A to Z Dermatology
Medical, Surgical and Cosmetic Dermatology

PATIENT INFORMATION

PATIENT NAME: LAST FIRST MI	SOCIAL SECURTIY NUMBER	
MAILING ADDRESS: STREET/PO	DATE OF BIRTH:	SEX (CIRCLE) FEMALE MALE
CITY: STATE: ZIP CODE:	HOME #:	CELL #:
EMAIL ADDRESS:	MARTIAL STATUS: (CIRCLE) SINGLE. DIVORCED. MARRIED. WIDOW. PARTNER	
RACE: (CIRCLE). CAUCASION. AMERICAN INDIAN. ALASKAN NATIVE. ASIAN. AFRICAN AMERICAN. NATIVE AMERICAN. PACIFIC ISLANDER OTHER:	ETHNICITY: (CIRCLE) HISPANIC. NON HISPANIC	
2ND SEASONAL ADDRESS: STREET/PO. APT#. CITY. STATE. ZIP CODE		

PERSON REPSONSIBLE FOR CHANGES

If person responsible for payment is different from patient, the complete below. If 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 CONACT:
PATIENT RELATIONSHIP TO RESPONSIBLE PARTH (CIRCLE: SPOUSE CHILD. OTHER:	WORK PHONE:

REFERRAL INFORMATION

PRIMARY CARE PHYSICIAN:	NAME OF REFERRING PHYSICIAN:

EMERGENCY CONTACT

IN CASE OF EMERGENCY NOTIFY: (FULL NAME)	PHONE:

INSURANCE INFORMATION

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

I hereby certify the above information is true and correct to the best of my knowledge. I also understand it's MY responsibility to understand my insurance coverage. I further understand that A to Z Dermatology will assist me in obtaining authorization from primary care physician or insurance company. However, if authorization is not obtained I may be financially responsible. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPAA guidelines. I authorize A to Z Dermatology to release any medical information including diagnosis, test results, reports and records pertaining to any treatment or examination rendered to me. I authorize payment of medical benefits to A to Z Dermatology.

PATIENT OR RESPONSIBLE PARTY SIGNATURE: _____ DATE: _____

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PATIENT CONSENT

CONSENT FOR TREATMENT
I authorize A to Z Dermatology LLC, it's employees and agents, including physicians, physician assistants, and other employees, to provide any healthcare services that my provider deems necessary to diagnosis and or treatment. The duration of this consent is indefinite and continues until revoked in writing. If a biopsy is performed, I authorize the Pathologists to send my specimen for a second opinion and or obtain special tests if medically necessary to ensure and accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and or supplemental policy. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

CONSENT FOR PHOTOS
I understand during the course of my treatment, photographs may be taken for clinical and education purposes. Audio taping, videotaping, or photography is not allowed by non-staff members.

CONSENT FOR FILING INSURANCE CLAIMS
I understand A to Z Dermatology required your signature on file for claims submission to your insurance company, Medicare and or supplemental policy when an assigned claim is filed. I understand that this authorization may include release of information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV). I also authorize A to Z Dermatology to appeal any denials to my Insurance Company, Medicare and or supplemental policy that is necessary for the processing of claims. I understand I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to A to Z Dermatology. I understand that should my account become delinquent; I will pay the collection and attorney's fees of A to Z Dermatology, if any. **Initial** _____

CONSENT FOR ELECTRONIC PRESCRIPTION HISTORY
I understand that to officer the best patient care, A to Z Dermatology will retrieve my prescription history that has been ordered and filed through and EHR system. I authorize A to Z Dermatology to import the prescription history obtained through and EHR system into my electronic chart.

CONSENT FOR APPOINTMENT REMINDERS/THIRD PART COMMUNICATIONS
I authorize A to Z Dermatology to send me appointment reminders via SMS text messages, phone calls and emails. I understand that message/data rate may apply to messages sent by A to Z Dermatology under my cell phone plan. I authorize A to Z Dermatology and third-party collection agents to utilize all contact information I have provided in efforts to communicate regarding my account. I agree that affiliates may contact me through text messages, ringless calls and emails to provide me with my bill and to remind me to pay for services provided by A to Z Dermatology, in compliance with federal and state laws. I understand that I am under no obligation to receive automated notification and may opt out of these communications at any time by following the prompts in the reminder. Further, I may revoke my consent to receive billing and payment communication by affiliates.

Patient or Responsible Party's Signature_____

Printed Patient's Name: _____

Date: _____

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PATIENT FINANCIAL POLICY

Thank you for choosing A to Z Dermatology for your skin care needs. We're committed to providing quality and affordable health care. Our team works hard to ensure you paperwork is filed accurately and promptly.

INSURANCE: We participate with insurance plans, including Medicare. As a courtesy, we will bill whichever insurance you have indicated. Please help us maintain current and accurate information by filling out our forms completely, legibly and informing us of any changes (I.e. address, phone numbers, name changes, medical insurance, etc.)

KNOW YOUR BENEFITS: All insurances including Medicare have different plans and benefits. Benefits are an arrangement between you and your insurance company. It's important to know what services are covered under your specific plan. Insurance plans have their own specific criteria for services they will and will not cover; and how frequently they will cover. It's impossible to know all of the many different employer group benefits from one employer to the next. Therefore, A to Z Dermatology cannot be held responsible for notifying the patient if a particular service is or is not covered. However, our staff will make every effort in assisting you with understanding you health benefits.

PROOF OF INSURANCE/ID: All patients are required to complete our patient information form. We must obtain a copy of your driver's license and a current valid insurance card. If you are unable to present your insurance card at the time of service or are covered by an insurance plan which we are not contracted, you are required to pay in full for services in advance.

COPAYMENTS, COINSURANCE AND DEDUCTIBLES: All patient responsibility such as copays, coinsurance and deductibles must be paid at the time of service. This is the contractual agreement between you and your insurance company. Refusing to pay your patient responsibility may be considered a break of contract with your health plan. We may decline to see patients for non-emergent visits if patient responsibility is not paid at the time of service.

CLAIMS SUBMISSION: As a courtesy we will submit your claims to the insurance companies we are contracted with and assist you in any way that's reasonable to help get your claim paid. Your insurance may need additional information from you. It's your responsibility to comply within a timely manner.

NONPAYMENT: In the event your insurance company does not pay your claim withing 60 days, the remaining balance will become your responsibility and a statement will be sent. Accounts that are 60 days past due may be turned over to a collection agency. Patient's sent to collections will be discharged from the practice after 30 days unless the balance is pain in full. Patient are notified by regular or certified mail that they have 30 days to establish alternative medical care. You can be seen at A to Z Dermatology for 30 days on a emergency basis.

NON-COVERED SERVICES: Your A to Z Dermatology provider may provide services that may not be covered with your insurance benefit plan. Patients or Guarantors are required to pay at the time of visit for non-covered services.

PRIVATE PAY/SELF PAY: Payments are due in full at time of service. No exceptions

"NO SHOW" POLICY: Any patients that does not show for their scheduled visit and failed to call within 24 hours of appointment time to cancel will be charged **$50**. Any patient that does not show for their scheduled surgery appointment and failed to call within 48 hours to cancel will be charged **$300.**

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, Pathology and Lab specimens sent outside of our office are billed independently of A to Z Dermatology. You may receive a bill from the outside lab and will be responsible to pay that facility.

I have read and agree with the above Patient Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

Patient or Responsible Party's Signature _____ Date: _____

Printed Patient's Name: _____

Responsible Party's Printed Name (if applicable): _____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICEOF PRIVACY PRACTICE

I _____ acknowledge that I have received a copy of A to Z Dermatology NOTICE OF PRIVACY PRACTICES. This notice describe how A to Z Dermatology may use and disclose my protected health information, restrictions on the use of disclosure of my health care information, and rights I may have regarding my proctected health Information.

_____ _____
(signature of Patient or Personal Representative) (date)

_____
(relationship to patient)

Personal Representative (family members, attorney, etc.). I hereby authorize A to Z Dermatology and it's employees to discuss, send and or receive medical information to the following:

Please provide their names and phone numbers below:

1. **Name: _____ Relationship: _____**

   Phone number: _____

2. **Name: _____ Relationship: _____**

   Phone number: _____

3. **Name: _____ Relationship: _____**

   Phone number: _____

Communication Consent

Authorization for Communication via Voicemail, email and text

I hereby allow non-melanoma skin cancer and non-cancerous test results, blood work results, and all other communication can be relayed in a voice message, text and email on the communication methods indicated in the box.	Phone Number: ( ) _____ - _____ Email: _____

By signing below, I certify that I have read the above information and my questions concerning A to Z Dermatology policies have been answered. My signature signifies my understanding and agreement with the above information. The duration of this consent is indefinite until revoked in writing.

PATIENT NAME:		PATIENT DOB	
PARENT/LEGAL GUARDIAN PRINTED NAME:		RELATIONSHIP TO PATIENT	
SIGNATURE:		DATE:	

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HISTORY AND INTAKE FORM

Patient Name:	DOB	AGE

CURRENT OR PAST MEDICAL HISTORY (MARK ALL THAT APPLY)

☐ Artificial Heart Valve/Infection	☐ Artificial joint replacement Year:	☐ Cold sores/herpes
☐ Hepatitis, Type _____	☐ HIV/AIDS	☐ Organ Transplant: Organ:_____ Year:_____
☐ Pacemaker: Year:	☐ Staph Bacterial Inftection	☐ MRSA Infection
☐ Vasovagal Reaction (fainting)	☐ Diabetes	☐ High Blood Pressure
☐ High Cholesterol	☐ Autoimmune Condition _____	☐ Hyperthyroid (high thyroid) ☐ Hypothyroid (low thyroid)
☐ Other: _____		

Surgical Procedures (within the past 2 years)

SKIN DISEASE HISTORY (PLEASE CHECK ALL THAT APPLY)

☐ ACNE: HAVE YOU TAKEN ACCUTANE IN THE PAST? YEAR:_____	☐ DRY SKIN	☐ PRECANCEROUS MOLES:	☐ ACTINIC KERATOSIS
☐ ECZEMA	☐ PSORIASIS	☐ FLAKING/ITCHY SCALP	☐ BLISTERING SUNBURN
☐ HISTORY OF HAY FEVER:		☐ HISTORY OF ASTHMA:	
HISTORY OF SKIN CANCERS: ☐ BASAL CELL CARCINOMA. ☐ SQUAMOUS CELL CARCINOMA ☐ MELANOMA		☐ FAMILY HITORY 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 ☐

LIST ALL MEDICATIONS TAKING IF NO LIST HAS BEEN PROVIDED:

_____

_____

ALLERGIES (LIST ALL ALLERGIES)

NO KNOWN DRUG ALLERGIES: ☐ _____

_____

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
☐ CHANGING MOLE	☐ RASH	☐ DEPRESSION
☐ IMMUNOSUPPRESSION	☐ THYROID PROBLEMS	☐ JOINT PAIN
☐ UNINTENTIONAL WEIGHTLOSS	☐ CHEST PAIN:	☐ OTHER:

ALERTS (check all that apply)

☐ ALLERGY TO ADHESIVE	☐ ALLERGY TO LIDOCAINE	☐ DEBFIBRILLATOR	☐ PACEMAKER
☐ BLOOD THINNERS	☐ PREGNANT	☐ RAPID HEARTBEAT TO EPINEPHRINE?	☐ GI UPSET

HAVE YOU RECEIVED ANY OF THE FOLLOWING VACCINATIONS (check all that apply)

☐ FLU (OCT-MAR)	☐ PNEUMONIA (65+ ONLY)	☐ SHINGLES (50+ ONLY)	☐ COVID

PHARMACY INFORMATION:

PHARMACY NAME:	ADDRESS OR CROSS STREETS	PHONE NUMBER

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