COLE DERMATOLOGY & SKIN CANCER CENTER

PLEASE PRINT.

☐Mr ☐Ms ☐Dr NAME _____ SEX ☐M ☐F

DATE OF BIRTH _____ LAST 4 DIGITS SS# _____
(FULL SS# of sponsor if TRICARE)

RACE (Select all that apply)	ETHNICITY
☐White ☐Black or African American ☐Asian ☐American Indian or Alaska Native ☐Native Hawaiian or Other Pacific Islander ☐Other	☐Non-Hispanic or Latino ☐Hispanic or Latino
PREFERRED LANGUAGE ☐English ☐Other _____	

ADDRESS _____ CITY _____ STATE _____ ZIP _____

PREFERRED CONTACT/PHONE NUMBER (_____) _____ ☐ MOBILE ☐ HOME ☐ WORK

ADDITIONAL CONTACT NUMBER (_____) _____ ☐ MOBILE ☐ HOME ☐ WORK

EMAIL ADDRESS _____

Note: Email address must be provided if you desire access to your patient portal, which can be used to communicate with our office (request refills, print biopsy reports, update your medical chart, etc.). Email addresses are confidential and are not shared with third parties or used for solicitation. Email addresses ARE used as a method for appointment reminders.

EMPLOYER _____ ☐Student ☐Retired ☐Disabled ☐Other

OCCUPATION (or prior occupation if retired) _____

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

Has any member of your family been treated at Cole Dermatology before? ☐Yes ☐No

If yes, who? _____

CONSENT FOR TREATMENT

I consent to treatment necessary or desirable for the care of me (or minor/dependent), 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 minor/dependent) 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.

✂ SIGNATURE _____ DATE _____

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 will 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 READ CAREFULLY AND INITIAL EACH ITEM.

___ 1. Costs not covered by your insurance (including deductibles, co-pays, and/or co-insurance) are payable at the time services are rendered. CHARGES CALCULATED AT CHECK IN/CHECK OUT ARE ESTIMATES UNLESS PRESENTED IN WRITING. We make every attempt to give you a precise calculation. However, due to the complex nature of medical insurance and varying specifics between plans (even those underwritten by the same insurance provider), this can be a difficult at times. After your insurance company processes a claim (you should receive an "explanation of benefits," or "EOB" stating all the details), you will be billed for any remaining balance or refunded in the event of overpayment. DO NOT CONFUSE THESE REMAINING BALANCES WITH "BALANCE BILLING" (WHEN A FACILITY CHARGES YOU DIRECTLY FOR A HIGHER AMOUNT THAN THAT CONTRACTED BY YOU INSURANCE). WE DO NOT BILL YOU FOR MORE THAN OUR CONTRACTED RATES WITH YOUR INSURER.

(CONTINUED ON NEXT PAGE)

(CONTINUED FROM PREVIOUS PAGE)

FURTHERMORE, ALL OF OUR CHARGES (EXCLUDING COSMETIC SERVICES) ARE SET BY YOUR INSURANCE COMPANY.

___ 2. Payments can be made by cash, check, money order, or credit/debit card at the time services are rendered. We accept Visa, MasterCard, Discover, and American Express.

___ 3. Please understand that as health care providers, our relationship is with you. **Your specific insurance policy is a contract between you and your insurance company**; we are not a party in that contract (as stated in #1, we have our own, separate contract with each insurance company that dictates our interactions with their policy holders. We accept many insurance plans, but please check with our office if you have questions. We will do our best to help with any concerns you may have. You are ultimately responsible regarding questions of coverage or other specifics related to your plan. Please contact your carrier if needed.

___ 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 for reasons/problems beyond our control.

___ 5. 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.

___ 6. Please be aware that some diagnoses (for example, skin discoloration or hair loss) **may be considered cosmetic or deemed not medically necessary by your insurance carrier**. Office visits and costs associated with these conditions may not be covered by your policy. It is your responsibility to know your plan.

___ 7. 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 administrative, collection, and/or attorney's fees.

___ 8. 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.

___ 9. Unless stated otherwise, specimens biopsied or removed during your visit will be sent for evaluation by a pathologist. This will incur a charge from a third party unrelated to Cole Dermatology, LLC (and not calculated into any charges/costs discussed by our office regarding fees for services performed here).

___ 10. Any patient 18 years or older will be the responsible party for his/her account (unless, due to incapacity, they have a qualified healthcare surrogate (see next page).

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

SIGNATURE _____ DATE _____

THIS PAGE IS ONLY APPLICABLE FOR PATIENTS YOUNGER THAN 18 OR PATIENTS WITH A QUALIFIED HEALTHCARE SURROGATE

FOR MINOR PATIENTS (OR PATIENTS WITH QUALIFIED HEALTH CARE SURROGATES)

The parent or guardian who accompanies a minor child or incapacitated adult is responsible for any payment due at the time of service as well as any balances after insurance has processed. Please note that Cole Dermatology, LLC does not mediate divorce or custody agreements.

Responsible party (guarantor) name _____

Responsible party address (if different from page 1) _____

Relationship to patient _____

X SIGNATURE _____ DATE _____

NOTE: All minors must have a parent or legal guardian present at their initial visit. Minors 15 years of age of 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 (see below).

I, _____, am the parent or 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: _____

X SIGNATURE _____ DATE _____

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? _____