DERMATOLOGY OF LEXINGTON, LLC.

(803) 951-1717

Patient Information as of @
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ______________________________
Last First Middle

Address ______________________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ May we text appointment? ☐ No ☐ Yes

Any restrictions for contacting you? ☐ No ☐ Yes E-mail ____________

Contact Restrictions: ____________ Drivers License # (include State) ____________

Age ____ Birthdate ____________ SS# ____________ Sex ☐Female ☐ Male

Marital Status ☐ Single: ☐ Married: **Unspecified** ☐ Married to: ____________

Race: ***Ethnicity:*** ____________ ***Language:*** ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ________ Is it okay to call you at work? ☐ Yes ☐ No

Address ______________________________
Street & Suite # City State Zip

Work/School Status

Work Full Time ☐ Student Full Time ☐ Retired ☐ Other ☐

Work Part Time☐ Student Part Time ☐

Emergency Contact
(Not in your household) ____________ Relationship to Patient ____________

Home Phone ____________ Work Phone ____________ Other Phone ____________

Pharmacy Name: ____________ **Pharmacy Address:** ____________

Primary Health Insurance Company ____________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ ________

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ____________

Policy # ____________ Group # ____________ Ins. Phone ____________

Referral Required? ☐ No ☐ Yes Copay? ☐ No ☐ Yes, $ ________

Insured: Name ____________ DOB ____________ Employer ____________

Authorization to Treat I hereby grant my permission to the physicians and staff of Dermatology of Lexington, LLC. to perform any necessary procedures to treat the medical condition(s) for which I am seeking assistance. I understand that, except in an emergency situation, the staff will discuss with me my treatment options and that I will have the opportunity to accept or refuse specific treatments.

Authorization to Release Information I hereby authorize Dermatology of Lexington, LLC. to share with my insurance carrier, their representatives, sponsoring agency, or the Social Security Administration, whichever is relevant, any such information that is requested by them as needed for the processing of insurance benefit claims including, but not limited to, Protected Health Information (PHI). I agree and consent to the use and disclosure of Protected Health Information (PHI) for insurance claim processing and acknowledge that a copy of the Notice of Privacy Practices is posted and copies available on the check in counter. Dermatology of Lexington, LLC will not release your Protected Health Information to any individual or entity, other than the above, without your express and written authorization.

Signature ______________________________ **Date** ____________

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Notice of Privacy Practices
For:

Dermatology of Lexington, LLC.

I hereby acknowledge that I, , have received the Notice of Privacy Practices for the above office.

- ☐ Documentation presented to patient, but patient refused to sign acknowledgement.
- ☐ Patient presented with an emergency situation and there was no time to give the Notice or receive a signature. Attempt to give the Notice, and get any acknowledgement will be handled as soon as possible.
- ☐ Documentation was presented to the patient but a communication failure prevented us from receiving the acknowledgement.
- ☐ The documentation was mailed to the patient but never returned to us.
- ☐ Other:____

Dermatology Employee preparing documentation ________________________ Date:

Dermatology Employee Signature ______________________________

Signature: Patient's Name/ Personal Representative (as defined by HIPAA)
Documentation of "Good Faith" attempt to get acknowledgement signature.

Patient/Personal Rep Signature: ____________________________ **Date:**

Description of Personal Representation and please attach copy of documentation: ________________________

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Compound Authorization for Release of Information

Name _____ _______________ Birthdate_____________

Dermatology of Lexington, LLC. is authorized to release protected health information about the above named patient to the persons/entities named below. The purpose is to inform the patient or others in keeping with the patients instructions.

Persons/Entities to Receive Information

Please check all that apply

Voicemail and/or Answering Machine: O – Home	O-Results of lab tests O-Confirmation/Cancellation Appts
Voicemail and/or Answering Machine: O – Work	O-Results of lab tests O-Confirmation/Cancellation Appts
Voicemail and/or Answering Machine: O – Cell	O-Results of lab tests O-Confirmation/Cancellation Appts
O-Employer/School (Verify Excuse)	O-Appointment absentee info.
O-Spouse _______________ (name)	O-Billing information O-Medical records
O-Parent _______________ (name)	O-Billing information O-Medical records
O-Other _______________ (name)	O-Billing information O-Medical records

Special Instructions ____

Description of Personal Representative's authority (attach necessary documentation)

Rights of the Patient

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed as described in this document by sending written notification to Dermatology of Lexington, LLC. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward.

I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing. This authorization shall be in effect until revoked by the patient.

Signature ________________________________ **Date** ________________

(Patient/Parent/Guardian)

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Dermatology of Lexington, LLC.

FINANCIAL POLICY

Patient Name: Date of Birth:___________
Today's Date:

*** FOR YOUR CONVENIENCE WE ACCEPT MAJOR CREDIT CARDS, CHECKS, TRAVELERS CHECKS, MONEY ORDERS, AND CASH ***

BASIC POLICY - Payment for service is due in full at the time service is provided in our office.
FOR PATIENTS WITH INSURANCE - We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary insurance companies for you. **COPAYMENTS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE. IF YOU DO NOT KNOW IF YOU HAVE MET YOUR DEDUCTIBLE WE WILL COLLECT IT AT THE TIME OF SERVICE. WHEN YOUR INSURANCE COMPANY SETTLES YOUR CLAIM WE WILL REFUND ANY DEDUCTIBLE OVERPAYMENT.** If your insurance carrier has not paid within 30 days of billing, professional fees are due and payable in full from you.
MEDICARE - We will bill Medicare for you. **COPAYMENTS AND DEDUCTIBLES ARE DUE AND PAYABLE AT THE TIME SERVICE IS PROVIDED.**
NONCOVERED SERVICES - Any services not covered by your existing insurance coverage will require payment in full at the time services are provided or upon notice of claim denial by your insurance company.
PERSONAL INJURY CASES - This office does not bill for auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens.
MISSED APPOINTMENTS -- For office visits, we require at least 24 hours' notice to cancel appointments. If you fail to notify the practice within 24 hours, you will be charged $25 for a missed appointment. For surgical visits, we require at least 48 hours' notice to cancel an appointment. . If you fail to notify the practice within 48 hours, you will be charged $50 for a missed appointment. If you miss a second appointment we may dismiss you from the practice.

I have paid my insurance deductible for calendar year 2018? ☐ Yes ☐ No ☐ Don't know

Deductible Amount $_______ Amount still owed for this year $________

MEDICARE PATIENTS: ASSIGNMENT OF BENEFITS - I request payment of authorized Medicare benefits be made on my behalf to **Dermatology of Lexington, LLC** for any services furnished me by the listed provider/supplier. I authorize any holder of medical information about me to release to the Center for Medicare Services (CMMS) (formerly the Health Care Financing Administration) and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in Item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. I agree to immediately forward any payments made to me personally by my insurer for services rendered by Dermatology of Lexington, LLC.

Patient's Name: **PROVIDER**

Patient's Signature:

DERMATOLOGY OF LEXINGTON, LLC

Patient's Medicare No.: Date:

ASSIGNMENT OF INSURANCE BENEFITS - Patients with insurance please read and sign below. I hereby assign all medical and/or surgical benefits for services rendered, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **Dermatology of Lexington, LLC.** This assignment will remain in effect until revoked by me in writing. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment. I agree to immediately forward any payments made to me personally by my insurer for services rendered by Dermatology of Lexington, LLC.

Signature: ____ Date: _____

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature: ____ Date: _____ _____

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Dermatology of Lexington, LLC.
Medical History

Patient : Today's Date

Reason for today's visit ____

Are you allergic to any medication's YES NO (circle one) If yes, list below:

____

____

Have you ever had dental anesthesia (Novocaine)? YES NO (circle one) Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over the counter meds, vitamins and herbals)

____________ ____________ ____________

____________ ____________ ____________

____________ ____________ ____________

Do you now, or ever had diseases or conditions of:

Lungs:	YES	NO	Other Systemic:	YES	NO
Bronchitis	O	O	Diabetes	O	O
Emphysema	O	O	Excessive thirst/hunger	O	O
Asthma	O	O	Thyroid	O	O
Chronic Cough	O	O	Kidney	O	O
Morning Cough	O	O	Bladder	O	O
Shortness of breath	O	O	Frequency/burning	O	O
Wheezing	O	O	Gastrointestinal		
Cardiocascular:			Stomach absorptive disorder	O	O
High Blood Pressure	O	O	Nausea, vomiting, diarrhea	O	O
Chest Pain	O	O	-When taking antibiotics	O	O
Heart Attack	O	O	Yeast infection		
Heart Murmur	O	O	-When taking antibiotics	O	O
Irregular Heartbeat	O	O	Arthritis/Joint Deformity	O	O
Phlebitis	O	O	Arthralgia	O	O
Inflammation of vein	O	O	Limited Motion	O	O
Blood Clots	O	O	Artificial Joint	O	O
Pacemaker	O	O	Convulsions, Epilepsy, Seizures	O	O
Pulmonary Embolism	O	O	AICD-Implant defibulator	O	O

List any other diseases or conditions ____

List surgical procedures you have had in the last 6 months ____

Do you now, or ever had diseases or conditions of:

Skin:	YES	NO		YES	NO
Skin Cancer	O	O	Psoriasis	O	O
Melanoma	O	O	Eczema	O	O
Scarring/Keloids	O	O	Family History Skin Cancer	O	O
Specific Skin Disease	O	O	Bleed Easily	O	O
Lupus	O	O			

Social history:

Do you drink alcohol?	O	O	If YES, ______ drinks per day
Do you use IV drugs?	O	O	If YES, what?____________________ How often? ____________
Do you smoke?	O	O	If YES, how much? ____________

Have you ever been exposed to HIV(AIDS)? YES NO

Are you pregnant? YES NO Due Date ____/____/____ Last menstrual period ____________________

What is your occupation? ____________________ Hobbies?____________________

Completed by ____________ **Signature**______________________________ **Date**____/____/____

Initials **Patient/Parent/Guardian**

Reviewed By ______________________________ **Date**____/____/____

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