

Date: ___ / ___ / ___

Patient Name: _____

Patient DOB: ___ / ___ / ___

Other Medical History:

Mark (x) if you are currently experiencing or recently experienced any of the following:

<input type="checkbox"/> Weight loss/gain	<input type="checkbox"/> Vision problems	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Heart problems	<input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Appetite problems
<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Joint pain/swelling	<input type="checkbox"/> Skin rashes
<input type="checkbox"/> Headaches	<input type="checkbox"/> Sleeping problems	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Immune problems	

Have you ever been treated for any of the following? Mark (x) if Yes

<input type="checkbox"/> Heart disease	<input type="checkbox"/> Vein/artery disease	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Depression	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid disease
<input type="checkbox"/> Migraine headaches	<input type="checkbox"/> Stroke	<input type="checkbox"/> Elev cholesterol/trig
<input type="checkbox"/> Cancer: (Type) _____		

List other Diseases: _____

Family Medical History: Please indicate all conditions that apply to family members (brother, sister, parents, grandparents, aunt, uncle) and NOTE RELATIONSHIP.

<input type="checkbox"/> High blood pressure _____	<input type="checkbox"/> Thyroid disease _____
<input type="checkbox"/> Asthma/allergies _____	<input type="checkbox"/> Heart disease _____
<input type="checkbox"/> Headaches _____	<input type="checkbox"/> Diabetes _____
<input type="checkbox"/> Stroke _____	<input type="checkbox"/> Chronic lung dz _____
<input type="checkbox"/> Seizure/epilepsy _____	<input type="checkbox"/> Alcoholism/substance abuse _____
<input type="checkbox"/> Kidney disease _____	<input type="checkbox"/> Bleeding disorder _____
<input type="checkbox"/> High cholesterol _____	<input type="checkbox"/> Ulcers _____
<input type="checkbox"/> Mental illness _____	<input type="checkbox"/> Cancer _____

Emergency Contact Information

Name: _____ Relationship: _____

Address: _____

Phone: _____

Patient Signature

Date

Date: ___/___/___

Patient Name: _____

Patient DOB: ___/___/___

List previous surgical procedures

Name of Procedure	Date of Procedure

List all current prescribed, over the counter and herbal medicines

Medication Name	Dosage	Frequency

List any allergies to medicines or dyes _____

List all other allergies _____

Do you use smokeless tobacco/cigarettes/cigars? (circle one) Yes _____ No _____

If yes, please list quantity per day _____

Do you drink alcohol? Yes _____ No _____

If yes, please list quantity per day _____

Daily caffeine intake: Coffee _____ Tea _____ Soda _____

Patient Signature

_____/_____/_____
Date

Reviewed by

_____/_____/_____
Date

PPD

Porter Premiere Dermatology
& Surgery Center

HIPPA Information and Consent Agreement

The Health Insurance and Accountability Act (HIPPA) provides safeguards to protect your privacy. Implementation of HIPPA requirements officially began on April 14, 2003. HIPPA provides rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal exchange of information necessary to provide you with office services. HIPPA provides certain rights and protections to you as the patient. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov.

Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, exam rooms, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, Protective Health Information and other documents and information.

Patients will be reminded of their appointments via telephone, e-mail or U.S. mail. We may send you other communication informing you of changes to office policy and new technology that you might find valuable.

You understand and agree to inspection and review of documents which may include Protected Health Information by government agencies or insurance payers in normal performance of their duties.

You agrees to bring any concerns or complaints regarding privacy to the attention of the office manager or the physician.

Your confidential information will not be used for the purposes of marketing or advertising or products, goods or services.

We agree to provide patients with access to their records in accordance with state and federal laws.

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Consent Agreement

A Consent to the use and disclosure of Health Information for Treatment, Payment, or Health Operation.

I, (Print Patient Name) _____, understand that as part of my healthcare, this practice originates and maintains health records describing my medical history, symptoms, examination, diagnosis, treatment, test results and any plan for future care and treatment. I understand that this information serves as:

- * A basis for planning my care and treatment
- * A means of communication among other health care professionals who contribute to my care
- * A means by which a third-party payer can verify that the services billed were actually provided
- * A tool for routine healthcare operations, such as assessing quality and reviewing the competence of healthcare professionals
- * A source of information for applying my diagnosis to my bill

I have been provided with a *Notice of Information Practices* that provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how any health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I wish to have the following restrictions to Use or Disclosure of my health information:

**I fully understand and accept/decline the terms of this consent
(circle one)**

**Signature of patient or legal
Representative**

Date

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Office Financial Policy

Patient Name: _____ DOB: ___/___/___

Dear Patient:

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Medicare:

We are Medicare participating providers. We will bill Medicare and Medigap carriers. You will be responsible at the time of service for payment of:

- a. The annual deductibles
- b. Co-payments
- c. Charges for non-covered or cosmetic services*

* You will be asked to sign an **Advanced Notice of Liability Form** in the event that a service is provided which we know is not covered by Medicare.

If you have Medicare, as well as secondary coverage with a commercial plan that is not Medigap or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and will be responsible for the balance.

Non-Medicare/Commercial Plans:

If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for all covered, medically necessary services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

- a. The annual deductibles
- b. Co-payments
- c. Charges for non-covered or cosmetic services

In the event that you, as the patient, or we, as the physicians, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

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Office Financial Policy (cont.)

For non-Medicare patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:

We will file both your primary and secondary insurance. If we do not receive payment from your primary or secondary carrier within 45 days of filing, you will be billed for the entire amount. Payment is due 10 days after receipt of the statement.

Delinquent accounts may result in your account being turned over to a collection agency, credit bureau reporting and/or discharge from the practice. After 90 days of non-payment, your account will be turned over to collections.

If you require us to transfer your records to another physician, other than your primary or referring physician, there will be a nominal fee. This fee must be paid prior to transfer of the records.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Signature of Patient

____/____/____
Date

Medicare Payment Policy

We strive to provide all of our patients with prompt and excellent medical care and assist you in the handling of your bill. In order to maintain your account in good standing, our requirements for payment of your account are as follows:

We participate in most insurance plans, not including Medicaid. If you have Medicaid as a secondary insurance, plan the 20% that Medicare does not cover is your responsibility. Payment in full is expected at each visit. Please contact your insurance company with any questions you may have regarding your coverage.

Because our services are rendered to YOU, you are responsible directly to us for settlement of your account. Please feel free to discuss your bill or charges at an early date to avoid misunderstandings.

I have read and understand the payment policy and agree to abide by its guidelines:

_____ Date _____

Signature of patient or responsible party