Elaine Miller, DO

Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History**: (please circle all that apply)

Anxiety

Arthritis

Artificial joints

Asthma

Atrial fibrillation

BPH

Bone Marrow Transplantation

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Diabetes

End Stage Renal Disease

GERD

Hearing Loss

Hepatitis

High blood pressure

HIV/AIDS

High cholesterol

Hyperthyroidism

Hypothyroidism

Leukemia

Lung Cancer

Lymphoma

Pacemaker

Prostate Cancer

Radiation Treatment

Seizures

Stroke

Valve Replacement

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Surgical History**: (please circle all that apply)

Appendix Removed

Bladder Removed

Mastectomy (Right, Left, Bilateral)

Lumpectomy (Right, Left, Bilateral)

Breast Biopsy (Right, Left, Bilateral)

Breast Reduction

Breast Implants

Colectomy: Colon Cancer Resection

Colectomy: Diverticulitis

Colectomy: IBD

Gallbladder Removed

Coronary Artery Bypass

PTCA

Mechanical Valve Replacement

Biological Valve Replacement

Heart Transplant

Joint Replacement, Knee (Right, Left, Bilateral)

Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years

Kidney Biopsy

Kidney Removed (Right, Left)

Kidney Stone Removal

Kidney Transplant

Ovaries Removed: Endometriosis

Ovaries Removed: Cyst

Ovaries Removed: Ovarian Cancer

Prostate Removed: Prostate Cancer

Prostate Biopsy

TURP

MOHS surgery – surgeon \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spleen Removed

Testicles Removed (Right, Left, Bilateral)

Hysterectomy: Fibroids

Hysterectomy: Uterine Cancer

Hysterectomy – ovaries removed

Hysterectomy – uterus only

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Disease History**: (please circle all that apply)

Acne

Actinic Keratoses

Asthma

Basal Cell Skin Cancer

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Melanoma

Poison Ivy

Precancerous Moles

Psoriasis

Squamous Cell Skin Cancer

None

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wear Sunscreen? 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(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any other family history: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: (Please enter all your prescription medications, the mg and how often you take or use the medications).

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_ I am not taking any medications at this time\_\_\_\_\_\_\_

\_\_\_\_ **I have a list for my medications (please attach)**

\_\_\_\_ **I take supplements**

**MEDICATION Allergies**: (Please enter all allergies) **NONE**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecological History: Females ONLY**

Date of last menstrual period \_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_/\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**: **(Please circle all that apply)**

Cigarette Smoking:

Never smoked

Quit: former smoker

Smokes less than daily

Smokes daily

Alcohol Use:

Alcohol: none

Alcohol: less than 1 drink a day

Alcohol: 1-2 drinks a day

Alcohol: 3 or more drinks a day

**\*\*65 years of age or older (Medicare):** Alcohol: how many times in last year have you had 5 (men) or 4 (women) or more drinks in a day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\*\*

Safety:

I feel safe at home.

I do not feel safe at home

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**: Are you **CURRENTLY** experiencing any of the following?

(please check yes or no for the following)

|  |  |  |
| --- | --- | --- |
| Symptom | Yes | No |
| Problems with bleeding |  |  |
| Problems with healing |  |  |
| Problems with scarring (hypertrophic or keloid) |  |  |
| FEMALES ONLY – History of irregular menses |  |  |
| Immunosuppression |  |  |
| Hay fever |  |  |
| Chest pain |  |  |
| Fever or chills |  |  |
| Night sweats |  |  |
| Unintentional weight loss |  |  |
| Sore throat |  |  |
| Blurry vision |  |  |
| Abdominal pain |  |  |
| Bloody stool |  |  |
| Bloody urine |  |  |
| Joint aches |  |  |
| Muscle weakness |  |  |
| Neck stiffness |  |  |
| Headaches |  |  |
| Cough |  |  |
| Shortness of breath |  |  |
| Wheezing |  |  |
| Anxiety |  |  |
| Depression |  |  |
|  |  |  |

Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Alerts**: Do you currently have any of the following?

(please check yes or no for the following)

|  |  |  |
| --- | --- | --- |
| Alert | Yes | No |
| Pacemaker |  |  |
| Defibrillator |  |  |
| Allergy to lidocaine |  |  |
| Allergy to topical antibiotics |  |  |
| Rapid heart beat with epinephrine |  |  |
| Premedication prior to surgery |  |  |
| Artificial joints within the past 2 years |  |  |
| Artificial heart valve |  |  |
| History of MRSA |  |  |
| Taking blood thinners |  |  |
| Pregnancy or planning a pregnancy |  |  |
| Allergy to adhesive |  |  |
| Yeast infection with antibiotics |  |  |
| GI “stomach” upset with antibiotics |  |  |
| HIV/AIDS |  |  |
| Hepatitis B |  |  |
| Hepatitis C |  |  |
| Allergy to latex |  |  |
| History of tanning bed use less than 15 times |  |  |
| History of tanning bed use greater than 30 times |  |  |
| Height (approximately) | ‘ “ |  |
| Weight (approximately) | lbs |  |
| Ebola Risk: Fever >=100.4°(F)/38° (C) |  |  |
| Ebola Risk: Resided or traveled to country with wide-spread Ebola transmission in the last 21 days |  |  |
| Ebola Risk: Contact with an Ebola patient without proper protective equipment in the last 21 days |  |  |
| Ebola Risk: Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain, and/or hemorrhage |  |  |

Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**The Dermatology Spot**

**Elaine Miller, DO**

1841 Martin Drive, Suite 200

Weatherford, Texas 76086

817/609-4114

817/609-4116 fax

**Please INITIAL :**

\_\_\_\_\_ I give Dr. Elaine Miller permission to take a photograph of my face for identification purposes in my chart.

\_\_\_\_\_ I give Dr. Elaine Miller permission to take a picture of my condition/biopsy site for documentation in the chart.

\_\_\_\_\_ I give Dr. Elaine Miller permission to send a picture of my condition/biopsy site to a referring physician to help further the treatment of my condition.

\_\_\_\_\_ I give Dr. Elaine Miller permission to use my picture for education purposes to help further the treatment of my condition with other doctors and medical institutions in the future.

\_\_\_\_\_ I am a patient of Dr. Elaine Miller. I hereby acknowledge receipt of Dr. Elaine Miller’s Notice of Privacy Practices. (Located in binder on waiting room table)

\_\_\_\_\_ We regret patients must sometimes wait a lengthy time to be seen by a physician. Due to the high demand of appointments and in order to be respectful of the medical needs of all of our patients please be courteous and call our office promptly if you are unable to attend an appointment. We always have patients on a cancellation list that need care. If you are unable to keep your scheduled appointment, we require 24 hour notice. If you miss 2 appointments without proper notification (as mentioned above) we reserve the right to dismiss the patient from care.

Name [please print]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OR

I am a parent or legal guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ [patient name].

Name [please print]: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: **** Parent **** Legal Guardian

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Information**

Patient’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Mailing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Phone \_(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell, home, work)

Alt Phone \_(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (cell, home, work)

Email Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Place of Birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth \_\_\_\_\_\_\_\_\_\_\_\_ Sex: Female / Male Social Security # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Ethnicity : (***please circle one***)Hispanic, Non Hispanic, Refuse Race \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Language spoken at home \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Married, Name of Spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_If Single, Name of Closest Relative \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred pharmacy (name & street) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your Primary Physician? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it ok to fax office visit notes and results to your PCP? (Please circle) Yes/No

Who referred you to our office? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have we seen another member of your family? Yes / No

If yes, name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*INSURANCE – You are responsible for checking your insurance regarding procedures performed*

**Primary Insurance\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Insured Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Relationship:** Self\_\_\_\_\_ Spouse\_\_\_\_\_ Parent\_\_\_\_

**Social Security(if needed to submit claims): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Medical Consent Authorization**

The undersigned does hereby authorize Dr. Elaine Miller to administer such treatment, prescribe medication, and perform such surgery as she deems necessary or advisable in the diagnosis and treatment of the patient’s condition. I authorize release of medical information to my insurance company.

Signature \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Authorization for Practice to Release**

**Protected Health Information**

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

To the extent that this form authorizes the sale of your Protected Health Information, such a disclosure will result in remuneration to the Practice.

* Leave a message on your answering machine regarding appointments? **YES or NO**
* Leave a message on your answering machine regarding lab and pathology results or any other health care issues? **YES or NO**
* Contact you at your place of employment regarding appointments, lab and pathology results or any other health care issues? **YES or NO**
* Discuss your medical condition with any member of your household? **YES or NO**

Please list

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

* If the patient is a minor, I allow the minor, once an established patient, to be seen without the accompaniment of a parent or guardian. **YES or NO**

**Expiration date of this authorization: ONE YEAR FROM DATE OF SIGNATURE**

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

This authorization was signed by:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sign Name – Patient or Representative **(18 and older must sign for themselves)**

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name – Patient or Representative

Relationship to Patient (if other than patient): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Patient Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

The Dermatology Spot

Financial Policy

We are happy and thankful that you have chosen us as one of your healthcare providers. As a partner in our relationship, it is important that you understand and agree on our financial policy.

We must first understand that our relationship is with you as our patient. Your insurance is a contract between you and your insurance company and possibly your employer. You are responsible to understand your policy and its terms including referrals and pre-certifications necessary prior to your visit.

**It is your responsibility to provide us with your most current billing information to include: Insurance I.D. Card, address, all available phone numbers, and contact information. We may ask for these updates at each visit.**

If we are participating providers with your insurance, this does NOT mean that all services provided are covered by your insurance. In many circumstances, most procedures “covered” will apply to your deductible. You are responsible to pay any differences in your insurance estimate and what is actually paid by your insurance as these numbers are often different.

If we are not providers for your insurance company, we will file with your insurance but we do not accept the discounted rate. It is your responsibility to know if The Dermatology Spot is in your network. There are 100s of policies within each insurance, it is impossible for us to know every one of them. If you would like us to become in network please talk to the front office staff.

We will send you a statement on a monthly basis of balances due. These must be paid in full or you must set up a payment plan with the office.  **If you have an overdue balance we will collect payment in full before you are seen.**

Balances may be paid by cash, check, or credit cards (Visa, MC, and Discover). There is a fee for any returned check.

If your account becomes delinquent and is sent to a collection agency or you have been dismissed as a patient, full payment of prior charges will be required in order for you to make an appointment.

***Full payment is due at time of service. I have read and understand this Financial Policy.***

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Responsible Party Date