EXCEPTIONAL
DERMATOLOGY CARE

Date: _____ / _____ / _____

Patient (Legal) Name: _____ Nickname: _____
SSN (>Age 18): _____ Date of Birth: _____
Sex: ☐ Male ☐ Female ☐ Other _____
Mailing Address: _____
(Street/PO Box, City, State, Zip Code)

Home Address: _____
(Street, City, State, Zip Code)

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widowed
Primary Phone: _____ ☐ Home ☐ Cell ☐ Other
E-Mail: _____
Emergency Contact: _____ Phone #: _____

Primary Insurance
Name of Primary Insurance Co.: _____
ID/Policy No.: _____ Group No.: _____
Subscriber/Insured: _____ Relationship: _____ Sex: _____
Date of Birth: _____

Secondary Insurance
Name of Primary Insurance Co.: _____
ID/Policy No.: _____ Group No.: _____
Subscriber/Insured: _____ Relationship: _____ Sex: _____
Date of Birth: _____

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SECTION I

What is your ethnicity?

Please check one or more boxes.

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ **Decline to specify**

Please select the racial category or categories with which you most closely identify with.

Check as many as apply.

☐ American Indian or Alaska Native ☐ Black or African American

☐ Asian ☐ Native Hawaiian or Other Pacific Islander

☐ White ☐ **Decline to specify**

What is your native language?

☐ English ☐ Spanish ☐ **Decline to specify**

Do you require a translator?

☐ Yes ☐ No

SECTION II

Please check the appropriate box if you'd like to receive our monthly emails about specials and VIP events.

☐ Yes ☐ No

How did you *first* hear about the practice? (Please check one)

☐ Magazine, newspaper or other print media. Please specify: _____

☐ Doctor Referral. Name of doctor: _____

☐ Insurance Directory. Please specify: _____

☐ Patient referral. Name of patient: _____

☐ Employee of Exceptional Dermatology Care. Name of employee: _____

☐ Internet. Please check which website you originally found us on:

- ☐ Google ☐ Yahoo ☐ Yelp ☐ Facebook ☐ Instagram
- ☐ Google+
- ☐ Other website. Please specify: _____

☐ Other referral source not listed above. Please specify: _____

☐ Walk-in

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Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice also contains a Patient Rights section describing your patient rights under the law. You have a right to review this Notice before signing this Consent. The terms of the Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor the agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for:

- Treatment (including direct and indirect treatment by other healthcare providers involved in your medical care)
- Payment from your insurance company or third party payers
- The day-to-day healthcare operations of our practice

You have the right to revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date you revoke this consent is not affected. The practice provides this form to comply with the Health Insurance Probability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment or healthcare operation
- The Practice has a Notice of Privacy Practices, and the Patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The Patient has the right to restrict the uses of their information but the practice does not have to agree to those restrictions
- The Patient may revoke this consent in writing at any time
- The Practice may condition receipt of treatment upon execution of this consent

Please provide us the name(s) of family members or other persons, if any, to whom we may release information regarding your general medical condition, financial account, or who have permission to pick up information you have requested.

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

☐ Self ☐ Parent ☐ Legal Guardian

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Our office is committed to providing excellent, affordable medical care. You have the right and responsibility of knowing the cost of your medical treatment. If you have health insurance and even if we bill your insurance company directly, you will be responsible for copayment, coinsurance, deductible, and non-covered amounts. For your convenience, our office accepts personal checks, credit cards, and cash, and when appropriate, can provide you with mutually agreed upon payment plan. It's also important to note that all cosmetic treatments are not covered by any health insurance plan and are due at the time of service. Please read the following carefully, as it outlines our financial policy.

It is important that insurance patients understand how insurance billing works. Insurance companies require us to break down every component of your office visit into universal, numerical procedure codes, and charge for each code. The insurance companies will arbitrarily change, combine, and disallow procedure codes, and then apply their company's individual fee schedule. The result is the insurance company's determination of "reasonable and customary" charges in the amount they are willing to cover. The insurance company usually reduces the actual reimbursement further by the individual policy's annual deductible, copayment or coinsurance.

This method of billing, designed by the insurance industry, forces us to bill at full price procedure codes that the insurance company will likely reduce, combine, or simply deny. This system in fact, has the insurance company determining our fees. If we have a contract with your insurance company, we write off the amount over the "reasonable and customary", and bill you for your coinsurance and deductible. If we do not have a contract with your insurance carrier, you are responsible for that amount as well as any deductible and coinsurance.

We are required by all insurance carriers to collect from patients any deductible and copayment or coinsurance amounts. These fees can be reduced only in those cases where true financial hardship can be demonstrated. If you feel that you are in a position of financial hardship, please discuss your financial hardship with our patient account supervisor. In the unlikely event you stop payment, are notified of Non-Sufficient Funds or your account is turned over to Collections, you will be responsible for all related costs.

Should you not be able to make a scheduled appointment, we ask that you provide us at least 24 hours advance notice. If you do not contact our office, a $50 Cancellation Fee will be applied to your account.

I have read and understand Exceptional Dermatology Care's financial policy as outlined above. The following constitutes an agreement between the undersigned patient/guarantor and Exceptional Dermatology Care.

In the event Exceptional Dermatology Care agrees to seek payment initially from my insurance company, I request payment to be made directly to them of all medical benefits otherwise payable to me for services rendered. I understand any final obligations for payment are mine. Any portions of my bill not paid by insurance are my responsibility and are due and payable upon demand. I hereby authorize Exceptional Dermatology Care to release all information necessary to secure payment of benefits.

Patient (Legal) Name: _____

Signature: _____ Date: _____

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PAST SURGERIES

Please check mark if you have had surgeries on the following organs:

- ☐ None
- ☐ Excision of Atypical Nevi
- ☐ Excision of Basal Cell Carcinoma
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell Carcinoma

MEDICAL CONDITIONS

Please check mark to indicate if you have the following:

- ☐ None
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Depressive Disorder
- ☐ Diabetes Mellitus
- ☐ Elevated Blood Pressure
- ☐ Gastroesophageal Reflux Disease
- ☐ Hearing Loss
- ☐ Human Immunodeficiency Virus Infection
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism

SKIN CONDITIONS

Have you had any of the following skin conditions:

- ☐ None
- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Atopic Dermatitis
- ☐ Basal Cell Carcinoma of Skin
- ☐ Dysplastic Nevus of Skin
- ☐ Eczema
- ☐ H/O: Asthma
- ☐ H/O: Hay Fever
- ☐ Malignant Melanoma
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Sunburn of Second Degree

Do you wear sunscreen? ☐ Yes ☐ No

Do you tan in a tanning salon? ☐ Yes ☐ No

FAMILY HISTORY OF MELANOMA

Do you have a family history of Melanoma? ☐ Yes ☐ No

- ☐ None
- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other: _____

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PREFERRED PHARMACY

Name: _____

Address: _____

(Street, City, State, Zip Code)

MEDICATIONS & ALLERGIES

Please list all medications you are currently taking:

1._____
2._____
3._____
4._____

Please list all medications you are allergic to:

1._____
2._____
3._____
4._____

SMOKING HABITS

What is your smoking status? (please check one):

☐ Current everyday smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoker
☐ Unspecified

ALCOHOL & DRUG USE

How many times in the past year you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adults older than 65? _____
Do you consume alcohol (EtOH or grain alcohol)? _____
Illicit drug use? ☐ Yes ☐ No

OCCUPATION

What is your occupation and workplace? _____