

**PATIENT INFORMATION**

PATIENT NAME: LAST FIRST MI		SOCIAL SECURITY #	
MAILING ADDRESS: STREET/PO		DATE OF BIRTH:	SEX (CIRCLE) FEMALE / MALE
CITY: STATE: ZIP CODE:		HOME #:	CELL #:
EMAIL ADDRESS:		MARITAL STATUS: (CIRCLE) SINGLE DIVORCED MARRIED WIDOW PARTNER	
RACE: (CIRCLE). CAUCASIAN. AMERICAN INDIAN. ALASKAN NATIVE. ASIAN. AFRICAN AMERICAN. NATIVE AMERICAN. PACIFIC ISLANDER OTHER PRIMARY LANGUAGE SPOKEN? _____		ETHNICITY: (CIRCLE) HISPANIC / NOT HISPANIC	
2 <sup>ND</sup> SEASONAL ADDRESS: STREET/PO. APT#. CITY. STATE. ZIP CODE			

**PERSON RESPONSIBLE FOR CHARGES**

If the person responsible for payment is different from the patient, then complete below. If the patient is a child, please indicate if parents are: (circle) Married Separated Divorced	
FULL NAME:	SOCIAL SECURITY NUMBER
MAILING ADDRESS:	DATE OF BIRTH:
CITY: STATE: ZIP CODE:	PREFERRED NUMBER TO CONTACT:
PATIENT RELATIONSHIP TO RESPONSIBLE PARTY (CIRCLE): SPOUSE CHILD OTHER:	WORK PHONE:

**PRIMARY CARE & REFERRAL INFORMATION**

PRIMARY CARE PHYSICIAN:	NAME OF REFERRING PHYSICIAN:
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**EMERGENCY CONTACT**

IN CASE OF EMERGENCY NOTIFY: (FULL NAME)	PHONE:
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**INSURANCE INFORMATION**

PRIMARY INSURANCE:	SECONDARY INSURANCE
NAME: _____ POLICY/ID# _____ _____	NAME: _____ POLICY/ID# _____ _____
GROUP# _____ DOB: _____ SS# _____	GROUP# _____ DOB: _____ SS# _____
RELATIONSHIP TO PATIENT: _____	RELATIONSHIP TO PATIENT: _____

By signing below, I (or my authorized representative), authorize A to Z Dermatology and their staff to conduct any diagnostic examinations, tests, and procedures and to provide any medications, treatment, or therapy necessary to effectively assess and maintain my health.

This consent provides us with your permission to perform reasonable and necessary medical evaluations, examinations, diagnosis, testing, and treatment. By signing below, you are indicating that (1) you intend this consent to be continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: \_\_\_\_\_

DATE: \_\_\_\_\_



## **PATIENT CONSENTS**

1. **ASSIGNMENT OF INSURANCE BENEFITS/PROMISE TO PAY:** I hereby assign and authorize payment directly to A to Z Dermatology all insurance benefits, sick benefits, or injury benefits due because of liability of a third-party. If eligible for Medicare, I request Medicare services and benefits. I further agree that this assignment will not be withdrawn or voided at any time until the account is paid in full. I understand that I am responsible for paying any account balance for applicable coinsurance and deductible amounts and for those amounts not otherwise covered by my insurance company in accordance with A to Z Dermatology's regular rates and terms. If I fail to make payment when due and the account become delinquent or is turned over to a collection agency or an attorney for collection, I agree to pay all collection agency fees, court costs and attorney fees. I also agree that any patient or guarantor overpayments may be applied directly to any delinquent account for which I or my guarantor is legally responsible at the time of the collection of the overpayment. I consent to work with my insurance company/ companies on my behalf on authorization, appeal on my behalf for any denial for reimbursement, coverage, or payment for services or care provided to me.

2. **PATIENT CONSENT FOR E-PRESCRIBING (ELECTRONIC PRESCRIBING):** I have been made aware and understand that the medical practices and offices may use an electronic prescription system which allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

3. **CONSENT TO RELEASE HEALTH INFORMATION:** I understand A to Z Dermatology uses an electronic medical record that contains information about my health from my past and current health care providers. I agree that this health information may be released through electronic medical records or by other means (for example, fax): (1) to A to Z Dermatology ; (2) to my past, current and future health care providers and other health care organizations that provide care to me; (3) to the health insurance company named in my medical record; and (4) to any other person named in my medical record who pays for my treatment. These people may use my health information: (1) to treat me; (2) to get paid for my treatment (for example, billing insurance companies), and (3) to do health care operations activities. I understand that these people will have access to all my health information in the medical record, including behavioral health and substance use disorder information (for example, drug and alcohol treatment), my medical history, diagnosis, hospital records, clinic and doctor visit information, medications, allergies, lab test results, radiology reports, sexual and reproductive health information, communicable disease related information (for example, sexually transmitted diseases), and HIV/AIDS-related information. I understand that I may take back this consent at any time, except if my health information has already been released to someone. I also understand that I may request a list of the health care organizations that have received my substance use disorder information. This consent will expire one year after my death.

4. **NOTICE OF PRIVACY PRACTICES:** Required pursuant to Health Insurance Portability and Accountability Act of 1996 (HIPAA), I acknowledge that I have received a copy of the Notice of Privacy Practices. I hereby consent to the use and disclosure of my protected health information as described in the Notice of Privacy Practices. This will include all my protected health information generated during office treatments.

5. GENERAL CONSENT FOR TESTS, TREATMENT, AND SERVICES: I have been informed of the treatment procedures considered necessary for me and that the treatments/ procedures will be directed by a physician or independent Advanced Practitioner, in accordance with state laws, scope of practice, and licensure of medical staff.

6. CONSENT TO PHOTO/VIDEO: I consent to the photographing, videotaping and/or video monitoring, including appropriate portions of my body, for medical and medical record documentation purposes, provided said photographs or videotapes are maintained in accordance with protected health information regulations.

7. CONSENT TO PHOTOGRAPH AT THE TIME OF REGISTRATION: I, or my authorized legal representative, hereby give consent to the medical practice to take my photograph at the time of registration. I understand this photograph will be stored in the medical practice's medical record electronically as my photo identification.

8. COMMUNICATIONS: I consent to this Facility, its successors or assignees contacting me via the methods I provide below. I understand the communications may occur in any manner, including calls to my cell phone or landline, voicemails, use of automated telephone dialing systems, use of artificial or prerecorded voice messages, or text messages. I understand the communications may be about any matter, including, but not limited to, my medical treatment, prescriptions, insurance eligibility, insurance coverage, scheduling, billing or collection of matters. I understand that these communications are not encrypted or secure, and I assume the risks of transmitting health information via unsecure means. I understand that the Facility is not responsible for paying any charges I incur from being contacted at the telephone number(s) or email address(es) provided. This consent also applies to any updated or additional contact information that I may provide. I understand that I will be able to change my preference at any time by contacting the Facility.

9. VIDEOTAPING/RECORDING: I understand and agree not to photograph, videotape, audiotape, record or otherwise capture imaging or sound on any device. I also understand it is my responsibility to assure those accompanying me to comply with this requirement.

10. NO SHOWS: Patients who miss more than three appointments within a six-month period may be discharged from our practice.

11. CONTACT PREFERENCES: Please indicate below the contact phone numbers that you authorize A to Z Dermatology to leave a phone message at or indicate that you do not want phone messages left at any contact phone number.

Ok to leave a phone message with detailed health information at following phone number:

Ok to leave a phone message with callback phone number only at the following phone number: \_\_\_\_\_

Do NOT leave a phone message at any number.

\*If we have permission to share your information with anyone else, in case we cannot reach you by phone, please fill in their name and phone number below:

OK to discuss & disclose any/all clinical information.

Name and Relationship to Patient

Contact Phone Number Contact #1

Contact #2

I have read this document, indicated my preferred method of communication, and agree to the terms for financial responsibility.

· I understand it is my responsibility to notify A to Z Dermatology of any changes to the communication permissions I have given in this document.

· I understand my responsibility for payment to A to Z Dermatology and have been given the opportunity to ask questions about it. If additional information is needed to ensure insurance coverage, I will provide it on an accurate and timely basis.

Signature \_\_\_\_\_ Date: \_\_\_\_\_



Medical, Surgical and Cosmetic Dermatology  
Expert Care, Every Tone, Every Story

**Agreement of Financial Responsibility**

Thank you for choosing A to Z Dermatology as your skin care provider. We are committed to providing quality care and service to all our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

- Please understand that payment of your bill is considered part of your treatment. Fees are payable when services are rendered. We accept credit cards, and pre-approved insurance for which we are a contracted provider and have a referral, if applicable. We no longer take cash or checks.
- Services are rendered to the patient, not the insurance company. As a courtesy, our office will file your insurance if proper information is received. You are responsible for co-pays, deductibles, non-covered services, co-insurance and items considered “not medically necessary” by your insurance company.
- For unpaid claims over 60 days, it is your responsibility to follow up with your insurance company, and the balance due is considered due and payable.
- It is your responsibility to know your own insurance benefits, including whether we are a contracted provider with your insurance company, your covered benefits and any exclusions in your insurance policy, and any pre-authorization requirements of your insurance company.
- We will attempt to confirm your insurance coverage prior to your treatment. It is your responsibility to provide current and accurate insurance information, including any updates or changes in coverage. Should you fail to provide this information, you will be financially responsible.
- If we have a contract with your insurance company, we will bill your insurance company first, less any copayment(s) or deductible(s), and then bill you for any amount determined to be your responsibility. This process generally takes 45-60 days from the time the claim is received by the insurance company.
- If we do not contract with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Proof payment and photo ID are required for all patients. We will ask you to make a copy of your ID and insurance card for our records. Providing a copy of your insurance card does not confirm that your coverage is effective, or that the services rendered will be covered by your insurance company.
- Please understand that some insurance coverage has Out-of-Network benefits that have co-insurance charges, higher co-payments, and limited annual benefits. If you receive services are part of an Out-of-Network benefit, your portion of financial responsibility may be higher than the In Network rate.
- **“NO SHOW” POLICY – Any patient that does not show for their scheduled visit and fails to call within the 24 hours prior to appointment time to cancel will be charged \$50. Surgery “No Shows up to \$300.**
- Pathology and Lab fees are billed independently, and you may receive and be responsible for a bill from the outside lab.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

PRINT \_\_\_\_\_  
SIGN \_\_\_\_\_  
DATE \_\_\_\_\_



# A to Z Dermatology

Medical, Surgical and Cosmetic Dermatology  
Expert Care, Every Tone, Every Story

## HISTORY AND INTAKE FORM

Patient Name:		DOB	AGE
<b>CURRENT OR PAST MEDICAL HISTORY (MARK ALL THAT APPLY)</b>			
Artificial Heart Valve/Infection	Artificial joint replacement Year:	<input type="checkbox"/> Cold sores/herpes	
Hepatitis, Type _____	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Organ Transplant: Organ: _____ Year: _____	
Pacemaker: Year:	Staph Bacterial Infection	<input type="checkbox"/> MRSA Infection	
Vasovagal Reaction (fainting)	<input type="checkbox"/> Diabetes	<input type="checkbox"/> High Blood Pressure	
High Cholesterol	Autoimmune Condition _____	<input type="checkbox"/> Hyperthyroid (high thyroid) <input type="checkbox"/> Hypothyroid (low thyroid)	
Other: _____			
<b>Surgical Procedures (within the past 2 years)</b>  			
<b>SKIN DISEASE HISTORY (PLEASE CHECK ALL THAT APPLY)</b>			
<input type="checkbox"/> ACNE: HAVE YOU TAKEN ACUTANE IN THE PAST? YEAR: _____	<input type="checkbox"/> DRY SKIN	<input type="checkbox"/> PRECANCEROUS MOLES:	<input type="checkbox"/> ACTINIC KERATOSIS
<input type="checkbox"/> ECZEMA	<input type="checkbox"/> PSORIASIS	<input type="checkbox"/> FLAKING/ITCHY SCALP	<input type="checkbox"/> BLISTERING SUNBURN
<input type="checkbox"/> HISTORY OF HAY FEVER:		HISTORY OF ASTHMA:	
<input type="checkbox"/> HISTORY OF SKIN CANCERS: <input type="checkbox"/> BASAL CELL CARCINOMA. <input type="checkbox"/> SQUAMOUS CELL CARCINOMA <input type="checkbox"/> MELANOMA		<input type="checkbox"/> FAMILY HISTORY OF MELANOMA WHICH RELATIVE(S)? _____	

DO YOU WEAR SUNSCREEN? YES NO SPF? _____	PREVIOUS RADIATION TREATMENT? YES. NO WHEN? _____ WHY? _____

**MEDICATIONS/DOSE  
DO NOT LEAVE BLANK!**

PROVIDED LIST TO OFFICE ( )	NO MEDICATIONS ( )
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**LIST ALL MEDICATIONS TAKING IF NO LIST HAS BEEN PROVIDED:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES (LIST ALL ALLERGIES)**

NO KNOWN DRUG ALLERGIES: ( )

\_\_\_\_\_

\_\_\_\_\_

**Advanced Care Directives**

Do you have a Health Care Proxy? Yes / No      Name: \_\_\_\_\_

Phone: \_\_\_\_\_

Do you have a Living Will? Yes / No

**SOCIAL HISTORY (CIRCLE OR MARK ALL THAT APPLY)**

CURRENT SMOKER	FORMER SMOKER	NEVER SMOKER	
# OF ALCOHOLIC DRINKS PER DAY: _____ —	SEXUALLY ACTIVE: YES NO	MULTIPLE PARTNERS: YES NO	IV DRUG USE: YES. NO

**REVIEW OF SYSTEM: Are you experiencing any of the following?**

PROBLEMS WITH BLEEDING	PROBLEMS WITH HEALING	PROBLEMS WITH SCARRING
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<input type="checkbox"/> CHANGING MOLE	<input type="checkbox"/> RASH	<input type="checkbox"/> DEPRESSION	
<input type="checkbox"/> IMMUNOSUPPRESSION	<input type="checkbox"/> THYROID PROBLEMS	JOINT PAIN	
<input type="checkbox"/> UNINTENTIONAL WEIGHTLOSS	CHEST PAIN:	OTHER:	
<b>ALERTS (check all that apply)</b>			
<input type="checkbox"/> ALLERGY TO ADHESIVE	ALLERGY TO LIDOCAINE	<input type="checkbox"/> DEFIBRILLATOR	PACEMAKER
<input type="checkbox"/> BLOOD THINNERS	<input type="checkbox"/> PREGNANT	<input type="checkbox"/> RAPID HEARTBEAT TO EPINEPHRINE?	<input type="checkbox"/> GI UPSET
<b>HAVE YOU RECEIVED ANY OF THE FOLLOWING VACCINATIONS (check all that apply)</b>			
<input type="checkbox"/> FLU (OCT-MAR)	<input type="checkbox"/> PNEUMONIA (65+ ONLY)	<input type="checkbox"/> SHINGLES (50+ ONLY)	<input type="checkbox"/> COVID
<b>PHARMACY INFORMATION:</b>			
PHARMACY NAME:	ADDRESS OR CROSS STREETS	PHONE NUMBER	
<b>How did you hear about us?</b>			

I hereby certify that the above information is true and correct to the best of my knowledge.

\_\_\_\_\_  
Patient/Guardian Name (**PRINT**)

\_\_\_\_\_  
Patient/ Guardian Signature

Date: \_\_\_\_\_



### **Patient Insurance Responsibility Agreement**

I understand that it is my responsibility to provide **current and accurate insurance information** at the time of each visit, including all active insurance cards.

If I **do not provide my insurance information or insurance cards** at the time of my visit, I agree to submit this information to A to Z Dermatology within **30 days** of my appointment.

- If I fail to provide my insurance information within 30 days, I understand that I will be **responsible for all charges** related to my visit(s).
- If I **omit or fail to disclose an active insurance policy**, and that omission prevents proper billing to my insurance, I agree that I will have **30 days** from the date of service to provide the correct information. After 30 days, I understand that I will be **financially responsible for the full balance**, and A to Z Dermatology will not re-bill my insurance.

I acknowledge that it is my responsibility to verify my insurance coverage and to inform A to Z Dermatology of any changes to my insurance prior to my visit.

Signature \_\_\_\_\_ Date: \_\_\_\_\_

### **Biopsy and Procedure Financial Responsibility**

I understand that during my visit, the provider may determine that a **biopsy, procedure, or lab test** is medically necessary to assist in my diagnosis or treatment.

I acknowledge that:

- These services may be **billed separately** from my office visit.
- It is **my responsibility** to verify insurance coverage and benefits for procedures and laboratory services.
- If my insurance requires a **referral, prior authorization, or deductible**, I am responsible for any portion of the charges not covered by my insurance.
- If I **do not provide accurate and current insurance information** within **30 days** of the procedure, or if I omit an active insurance policy, I will be **financially responsible for all associated costs**. I understand that by receiving care, including biopsies or procedures, I am accepting financial responsibility for all services not covered or paid by my insurance plan.



**CONSENT TO AMBIENT DOCUMENTATION**

Our practice uses secure AI-assisted ambient documentation technology to help create clinical notes during your visit. This system listens to the medical discussion and generates a draft note for provider review.

Transcript data is retained only until the note is finalized by the provider, or for a maximum of seven (7) days, whichever occurs first, after which it is automatically deleted.

All information is handled as Protected Health Information in compliance with HIPAA privacy and security standards.

- I consent to AI-assisted documentation
- I decline AI-assisted documentation