The DERM Center

PATIENT DEMOGRAPHICS

Date: _____

PATIENT INFORMATION (Please Print)

LAST NAME:_____ FIRST NAME:_____ M.I.:____

DOB:_____ BIRTH SEX: Male ◯ Female ◯ LANGUAGE:_____

RACE:_____ MARITAL STATUS:_____ SSN:_____

ETHNIC GROUP: ____Not Hispanic/Latino ____Hispanic/Latino ____Decline to Answer ____Unknown

HOME PHONE:_____ MOBILE PHONE:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

EMPLOYER:_____

EMAIL ADDRESS:_____

GUARANTOR (If different from patient or patient is a minor) **RELATION:_____**

LAST NAME:_____FIRST NAME:_____

DOB:_____PHONE:_____

ADDRESS:_____

CITY/STATE/ZIP:_____

PREFERRED PHARMACY

PHARMACY NAME / LOCATION:_____

ADDITIONAL INFORMATION (Please Print)

REFERRING PROVIDER _____ PRIMARY CARE PROVIDER _____

INSURANCE INFORMATION (Please Print)

(1) **PRIMARY INSURANCE** _____ MEMBER ID/GROUP #_____

POLICY HOLDER NAME_____ POLICY HOLDER DOB_____

RELATIONSHIP TO SUBSCRIBER_____

(2) **SECONDARY INSURANCE** _____ MEMBER ID/GROUP #_____

POLICY HOLDER NAME_____ POLICY HOLDER DOB_____

RELATIONSHIP TO SUBSCRIBER_____

EMERGENCY CONTACT (Please Print) **RELATION:_____**

NAME_____ PHONE NUMBER_____

Copays are due at the time of service. Patients with annual deductibles are asked to make a $100.00 payment upon checking in for each visit. This covers applicable copays and is applied to your patient balance and deductible after your visit is processed by insurance. Cash pay/elective services must be paid in full on the date of service. Past due accounts must be paid in full prior to scheduling.

As the responsible party, I agree to pay any collection or attorney fees owed in addition to court costs if my account becomes outstanding and is forwarded to a collection agency. **No-Show Appointments:** More than one office visit missed will incur a **$25.00 no show fee**; Any surgeries/procedures missed will incur an **automatic $75 no show fee**. This fee must be paid in full prior to rescheduling your appointment.

PATIENT/GUARANTOR SIGNATURE _____ DATE _____

The DERM Center

Patient Name: _____

HISTORY & INTAKE / HEALTH INFORMATION

PAST MEDICAL HISTORY: (Please check all that apply)

- ❑ Anxiety disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial fibrillation
- ❑ BPH (Benign Prostatic Hypertension)
- ❑ Cerebrovascular accident
- ❑ COPD (Chronic Obstructive Pulmonary Disea
- ❑ Coronary artery disease
- ❑ Depression
- ❑ Diabetes
- ❑ Elevated blood pressure
- ❑ End-stage renal disease
- ❑ Epilepsy (Seizures)
- ❑ GERD (Gastroesophageal Reflux Disease)
- ❑ History of hypertension
- ❑ HIV (Human Immunodeficiency Virus Infectior
- ❑ Hypercholesterolemia
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Inflammatory disease of liver
- ❑ Leukemia
- ❑ Malignant lymphoma
- ❑ Malignant tumor of breast
- ❑ Malignant tumor of colon
- ❑ Malignant tumor of lung
- ❑ Malignant tumor of prostate
- ❑ Radiation treatment
- ❑ Transplantation of bone marrow
- ❑ Other_____

PAST SURGICAL HISTORY: (Please check all that apply)

- ❑ Abdominoperineal resection
- ❑ Bilateral replacement of knee joints
- ❑ Biopsy of breast
- ❑ Biopsy of prostate
- ❑ Coronary artery bypass graft
- ❑ Entire transplanted kidney
- ❑ Excision of basal cell carcinoma
- ❑ Excision of melanoma
- ❑ Excision of squamous cell carcinoma
- ❑ History of colostomy
- ❑ History of tubal ligation
- ❑ History of appendectomy (removal of appendix)
- ❑ History of cholecystectomy (removal of gallbladder)
- ❑ History of colectomy (removal of colon)
- ❑ History of liver excision
- ❑ History of coronary angioplasty
- ❑ History of tissue graft heart valve replacement
- ❑ History of total cystectomy
- ❑ History of transurethral prostatectomy
- ❑ Hysterectomy
- ❑ Kidney biopsy
- ❑ Lower anterior resection of rectum
- ❑ Lumpectomy of breast
- ❑ Lumpectomy of left breast
- ❑ Lumpectomy of right breast
- ❑ Mastectomy of left breast
- ❑ Mastectomy of right breast
- ❑ Mechanical heart valve replacement
- ❑ Oophorectomy (removal of ovary(ies)
- ❑ Pancreatectomy (removal of pancreas)
- ❑ Percutaneous extraction of kidney stone
- ❑ Portosystemic shunt operation
- ❑ Prostatectomy (removal of prostate)
- ❑ Prosthetic arthroplasty of bilateral hips
- ❑ Splenectomy (removal of spleen)
- ❑ Surgical skin biopsy
- ❑ Total nephrectomy
- ❑ Total orchidectomy
- ❑ Total replacement of left hip
- ❑ Total replacement of right hip
- ❑ Total replacement of left knee
- ❑ Total replacement of right knee
- ❑ Transplantation of heart
- ❑ Transplantation of liver
- ❑ Other_____

SKIN CONDITION HISTORY: Please check all that apply)

- ❑ Acne
- ❑ Actinic keratosis
- ❑ Asteatosis cutis (very dry skin)
- ❑ Basal cell carcinoma
- ❑ Contact dermatitis due to poisc
- ❑ Dysplastic nevus of skin
- ❑ Eczema
- ❑ History of asthma
- ❑ History of hay fever/allergies
- ❑ Malignant melanoma
- ❑ Pruritus (itching) of scalp
- ❑ Psoriasis
- ❑ Squamous cell carcinoma
- ❑ Sunburn of second degree
- ❑ Other_____

Do you wear sunscreen? □ Yes □ No If yes, what SPF? _____

Do you tan in a tanning bed? □ Yes □ No

Family history of melanoma? □ Yes □ No If yes, which relative? _____

Any other family history? _____

MEDICATIONS / DOSAGE / FREQUENCY:

_____

_____

ALLERGIES:

_____

_____

SOCIAL HISTORY: (Please circle)

Smoking/Vaping: □ No □ Quit / Former Smoker □ Occasional □ Daily

Alcohol Use: □ No □ Yes (How much/often? _____)

Have you received a flu shot within the last year? ❑ Yes ❑ No

Have you received the pneumonia vaccine within the last 10 years? ❑ Yes ❑ No

_____Patient Initials

The DERM Center

HEALTH INFORMATION/ ROS

REVIEW OF SYSTEMS: Are you <u>currently</u> experiencing any of the following?
(Please check Yes or No)

Symptom	Yes	No	**Symptom**	Yes	No
Fever/Chills			Problem with Healing		
Night Sweats			Problem with Scarring/Keloids		
Unintentional Weight Loss			Rash		
Shortness of Breath			Headache		
Cough			Seizures		
Chest Pain			Anxiety		
Abdominal Pain			Depression		
Joint Aches			Hay Fever		
Muscle Weakness			Problems with Bleeding		
Thyroid Problems			Immunosuppression		

Other Symptoms:_____

ALERTS: Do any of these apply to you **<u>currently</u>**? (Please check Yes or No)

Symptom	Yes	No	**Symptom**	Yes	No
Pregnant			Defibrillator		
Breastfeeding			Pacemaker		
Artificial Joint			History of MRSA		
Artificial Heart Valve			HIV Positive		
Blood Thinners			History of Hepatitis B		
Allergy to Lidocaine			History of Hepatitis C		
Allergy to Latex			Rapid Heartbeat with		
Allergy to Topical Antibiotics			Prophylactic Antibiotics		
Allergy to Adhesive			Fainting with Procedures		

Other Symptoms:_____

_____Patient Initials:

The **DERM** Center

Financial Policy

POINT-OF-SERVICE (POS) COLLECTIONS POLICY

The DERM Center participates in POS Collections and asks **each patient to pay a portion of their services prior to checking in for their visit**. This policy applies to those that are insured and need to pay a deductible, copay, or coinsurance amount, or those who pay solely out-of-pocket. By collecting payment at point of service (POS) we are able to spend less time billing patients and more time *treating* them. Additionally, each patient has a legally bound contract with their insurance company. By enforcing our policy and collecting the patient's financial obligation, we are doing our part to enforce those terms.

OUR POLICY

INSURED PATIENTS ($100.00) Patients with annual deductibles are asked to pay **$100.00** on the day of their office visit. This payment goes toward paying down costs associated with your visit. (Copay, deductible, coinsurance.) This policy applies to each office visit until you have met your deductible, at which time we will only take payment for any required copay/coinsurance amounts. Eligibility and deductible/copay/coinsurance amounts will be verified during check in.

UNINSURED/CASH PAY PATIENTS ($179.00 + addn'l visit fees) Services must be paid IN FULL on the day of service. A down payment of **$179.00** is collected upon checking in for the visit. Additional fees associated with your diagnosis/treatment will be provided in the room prior to those additional services being rendered. Fees associated with your diagnosis/treatment will be collected in full at checkout.

SURGERIES / PROCEDURES a **30% down payment** will be required prior to scheduling any surgeries or procedures for patients that have annual deductibles that have not been met. (30% of the billable charges.) This payment is applied toward applicable deductible / copays / out of pocket expenses.

PAST DUE BALANCES must be paid in full prior to scheduling future appointments.

MINORS must be accompanied by their guarantor on their first visit and payment prior to services is required. Should the minor attend future appointments without a guardian present, payment is still required prior to being seen or the appointment will be rescheduled.

IF YOU ARE UNABLE TO MAKE THESE PAYMENTS IN FULL AT THE TIME OF YOUR VISIT, YOU WILL BE ASKED TO RESCHEDULE.

INSURANCE GUIDELINES

Your insurance is a contract between your insurance company and you. It is your responsibility to know and understand the terms, guidelines, and limitations of your plan. Deductibles, coinsurance, and copays are the responsibility of the policy holder at the time of service. It is also your responsibility to advise us of any changes in your insurance. If we are contracted with your insurance company, we will submit your claim for processing. Should they deny your claim or deem a service "not a benefit" or a "non-covered service" you will be responsible for the balance.

IN NETWORK VS OUT OF NETWORK - We participate with most major insurance companies. However, most have more than one plan for individual participants that contain varying coverage benefits. Your plan may be considered either in-network or out-of-network. It is your responsibility to understand your individual plan's coverage benefits to make sure the plan covers the services to be rendered.
*We currently do NOT accept Medicaid plans.

- ***NO SURPRISES ACT OF 2022*** *- In accordance with the No Surprises Act of 2022, it is your responsibility to see participating providers within your individual plan. Should your plan not participate with The DERM Center or a provider of The DERM Center, and you receive medical services, you will be billed the Out of Network patient responsibility or non-participating balances as they pertain to services provided.*

REFERRALS - It is your responsibility to ensure we have any required referrals or pre-certifications **prior** to your visit. If we do not, you will be responsible for payment, or will need to reschedule your appointment.

BILLING GUIDELINES

We will send your claim to your insurance company for processing. We will apply payments made at the time of your visit toward this balance and any remaining balances will be mailed to you. Payment for these balances are due upon receipt.

COLLECTIONS

Outstanding accounts will be forwarded to a collection agency at the patient's expense. *Outstanding accounts will not be able to schedule appointments with The DERM Center until the balance is paid in full.*

CONTINUED ON NEXT PAGE >>>

LABORATORY SERVICES (PATHOLOGY / LABS / SPECIMENS)

Some services, such as biopsies, procedures requiring the removal of a specimen, and bloodwork, require specimens to be sent to a laboratory for processing. You will receive a separate bill from this laboratory. **If your insurance requires the use of a specific lab, this must be clearly communicated to our staff prior to services being provided.** Because these charges are separate and generated outside of our practice, any questions about laboratory billing must be directed to the resulting agency on your bill.

PAYMENTS

The DERM Center accepts payment in the form of cash, credit/debit (not AMEX), money order, and check. **Post-dated checks will not be accepted,** and all **returned checks will incur a $50 returned check fee** and will be applied to the patient's account. Payments can be made through your patient portal, online through our website, in person, and by phone. Payment arrangements may be considered for those patients who need assistance in meeting their account obligation. (Not applicable to past due accounts.) The DERM Center reserves the right to set the terms and conditions for any payment arrangement.

MISSED APPOINTMENT FEES

We respectfully request that you provide notice if you are unable to make your appointment. We understand that unforeseen events may result in the need to cancel your appointment at the last minute. However, if you miss more than one appointment within one calendar year, the following no-show fees will be applied to your account and MUST be paid prior to rescheduled:

OFFICE VISITS: $25.00 No Show Fee
SURGERY / PROCEDURE: $75.00 No Show Fee

By signing this agreement: (Please review, initial, and sign)

_____(INITIAL) If insured AND with an annual deductible, I understand **$100.00** is due upon checking in for each of my visits and that these payments will be applied to my processed claims, toward my copay/deductible/out of pocket expenses.

_____(INITIAL) If cash pay/uninsured I understand **$179.00** is due upon checking in for each of my visits, as well as diagnosis/treatment fees that will be collected upon checking out for my visit. I understand that $179.00 is ONLY the cost of the office visit.

_____(INITIAL) I understand that more than one no show will result in a **$25.00** or **$75.00** no-show fee that will be applied to my account and will need to be paid in full prior to rescheduling my missed appointment.

_____(INITIAL) I understand that surgeries and/or procedures require a **30% down payment** prior to scheduling unless I have met my annual deductible, at which time applicable coinsurance estimates will be provided.

I hereby assign all applicable health insurance benefits and all rights and obligations that I and my dependents have under my health plan to The DERM Center and The DERM Center's representatives (hereinafter, "My Authorized Representatives") and I appointment them as my authorized representative with the power to: (1) File medical claims, appeals, and grievances with the health plan and (2) Discuss/divulge any of my personal health information or that of my dependents with any third party including the health plan. I certify that the health insurance information that I provided is accurate as of the date set forth below and that I am responsible for keeping it updated. I hereby authorize My Authorized Representatives to: (1) release information necessary to my health plan (or its administrator) regarding my diagnosis and treatments; (2) process insurance claims generated in the course of treatment. I understand that refusal to sign this form will result in my appointment being canceled or rescheduled.

_____ _____
(Patient Name - PRINT) (Guarantor Name - PRINT)

_____ _____
(Patient Signature) (Guarantor Signature)

_____ _____
(DATE) (DATE)

HIPAA CONSENT
FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT, PARENT OR GUARDIAN (IF MINOR) GIVING CONSENT

Patient Name:_____ Date of Birth:_____

Parent/Guardian Name (If Minor): _____

SECTION B: TO THE PATIENT — PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your protected health information (PHI) to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice is posted at the front desk, or you may request a printed copy from our receptionist. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to Amanda Baker, Practice Manager, at 651 East 4th Street, Suite 302, Chattanooga, Tennessee 37403. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and The DERM Center's Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature:_____Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient: _____

PHI DISCLOSURE AUTHORIZATION

Patient Name:_____ Date of Birth:_____

The DERM Center will NOT release any information on any patient, whether by phone or in person, without the written permission from the patient. This includes medical records, test results, disability forms, prescriptions, appointment details, etc., unless written consent is obtained from the patient or responsible party.

Please specify any individual(s) you give The DERM Center permission to release the above PHI to:

Name / Relationship (Please Print): _____

Phone Number: _____

Name / Relationship (Please Print): _____

Phone Number: _____

Name / Relationship (Please Print): _____

Phone Number: _____

TEXT MESSAGES: The DERM Center can send me text messages on my mobile phone. (These messages include important practice communication (weather, closures, etc.) and appointment reminders.)

YES NO

VOICEMAILS: The DERM Center may leave voicemails in reference to scheduling, treatment, or results on the following (**CIRCLE** all that apply:

MOBILE HOME WORK

Signature:_____ Date:_____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient:_____