cole | dermatology

Medical & Surgical Dermatology

PLEASE PRINT.

☐Mr ☐Ms ☐Dr NAME ______________________________ SEX ☐M ☐F

DATE OF BIRTH ____________________ LAST 4 DIGITS SS# ____________________
(FULL SS# of sponsor if Tricare)

PREFERRED LANGUAGE ☐English ☐Other ________________

ADDRESS ______________________ CITY ______________ STATE _____ ZIP ________

HOME PH (____) ____________ WORK PH (____) ____________ CELL PH (____) ____________

PREFERRED CONTACT NUMBER (appointment reminders, biopsy results, etc) ☐Home ☐Work ☐Cell

EMPLOYER ________________ OCCUPATION ________________ ☐Student ☐Retired

RACE	ETHNICITY
☐White ☐Black or African American ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander ☐Asian ☐Other	☐Non-Hispanic or Latino ☐Hispanic or Latino

How did you hear about us? ______________________________

Has any member of your family been treated at Cole Dermatology before? ☐Yes ☐No
If yes, name of family member(s) ______________________________

Marital Status ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated Spouse's Name ________________

Are you: ☐Insured (If so, please provide copy of your insurance card(s)).

☐Self Pay (Please note that payment is due when services are rendered).

Name of Person Responsible for Bill (if patient is a minor) ________________ Date of Birth ________

Responsible Party's Address ________________ Relationship to Patient ________________

CONSENT FOR TREATMENT

I consent to treatment necessary or desirable to the care of me (or my minor), including but not limited to, medicine, performance of procedures and ordering of laboratory or other studies that may be used by the physician or his qualified surrogate.

SIGNATURE ______________________________ DATE ________________

RELEASE OF MEDICAL INFORMATION

I authorize Cole Dermatology, LLC to release information concerning my (or my minor's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits or to the Social Security Administration and Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original and assign directly to Cole Dermatology, LLC all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am responsible for all final charges whether or not they are paid by insurance. Regulations pertaining to Medicare assignment of benefits apply. I authorize Cole Dermatology, LLC to communicate my medical diagnoses and treatment plan as necessary to secure payment of benefits and to other physicians involved in my care.

SIGNATURE ______________________________ DATE ________________

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the privacy practices of Cole Dermatology, LLC and that I have read (or had the opportunity to read if I so chose) and understand the Notice. This acknowledgement is **requested** per federal law/HIPAA requirement.

SIGNATURE ______________________________ DATE ________________

CONTINUED ON BACK

PROTECTED HEALTH INFORMATION RELEASE

I authorize Cole Dermatology, LLC to discuss or release my health information to the person or persons listed below. Examples include (but are not limited to) someone calling on your behalf regarding prescription refills, biopsy results, etc., or our office leaving a message (biopsy results, appointment reminders, etc.) with someone over the phone when you are not available. I understand that it is my responsibility to notify Cole Dermatology, LLC in writing should my desires change.

Name ___________________________________ Relationship to patient ____________________ Ph (_______)_____________________

Name ___________________________________ Relationship to patient ____________________ Ph (_______)_____________________

☐**DECLINE (Information with not be shared with ANYONE except as permitted/required by law; leave above fields blank and sign below.)**

SIGNATURE ____ DATE ______________________________

OFFICE AND FINANCIAL POLICIES

PLEASE INITIAL EACH ITEM.

____ 1. Payment is expected in full by cash, check, money order, or credit/debit card at the time services are rendered. We accept Visa, MasterCard, Discover, and American Express.

____ 2. Any patient 18 years or older will be the responsible party for his/her account. The parent or guardian accompanying a minor child is responsible for any payment due at the time of service. Cole Dermatology, LLC does not mediate divorce or custody agreements.

____ 3. Please understand that as health care providers, our relationship is with you. Your insurance policy is a contract between you and your insurance company; we are not a party in that contract. We accept many insurance plans, but please check with our office for specifics. You are ultimately responsible for checking with your insurance company regarding coverage.

____ 4. In order to correctly file your visit with your insurance company, you may be asked to present your current insurance card at each visit. Without the necessary information, we will be unable to bill your insurance company on your behalf. You are responsible for any and all charges we are unable to bill to your insurance.

____ 5. Costs not covered by your insurance (including deductibles, co-pays, and co-insurance) are payable at the time services are rendered. Any overpayment will be reimbursed to you.

____ 6. Some insurance policies require a primary care referral to see a specialist. While we make every effort to inform you if one is required, it is ultimately your responsibility to ensure a proper referral is obtained prior to your visit.

____ 7. Please be aware that some diagnoses (e.g., skin discoloration and hair loss) may be considered cosmetic or not medically necessary by your insurance carrier. Costs associated with these conditions may not be covered by your policy. It is your responsibility to know your plan.

____ 8. Accounts over 120 days past due are subject to a referral to an outside collection agency. In addition to account balances, the responsible party will be billed for all associated collection and/or attorney's fees.

____ 9. To ensure prompt and efficient patient care, we require 24-hour notice to reschedule or cancel appointments. A reactivation fee up to $50.00 may be assessed for each missed appointment in order to reschedule if you "no-show" or fail to give 24-hour notice. Patients arriving more than 15 minutes after their appointment time may be asked to reschedule. Habitual no-shows or last-minute appointment changes may result in dismissal from the practice.

____ 10. Unless stated otherwise, specimens biopsied/removed will be sent for pathologic examination. This will incur a pathology fee unrelated to Cole Dermatology, LLC.

I have read and understand the Office and Financial Policies and agree to abide by its contents.

SIGNATURE ____ DATE ______________________________

FOR MINOR PATIENTS ONLY: All minors must have a parent or legal guardian present at their initial visit. Minors 15 years of age or younger MUST have an authorized adult present for each office visit. Patients 16 or 17 years of age may be seen at follow up visits without an adult if prior consent has been given by the parent/guardian (below).

I, _________________________________, am the parent/legal guardian of ______________________________________. I authorize health care professionals at Cole Dermatology, LLC to provide medical care to my minor child, including, but not limited to, diagnostic examinations and necessary medical treatment (including minor surgical procedures) when they arrive unaccompanied at the office and/or with an authorized adult.

Please list authorized adults below:

Name: ____ Relationship to patient: ________________________________

Name: ____ Relationship to patient: ________________________________

Name: ____ Relationship to patient: ________________________________

SIGNATURE ____ DATE ______________________________

PLEASE RETURN THIS SHEET TO RECEPTIONIST BEFORE PROCEEDING TO EXPEDITE CHECK-IN

Please Print **PATIENT HISTORY FORM**

Patient Name ____ Age ______________

Reason for visit ____

PAST MEDICAL HISTORY Indicate below any conditions that you either have or have had in the past.

☐NONE
☐Anxiety
☐Arthritis
☐Asthma
☐Atrial Fibrillation (irregular heartbeat)
☐Bone Marrow Transplantation
☐Breast Cancer
☐Colon Cancer
☐COPD
☐Coronary Artery Disease
☐Depression
☐Diabetes
☐End Stage Renal Disease
☐GERD/reflux
☐Other: ___________________________
☐Hearing Loss
☐Hepatitis (Hep B, Hep C)
☐Hypertension (high blood pressure)
☐HIV / AIDS
☐Hypercholesterolemia (high cholesterol)
☐Hyperthyroidism
☐Hypothyroidism
☐Leukemia
☐Lung Cancer
☐Lymphoma
☐Prostate Cancer
☐Radiation Treatment
☐Seizures
☐Stroke

PAST SURGICAL HISTORY Have you had any of the following? ☐NONE

☐Organ Transplant If so, type: ________________ year: ____________________________
☐Heart Valve Replacement If so, year: _______
☐Joint Replacement(s) If so, which joint(s): ___________ year: ____
☐Skin surgery for: ☐Basal Cell Carcinoma ☐Squamous Cell Carcinoma ☐Melanoma
☐Other: ___________________________

SKIN DISEASE HISTORY Have you had any of the following conditions? ☐NONE

☐Acne
☐Actinic Keratoses
☐Asthma
☐Basal Cell Skin Cancer
☐Blistering Sunburns
☐Eczema
☐Other: ___________________________
☐Flaking or Itchy Scalp
☐Hay Fever/Allergies
☐Melanoma
☐Precancerous Moles
☐Psoriasis
☐Squamous Cell Skin Cancer

Do you wear sunscreen regularly? ☐Yes ☐No If Yes, what SPF? _______
Do you tan in a tanning salon? ☐Yes ☐No
Do you have a family history of melanoma? ☐Yes ☐No If Yes, which relative? _______________

Please Print **PATIENT HISTORY FORM**

REVIEW OF SYSTEMS

Do you have any problems with bleeding? ☐Yes ☐No
Do you form keloids or thick scars? ☐Yes ☐No
Do you have a pacemaker or defibrillator? ☐Yes ☐No

MEDICATIONS ☐NONE

Current medications and dosages (including prescribed, over-the-counter, and vitamins/ supplements).

____

____

____

____

____

What is your preferred pharmacy? ______________________________

ALLERGIES ☐NONE

Please list medication allergies that you have, and the resulting reaction (hives, nausea, etc).

____

____

____

____

Are you allergic to local anesthetic (lidocaine, etc?) ☐Yes ☐No
Are you allergic to adhesives or bandages? ☐Yes ☐No

SOCIAL HISTORY

Do you live ☐Alone ☐with Spouse ☐with Family ☐with Friend ☐Other

SMOKING STATUS ☐Never Smoker ☐Current every day smoker ☐Current some day smoker
☐ Former smoker ☐Smoker, current status unknown ☐Unknown if ever smoked

What is your occupation? ______________________________

Has anyone in your family been treated at our office before? ☐Yes ☐No If yes, Who? ________________