

PATIENT DEMOGRAPHICS

Date:	

PATIENT INFORMATIO	N (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 PHON	VE:	
ADDRESS:				
GUARANTOR (If differe	ent from patient or patient is a			
LAST NAME:		FIRST N	IAME:	
	PHON			
PREFERRED PHARMAC	Υ			
PHARMACY NAME / LOCA	ATION:			
ADDITIONAL INFORMA				
REFERRING PROVIDER		PRIM	IARY CARE PROVIDER	
INSURANCE INFORMAT	FION (Please Print)			
(1) PRIMARY INSURANCE		MEMBE	ER ID/GROUP #	
POLICY HOLDER NAME			POLICY HOLDER DOB	
RELATIONSHIP TO SUBSCE	RIBER			
	ICE			
POLICY HOLDER NAME			POLICY HOLDER DOB	
RELATIONSHIP TO SUBSCE	RIBER			
EMERGENCY CONTACT	(Please Print)		RELATION:	
	·	PHONE N		
This covers applicable copay	of service. Patients with annual ded ys and is applied to your patient bal on the date of service. Past due acc	ance and deductible a	fter your visit is processed by in	_
forwarded to a collection age	gree to pay any collection or attorne ency. No-Show Appointments: More d will incur an automatic \$75 no sho	e than one office visit n	nissed will incur a \$25.00 no sho	w fee ; Any

PATIENT/GUARANTOR SIGNATURE ______ DATE _____



Patient Name:			

HISTORY & INTAKE / HEALTH INFORMATION

PASI	MEDICAL HISTORY: (Please check all that apply)		
	Anxiety disorder		1111//11
	Arthritis		HIV (Human Immunodeficiency Virus Infection
	Asthma		Hypercholesterolemia
	Atrial fibrillation		Hyperthyroidism
	BPH (Benign Prostatic Hypertension)		Hypothyroidism
	Cerebrovascular accident		Inflammatory disease of liver Leukemia
	COPD (Chronic Obstructive Pulmonary Disea:		
	Coronary artery disease		Malignant lymphoma
	Depression		Malignant tumor of breast
	Diabetes		Malignant tumor of colon
	Elevated blood pressure		Malignant tumor of lung
	End-stage renal disease		Malignant tumor of prostate
	Epilepsy (Seizures)		Radiation treatment
	GERD (Gastroesophageal Reflux Disease)		Transplantation of bone marrow
	History of hypertension		Other
PAST :	SURGICAL HISTORY: (Please check all that apply)		
	Abdominoperineal resection		Lumpectomy of breast
	Bilateral replacement of knee joints		Lumpectomy of left breast
	Biopsy of breast		Lumpectomy of right breast
	Biopsy of prostate		Mastectomy of left breast
	Coronary artery bypass graft		Mastectomy of right breast
	Entire transplanted kidney		Mechanical heart valve replacement
	Excision of basal cell carcinoma		Oophorectomy (removal of ovary(ies)
	Excision of melanoma		Pancreatectomy (removal of pancreas)
	Excision of squamous cell carcinoma		Percutaneous extraction of kidney stone
	History of colostomy		Portosystemic shunt operation
	History of tubal ligation		Prostatectomy (removal of prostate)
	History of appendectomy (removal of appendix)		Prosthetic arthroplasty of bilateral hips
	History of cholecystectomy (removal of gallbladder)		Splenectomy (removal of spleen)
	History of colectomy (removal of colon)		Surgical skin biopsy
	History of liver excision		Total nephrectomy
	History of coronary angioplasty		Total orchidectomy
	History of tissue graft heart valve replacement		Total replacement of left hip
	History of total cystectomy		Total replacement of right hip
	History of transurethral prostatectomy	_	Total replacement of left knee
	Hysterectomy	_	Total replacement of right knee
_	Kidney biopsy		Transplantation of heart
_	Lower anterior resection of rectum		Transplantation of liver
_	zone. anterior resection of rectain		Other

SKIN CONDITION HISTORY:	: Please check	all that apply)	
☐ Acne			History of asthma
☐ Actinic keratosis			,
☐ Asteatosis cutis (v	ery dry skin)		, , ,
☐ Basal cell carcinon			_
☐ Contact dermatitis	s due to poiso		
Dysplastic nevus o	•		
☐ Eczema	-		•
		u	Other
Do you wear sunscreen?	□ Yes	□ No If ye	es, what SPF?
Do you tan in a tanning bed	d? □ Yes	□ No	
Family history of melanoma	a? □ Yes	□ No If ye	es, which relative?
Any other family history?			
MEDICATIONS / DOSAGE /	FREQUENCY:		
ALLEDOIEC			
ALLERGIES:			
SOCIAL HISTORY: (Please ci	rcle)		
Smoking/Vaping:	□ No	□ Quit / Former Smoker	□ Occasional □ Daily
Alcohol Use:	□ No	☐ Yes (How much/often?)
Have you received a flu sho	t within the la	ast year?	☐ Yes ☐ No
Have you received the pre-	ımonia vassin	ne within the last 10 years?	□ Vos □ ∵
Have you received the pneu	amonia vaccin	ie within the last 10 years?	☐ Yes ☐ No
Dationt Initials			
Patient Initials			



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:	3	

ALERTS: Do any of these apply to you currently? (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. <u>Additional fees</u> 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.

<u>IN NETWORK VS OUT OF NETWORK</u> - 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.

<u>REFERRALS</u> - It is your responsibility to ensure we have any required referrals or pre-certifications <u>prior</u> 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.

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

(Patient Signature)

(DATE)

OFFICE VISITS: \$25.00 No Show Fee

SURGERY / PROCEDURE: \$75.00 No Show Fee

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:

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. 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 (INITIAL) 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)

(Guarantor Signature)

(DATE)

HIPAA CONSENT

FOR USE AND DISCLOSURE OF HEALTH INFORMATION



SECTION A: PATIENT, PARENT OR GUARDIAN (IF M	INOR) GIVING CONSENT
Patient Name:	Date of Birth:
Parent/Guardian Name (If Minor):	
SECTION B: TO THE PATIENT — PLEASE READ THE F	OLLOWING STATEMENTS CAREFULLY
	onsenting to our use and disclosure of your protected health
information (PHI) to carry out treatment, payment	activities, and healthcare operations.
this Consent. Our Notice provides a description of cuses and disclosures we may make of your protected	ead our Notice of Privacy Practices before you decide whether to sign our treatment, payment activities, and healthcare operations, of the ed health information, and of other important matters about your is posted at the front desk, or you may request a printed copy from fully and completely before signing this Consent.
	s as described in our Notice of Privacy Practices. If we change our rivacy Practices, which will contain the changes. Those changes may hat we maintain.
submitted to Amanda Baker, Practice Manager, at 6 understand that revocation of this Consent will not	this Consent at any time by giving us written notice of your revocation 651 East 4 th Street, Suite 302, Chattanooga, Tennessee 37403. Please affect any action we took in reliance on this Consent before we to treat you or to continue treating you if you revoke this Consent.
SIGNATURE	
	have had full opportunity to read and DERM Center's Notice of Privacy Practices. I understand that, by o your use and disclosure of my protected health information to carry operations.
Signature:	Date:
If this Consent is signed by a personal representati	ive on behalf of the patient, complete the following:
Personal Representative's Name:	
Relationship to Patient:	

PHI DISCLOSURE AUTHORIZATION



Patient Name:			Date of Birth:
	ludes medical	records, test	whether by phone or in person, without the writte results, disability forms, prescriptions, appointmer responsible party.
Please specify any individual(s) you giv	e The DERM C	enter permissio	on to release the above PHI to:
Name / Relationship (Please Print):			
Phone Number:			
Name / Relationship (Please Print):			
Phone Number:			
Name / Relationship (Please Print):			
Phone Number:			
VOICEMAILS: The DERM Center may le (CIRCLE all that apply:			IO o scheduling, treatment, or results on the following
	MOBILE	НОМЕ	WORK
Signature:			Date:
Makin Company to the self			
, , , ,	•		ehalf of the patient, complete the following:
Personal Representative's Name:			
Relationship to Patient:			