Advanced Dermatology & Skin Cancer Associates, PLLC
Purvisha Patel, M.D., FAAD, FASDS
Board-Certified Dermatologist/Fellowship-Trained Mohs & Cosmetic Surgeon

Patient Name: _____, _____, _____
Last Name First Name Middle Initial

Address: _____

_____, _____ _____ Marital Status: □ Married □ Single □ Divorced □ Widowed
City State Zip Code

Date of Birth _____/_____/_____ Age: _____ Sex: _____ Social Security No:_____

Home Phone # (_____)_____ Work Phone #(_____)_____ Cell #(_____)_____

Email address:_____ Drivers License #:_____ Occupation:_____

Preferred Pharmacy with Street Location:_____

Patient Employer: _____

Business Address:_____

Responsible Party: _____ Relationship to patient: _____

How were you referred to our practice? □ Friend/Relative □ Hospital Referral □ Advertisement □ Physician _____

Are you interested in any cosmetic or laser treatment, if so? _____

Spouse's/ Responsible Party Information:

Name: _____, _____, _____
Last Name First Name Middle Initial

Address: _____, _____ _____ _____
City State Zip Code

Date of Birth _____/_____/_____ Social Security No:_____

Work Phone #(_____)_____ Cell #(_____)_____ Drivers License #:_____

Insured Information:
Primary Insurance Company: _____

Policy Holder: _____, _____, _____ DOB: _____/_____/_____
Last Name First Name Initial

Insurance Company Address:_____, _____ _____ _____
Street City State Zip Code

Policy Number: _____ Group Number: _____ Effective Date:_____
Co-Pay Required_____

Secondary Insurance Company: _____

Policy Holder: _____, _____, _____ DOB: _____/_____/_____
Last Name First Name Initial

Insurance Company Address:_____, _____ _____ _____
Street City State Zip Code

Policy Number: _____ Group Number: _____ Effective Date:_____
Co-Pay Required_____

To the best of my knowledge, the above information is complete and correct. I understand that my insurance coverage is a contract between myself and my insurance company and I take full responsibility for financial obligations incurred.

_____ _____
Patient Signature/Guardian Signature **Date Signed**

Advanced Dermatology & Skin Cancer Associates, PLLC
Purvisha Patel MD, FAAD, FASDS
Board Certified Dermatologist/Fellowship Trained Mohs & Cosmetic Surgeon

Video & Photography Policy:

I understand that Advanced Dermatology and Skin Cancer Associates will take my picture and use it only as a Patient Identifier. This picture will be used strictly for the use of my personal medical chart and will fall under the guidelines of HIPPA laws and will be protected as Private Health Information (PHI).

Patient Signature/Guardian Signature: _____ Date:_____

I understand that if I undergo Surgery or a cosmetic procedure at this facility, photos may be taken, by the staff, of the procedure site. These pictures will be used strictly for charting and record keeping purposes. They are medically necessary in documenting each patient's case. These pictures will be used strictly for the use of my personal medical chart and will fall under the guidelines of HIPPA laws and will be protected as Private Health Information (PHI).

Patient Signature/Guardian Signature: _____ Date:_____

I understand that taking personal videos, photographs or recordings of any kind in this facility are strictly prohibited, unless mutually consented. In the event that unauthorized personal videos, photos, or recordings taken in the office of any type are posted on line through email, websites, social media, ect. ADSCA cannot be held responsible, accountable, or liable.

Patient Signature/Guardian Signature: _____ Date:_____

Advanced Dermatology & Skin Cancer Associates, PLLC
Purvisha Patel MD, FAAD, FASDS
Board Certified Dermatologist/Fellowship Trained Mohs & Cosmetic Surgeon

CONSENT FOR CARE

I hereby give my consent for treatment to Purvisha Patel, M.D.

Signature:_____ _____ Date:_____
Patient, Parent or Guardian Relationship

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to Purvisha Patel, M.D. for services rendered to me or my dependants. I also authorize this office to release any information necessary to expedite insurance claims. I understand that I am responsible for any balance not covered by insurance and/or collection costs and legal fees incurred in an attempt to collect said balance.

Signature:_____ _____ Date:_____
Patient, Parent or Guardian Relationship

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Purvisha Patel, M.D. for services furnished me by that provider. I also authorize any holder of medical information about me to release to the Center for Medicare/Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature:_____ _____ Date:_____
Patient, Parent or Guardian Relationship

AUTHORIZATION TO LEAVE MESSAGE

I hereby authorization Purvisha Patel, M.D. to leave a message regarding pending appointments/or tests at my residence. ___yes ___ no. It is ok to leave a message with my employer ___yes ___no. It is ok to leave a message with family member: _____ (list who) phone number _____.

Signature: _____ _____ Date:_____
Patient, Parent or Guardian Relationship

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed October 2005.

Signature: _____ _____ Date:_____
Patient, Parent or Guardian Relationship

Advanced Dermatology & Skin Cancer Associates, PLLC
Purvisha Patel MD, FAAD, FASDS
Board Certified Dermatologist/Fellowship Trained Mohs & Cosmetic Surgeon

FINANCIAL POLICY

Thank you for choosing Advanced Dermatology and Skin Cancer Associates to serve you and your family's dermatology needs. We are pleased to participate in your family's health care and look forward to establishing a lasting relationship as one of your health care providers. As part of this relationship, we wish to establish our expectations of your financial responsibility as outlined in our Financial Policy. Your medical insurance is a contract between you and your insurance company. We can often help with providing information to help you in filing your claims, but you are primarily responsible for any charges that you have incurred as a patient with Advanced Dermatology. Please review and sign the following financial policy prior to your office visit.

1) **COPAYMENTS, DEDUCTIBLES, AND FEES** – All copayments, insurance deductibles, and fees for services not covered by your insurance policy are due at the time that service is rendered. We accept cash, check, or credit cards.

2) **INSURANCE** – Patients must complete and sign information in regards to your insurance prior to seeing the physician. You must present a current insurance card at each visit. If you or one of your children does not present a current insurance card, you will be responsible for payment at the time of your visit. You will receive reimbursement from Advanced Dermatology if your insurance pays the claim at a later date. If your insurance carrier is not one with which we participate, you are responsible for payment in full. Insurance plans and Medicare consider some services to be "noncovered," in which case you are responsible for payment in full.

3) **MINORS AND DEPENDENTS** – Parents and guardians are responsible for payments for their dependents at the time that service is rendered. Minors and dependents must present a valid insurance card at each visit if a claim is to be filed. See item #2 above if an insurance card is not presented.

4) **PROMPT PAYMENT** – Just as we make every effort to accommodate you when you are in need of medical care, we expect that you will make every effort to pay your bill promptly. If you have a financial hardship or if you are unable to pay your bill in its entirety please contact our billing office to discuss payment options. If your accont becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collections agency.

5) **LAB AND PATHOLOGY SERVICES** – Lab and pathology services are often utilized as a result of services provided by Advanced Dermatology. Any charges for lab and pathology services will be billed directly to you and/or your insurance company. These charges are your full responsibility.

6) **COSMETIC AND MEDICAL SERVICES** – Cosmetic services are separate charges and are not covered by your insurance. If medical services are addressed at the same appointment as a cosmetic consult, additional charges for the medical services will be charged and billed to your insurance company. Copays for the medical services will also be due at the time of visit.

7) **RETURNED CHECKS** – There will be a $25.00 charge for any check returned by your bank for any reason.

I have read the Financial Policy and agree to its terms.

Patient Signature/Guardian Signature: _____ Date:_____

Advanced Dermatology & Skin Cancer Associates, PLLC
Purvisha Patel MD, FAAD, FASDS
Board Certified Dermatologist/Fellowship Trained Mohs & Cosmetic Surgeon

PATIENT REPRESENTATIVE INFORMATION

Patient Name _____ Date of Birth_____

Please list the names of persons that you wish to have access to your Protected Health Information. Please note the HIPAA privacy rule prohibits us from disclosing your health information without your authorization. Your representative must be listed or we will be unable to discuss your care with them.

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

Please list the name of the person with whom we can discuss your bill

Name_____Relationship_____

Name_____Relationship_____

Name_____Relationship_____

****Representative must provide patient date of birth and address to receive information****

**** Authorization will remain effective until new/updated documentation received.****

Patient/Guardian Signature_____ Date _____

7658 Poplar Pike ‖ Germantown TN 38138 ‖ Tele: 901/759-2322 ‖ Fax: 901/759-2077

Advanced Dermatology & Skin Cancer Associates, PLLC
Purvisha Patel MD, FAAD, FASDS
Board Certified Dermatologist/Fellowship Trained Mohs & Cosmetic Surgeon

MEDICAL HISTORY

Patient Name _____ Today's Date _____

Primary Insurance Company _____ Employer _____

Referring Doctor _____

Are you pregnant? Y N Are you trying to become pregnant? Y N
Are you nursing? Y N

Please list all allergies	Please list all medications you take

Do You Have or Have You Had Any of the Following

Mitral Valve Prolapse Y N	Rheumatic Fever Y N
Do you need antibiotics prior to having dental work? Y N	Epilepsy, Seizures, Fainting Spells Y N
Heart Murmur Y N	High Blood Pressure Y N
Pacemaker Y N	Heart Attack Y N
Heart Disease Y N	Abnormal Bleeding/Hemophilia Y N
Asthma Y N Hay Fever Y N	Skin Allergies Y N
Arthritis Y N	HIV/Aids Y N
Kidney Disease Y N	Liver Disease Y N
Thyroid Disease Y N	Diabetes Y N
Drug/Alcohol Dependency Y N	Glaucoma Y N
Cancer Y N If yes, what type	Specific Skin Diseases Y N If yes, what type?
Personal History of Skin Cancer Y N If yes, what type?	Family History of Skin Cancer Y N if yes, what type? Which Relative?
Do you smoke Y N Number of packs per day	Do you drink alcohol Y N Number of drinks per week

Doctor's Comments _____

1. Date _____ Comments _____ Initials _____
2. Date _____ Comments _____ Initials _____
3. Date _____ Comments _____ Initials _____