Advanced Dermatology & Skin Cancer Associates, PLLC

▪ Purvisha J Patel, MD ▪ Matthew Craig Gordon, MD
▪ Natalie Morgan, PA-C ▪ Alexis Johnson, PA-C ▪ Jennifer Hinders, PA-C ▪ Jodie Holmes, NP ▪ Misty Moore, NP

Patient Full Name: *As listed on your insurance card*

_____

Patient Mailing Address:

_____**City**_____**State**_____**Zip**_____

Pharmacy Name/Address/Phone Number :

Email address: _____

NOTIFICATION OF LAB/PATHOLOGY REQUIREMENTS- If your insurance company requires a specific laboratory or pathology lab please specify_____

Marital Status: □ **Married** □ **Single** □ **Divorced** □ **Widowed**

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

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

Preferred method of communication: □ **Phone** □ **TEXT** □ **Email**

Patient Employer and Address: _____ **Occupation:** _____

Emergency Contact: Name_____ **Relationship:** _____ **Phone Number:** _____

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

Responsible Party Name & Address (if patient is a minor)

_____

Responsible Party: Date of Birth _____/_____/_____

PRIMARY
Insurance:_____

Policy#:_____**Group#**_____

Insured: Name_____**DOB:**_____**Employer:**_____

Gender: _____ **Relationship to Insured:** _____**SS#:**_____

SECONDARY
Insurance_____

Policy#_____**Group#:**_____

Insured: Name_____ **DOB:** _____**Employer:**_____

Gender: _____**Relationship to Insured:** _____**SS#:**_____

CONSENT FOR CARE

I hereby give my consent for treatment to ADSCA, I understand that pictures may be taken as a patient identifier. Clinical photos may be taken for charting, research and/or promotional purposes. Your privacy WILL BE PROTECTED per HIPAA Law. I further understand that taking personal videos/photos/recordings is prohibited unless authorized by ADSCA. In the event that unauthorized material/photos are taken by patient in the office and posted online through social media, websites, email, etc. ADSCA cannot be held responsible, accountable, or liable.

*Initial here*_____

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize payment to Purvisha Patel, M.D./ADSCA 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. *Initial here*_____

LIFETIME AUTHORIZATION TO FILE MEDICARE

I request that payment of authorized Medicare benefits be made either to me or on my behalf to ADSCA. 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. *Initial here*_____

AUTHORIZATION TO LEAVE MESSAGE

I hereby authorization ADSCA. 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: _____. *Initial here*_____

_____ _____
Patient Signature/Guardian Signature Date Signed

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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 account 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. Co pays 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.

8) **NOTIFICATION OF LAB/PATHOLOGY REQUIREMENTS**- If your insurance company requires a specific laboratory, other than our laboratory of AEL or UT Derm Path

9) **MEDICAL RECORDS REQUEST-**The preparation of medical forms and records require time to complete. Completion of these forms may take up to 10 business days. There is a $30.00 charge for the preparation of form(s). This charge is not covered by your insurance company, and is payable by you prior to the completion of these forms. Our policy is to return completed forms directly to the patient, either in person or via mail. We do not fax forms to employers or insurance entities.

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

I have read the Financial Policy and agree to its terms. Expires: 12-31-2099 unless updated by Patient or ADSCA

Patient Signature/Guardian Signature: _____

Date_____

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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_____

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.****

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

Patient/Guardian Signature_____ Date _____

Expires 12-31-2099 unless otherwise updated by patient or ADSCA

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MEDICAL HISTORY

Patient Name **Today's Date**

Primary Insurance Company

Referring Doctor **PHARMACY**

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/Hepatitis C 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_____Intials_____