Leavitt Medical Assoc. of NV

PATIENT INFORMATION: Date: _____

NAME: _____ Mr. Mrs. Ms. Miss
Last First MI Circle one

PHONE: (Home) _____ (Cell) _____

E-MAIL ADDRESS: _____

ADDRESS: _____
Street Address City State Zip Code

BIRTHDATE: _____/_____/_____ AGE: _____ SSN: _____ SEX: M_____F_____

OCCUPATION: _____EMPLOYER:_____

MARITAL STATUS: _____ SPOUSE'S NAME: _____

PATIENT'S PERSONAL PHYSICIAN: _____

EMERGENCY CONTACT: _____
Name Phone # Relationship

BILLING INFORMATION: (Write ***"SAME"*** if patient, otherwise please provide information) *If **STUDENT,** please put parent/guardian information here.*

RESPONSIBLE PARTY: _____
Last First MI

ADDRESS: _____
Street Address City State Zip Code

PATIENT REFERRAL SOURCE: How did you hear about our practice? (Please check all that apply)

- O ANOTHER PHYSICIAN/PROVIDER:_____
- O INSURANCE COMPANY:_____
- O FRIEND/FAMILY MEMBER:_____
- O INTERNET/WEB SEARCH
- O OTHER – PLEASE LIST:_____

PRIVACY POLICY NOTICE

I acknowledge that I understand the privacy policies mandated by the Health Insurance Portability and Accountability Act (HIPAA) that went into effect April 14, 2003.

FINANCIAL AGREEMENT & INSURANCE AUTHORIZATION

I request that payment of authorized Medicare or other insurance benefits be made on my behalf to the ADCS Henderson, NV office, P.C. for any services furnished to me by either physician / supplier. I authorize the ADCS Henderson, NV, P.C. to release to the Health Care Financing Administration and its agents or my insurance company any information needed to determine these benefits payable for related services. **I understand that I am responsible for understanding my insurance coverage. I understand that prior authorization of services does not necessarily guarantee payment. I understand that I am responsible for any deductibles, coinsurance, co-pays and services deemed not medically necessary by my insurance carrier.**

BY SIGNING BELOW, PATIENT/GUARDIAN UNDERSTANDS THE TERMS OF OUR PRIVACY POLICY NOTICE AND FINANCIAL AGREEMENT AND INSURANCE AUTHORIZATION.

SIGNED: _____ DATE: _____
PARENT/GUARDIAN SIGNATURE IF PATIENT IS A MINOR: _____

MEDICAL HISTORY

Leavitt Medical Assoc. of NV

The doctors and staff of Advanced Dermatology & Cosmetic Surgery are pleased that you have chosen us for your healthcare needs. Please complete this form so we may better serve you. The information you provide will assist us in attending to your healthcare needs more effectively and efficiently. It is important that you provide us with any changes or updates (address, insurance company, etc.) each time you see us. For more information about the products and services we offer, please speak with a member of our staff.

Patient_____**Date**_____

Reason for today's visit_____

Do you have now, or have you ever had diseases or conditions of: (if yes, please circle all applicable)

Lungs

Bronchitis	Emphysema	Asthma	Chronic Cough	Morning Cough

Vascular

High Blood Pressure	Chest Pain	Heart Attack	Heart Murmur	Irregular Heartbeat
Pacemaker	Blood Clot/Phlebitis	Mitral Valve Prolapse		

Other Systemic

Diabetes	Thyroid	Kidney	Bladder	Stomach
Bowel	Hepatitis A/B/C	Glaucoma	Arthritis/Joint	Cancer

Current Medication			**If yes, please explain, otherwise mark "N/A"**
Do you have any allergies to food or medicine?	**Y**	**N**	_____
Do you currently use any prophylactic antibiotics?	**Y**	**N**	_____
Do you currently drink alcohol?	**Y**	**N**	_____
Do you currently use IV drugs?	**Y**	**N**	_____
Do you currently take any medication?	**Y**	**N**	_____
Have you ever been exposed to HIV/AIDS?	**Y**	**N**	_____
Have you ever had dental anesthesia (Novocain)?	**Y**	**N**	Have you ever had a blood transfusion? **Y** **N**
Are you latex intolerant?	**Y**	**N**	Any Adverse Reaction? **Y** **N**

Skin			**If yes, please explain, otherwise mark "N/A"**
Have you ever had skin cancer?	**Y**	**N**	_____
Family History of skin cancer?	**Y**	**N**	_____
Do you currently use skin care products?	**Y**	**N**	_____

When exposed to the sun, do you: Tan Tan & Burn Burn

List any other disease or condition we should be aware of: _____

List surgical procedures performed within the last 6 months: _____

_____

Please answer the following questions:

1. Do you smoke? **Y** **N**
2. (Women) Are you pregnant? **Y** **N**
   If no, date of last menstrual period: _____
3. What is your occupation? _____
4. Do you bleed easily? **Y** **N**
5. Do you have artificial joints, pins, or screws? **Y** **N**
6. Do you require antibiotics prior to surgery? **Y** **N**

Preferred Pharmacy: _____ **Pharmacy Phone Number:** _____

Pharmacy Location: _____

Primary Care Provider: _____ **Primary Care Phone Number:** _____

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Permission to Release Medical Information

ADCS Henderson, NV has my permission to leave personal medical information and billing Information in the following locations in the event that I cannot be reached directly:

INITIAL BELOW:

YES _____ NO _____ N/A_____ ---- Home answering machine/voicemail

INITIAL BELOW:

YES _____ NO _____ N/A_____ ---- Cell phone voicemail

INITIAL BELOW:

YES _____ NO _____ N/A_____ ---- OK to discuss billing info/ medical results with:

Name: _____

Relationship to patient: _____

Phone number: _____

_____ _____

Print patient name Date of birth

_____ _____

Patient signature Today's date

_____ _____

Parent/Guardian signature if patient is a minor Relationship to patient

_____ _____

Office staff witness Today's date

Leavitt Medical Assoc. of NV

Financial Policy Addendum 2017

It is the responsibility of all patients/guarantors to understand their insurance. Please be advised that many procedures performed in this office may apply to your annual deductible or may require additional out-of-pocket expenses beyond your co-pay (i.e. Co-insurance). **Tests and treatments performed in our office are necessary to ensure proper diagnosis and care for our patients.**

All biopsies and mole removals performed in this office will be submitted to pathology for analysis. Biopsies are an example of a procedure that could be subject to a deductible or co-insurance. **In the event that special stains are required for pathology, there will be additional lab fees submitted to your insurance. Once that claim has been processed you will receive a statement if there is any remaining patient responsibility. Please be aware that additional copays are also required by many insurance companies for pathology.**

Other examples include:

- Liquid nitrogen for the destruction of lesions such as warts or pre-cancerous lesions (classified as surgery by all insurance companies)
- All excisions including removal of skin cancer and atypical moles
- Injections (considered a procedure by all insurance companies)
- Photodynamic therapy
- PUVA/UVB light box treatment

It is important for our patients to be aware that a covered benefit does not mean it will be paid for if your annual deductible has not been satisfied.

All costs for services rendered are calculated at check-out. This is an ***estimate*** based on our contract with your insurance carrier. Payment is due at check-out unless prior arrangements have been made. Because these are ***estimates only***, the final cost for services is not fully known until the claim has been adjudicated by your insurance. You will be billed for any additional costs after adjudication or refunded if the fees are less than estimated. **Please note that statements are not mailed for balances under $10.00. These balances will be collected at your next visit**.

We accept several forms of payment for your convenience:

- Visa, MasterCard, Discover, and American Express
- Checks, money orders, or cash
- We now accept Care Credit

I have read and understand the above.

Patient signature: _____ Date: _____

Print Patient Name: _____

Guardian signature (if patient is under 18 years of age): _____

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Patient Medication List

Medication	Dosage	Frequency	Purpose

Leavitt Medical Assoc. of NV

Exhibit 1
Revised August 1, 2017

WRITTEN ACKNOLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

Leavitt Medical Assoc. of NV, Inc.

I, _____, have (1) received a copy of the Notice of Privacy Practices or (2) have

been offered a copy of the Notice of Privacy Practices but declined to accept a copy.

_____ _____
Patient Signature (or parent/legal guardian if patient is a minor) Date

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WRITTEN ACKNOWLEDGEMENT OF PATIENT REFUSAL TO SIGN A
RECEIPT OF NOTICE OF PRIVACY PRACTICES

On the _____ day of _____, 2017, the Notice of Privacy Practices was:

_____ offered and/or given to _____.

_____ the patient accepted a copy of the Notice of Privacy Practices but refused to sign an acknowledgement that it was given to the patient.

____ the patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

_____ _____
Signature of Employee that offered the patient the NPP Date