*:** Please note that these conditions are generally considered cosmetic by insurance companies and treatment is not a covered benefit.

_____
Initial/date

***Skin tags & Lipomas*:** Your insurance may or may not cover the treatment of skin tags or lipomas. You will be responsible for payment at the time of visit. As a courtesy, we will bill your insurance and reimburse you if there is coverage.

_____
Initial/date

Please read and initial and date that you have read and understand the above information.

January 2019