Cole Dermatology & Skin Cancer Center

☐Mr ☐Ms ☐Dr NAME _____ SEX ☐M ☐F

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

PRIMARY CARE DOCTOR/PRACTITIONER _____

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 PHONE NUMBER (_____)_____ ☐MOBILE ☐HOME ☐WORK

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

EMAIL ADDRESS _____

NOTE: Email addresses are used to access your patient portal, which can be used to access and print biopsy reports, update your medical chart, request refills, etc. Email addresses are confidential and ARE NOT shared with or sold to third parties or used for solicitation by Cole Dermatology. Email addresses ARE used as a method for appointment reminders.

EMPLOYER _____ ☐Student ☐Retired ☐Disabled ☐Other

OCCUPATION (or prior occupation if retired/disabled) _____

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

Has any member of your family been treated at Cole Dermatology before? ☐Yes ☐No
If yes, who?_____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of the privacy practices of Cole Dermatology, LLC. Additional copies may be printed from our website at www.colederm.com.

SIGNATURE _____ DATE _____

CONSENT FOR TREATMENT AND INSURANCE FILING

I consent to treatment necessary for care to me (or my 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.

I authorize Cole Dermatology, LLC to release information concerning my (or my minor/dependent) health care 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 charges deemed by my insurance to be patient responsibility.** I authorize Cole Dermatology, LLC to communicate my medical diagnoses and treatment plan as necessary to secure payment of benefits and to other physicians or providers involved in my care.

SIGNATURE _____ DATE _____

RELEASE OF PROTECTED HEALTH INFORMATION

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 my behalf regarding prescription refills, biopsy results, etc, or office leaving a message (biopsy or lab results) with someone over the phone when I am not available. I understand that it is my responsibility to notify Cole Dermatology, LLC in writing should my desires change.

1. Name _____ DOB (for verification purposes) _____
   Relationship to patient _____ Contact Number (_____)_____

2. Name _____ DOB (for verification purposes) _____
   Relationship to patient _____ Contact Number (_____)_____

☐**DECLINE (Information will not be shared with ANYONE except as permitted/required by law**

SIGNATURE _____ DATE _____

OFFICE AND FINANCIAL POLICIES

1. Costs not covered by your insurance (including deductibles, co-payments, 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 attempt to give you a precise calculation. However, due to the complex nature of medical insurance and varying specifics between plans, this can be difficult at times. Once claims submitted to your insurance have been processed, you will be billed for any remaining patient responsibility (deemed by your insurance, available for review on your EOB that you will receive from them) or refunded in the event of over payment.

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. **<u>As healthcare providers, our relationship is with you</u>**. Your specific insurance policy is a contract between YOU and YOUR insurance company; we are not a party in that contract. We accept many insurance carriers and plans, but please check with our office if you have questions and we will do our best to help with any concerns that 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 a 24-hour notice to reschedule or cancel appointments. A no-show fee will be assessed for each missed appointment without the required notice. Patients arriving more than 15 minutes after their appointment time may be asked to reschedule. Habitual abuse of this policy 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 they are incapacitated) – see qualified healthcare surrogate on 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

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 DOB: _____

Relationship to patient _____

SIGNATURE _____ DATE _____

NOTE: 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 (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 surigical 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 Print

PATIENT HISTORY FORM

Patient Name _____ Age _____

Reason for today's visit _____

PAST MEDICAL HISTORY Check 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
- ☐Dementia
- ☐Depression
- ☐End Stage Renal Disease
- ☐Other _____
  _____
- ☐Epilepsy
- ☐GERD/reflux
- ☐Hearing Loss
- ☐Hepatitis (Hep B, Hep C)
- ☐Hypertension (high blood pressure)
- ☐HIV / AIDS
- ☐High cholesterol
- ☐Hyperthyroidism
- ☐Leukemia
- ☐Lung Cancer
- ☐Lymphoma
- ☐Prostate Cancer
- ☐History of radiation treatment
  Body location _____
- ☐Stroke

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

☐Organ Transplant If so, type: _____ year: _____

☐Heart Valve Replacement If so, type: _____ year: _____

☐Joint Replacement(s) If so, type: _____ year: _____ type: _____ year: _____

☐Skin surgery for: ☐Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐Melanoma
☐ Other: _____

☐ Other Surgeries: _____

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

- ☐Actinic Keratoses
- ☐Basal Cell Carcinoma
- ☐Eczema
- ☐Other: _____
  _____
- ☐Melanoma
- ☐Dysplastic moles/nevi
- ☐Psoriasis
- ☐Squamous Cell Carcinoma

Do you wear sunscreen regularly? ☐Yes ☐No If Yes, what SPF? _____

Do you tan in a tanning bed/salon? ☐Yes ☐No

Do you have a family history of melanoma ☐Yes ☐No If Yes, which relative? _____

Patient History Form

Do you take blood thinners? ☐Yes ☐No
Do you form keloids or thick scars with skin surgery or injury? ☐Yes ☐No
Do you have a pacemaker or defibrillator? ☐Yes ☐No
Do you have other implanted devices (spinal cord stimulator, deep brain stimulator, cochlear implant, etc.)? ☐Yes ☐No

MEDICATIONS ☐None
List current medications and dosages (include prescribed, over-the-counter, and all vitamins/supplements).

_____

_____

_____

_____

_____

_____

_____

What pharmacy do you use? _____

ALLERGIES ☐NONE

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

_____

_____

_____

_____

Are you allergic to local anesthetics (lidocaine, etc.)? ☐Yes ☐No If yes, which one(s) _____
Are you allergic to adhesives or bandages? ☐Yes ☐No

SOCIAL HISTORY

Do you live ☐Alone ☐with Spouse ☐with Family ☐with Friend/Roommate ☐Other
SMOKING STATUS ☐Never Smoker ☐Former Smoker ☐Current smoker

FOR PATIENTS 65 YEARS OF AGE AND OLDER:

1. Do you have a health care proxy (someone who you would like to make healthcare decisions on your behalf should you become incapacitated)? ☐Yes ☐No If yes, who:

Name: _____ Phone No: (_____)_____

2. What is your advanced care directive? Should you have a major medical event while in this office, what is your preference regarding resuscitation efforts?

☐FULL CPR ☐DO NOT INTUBATE ☐DO NOT RESUSCITATE