

BRYKERWOOD SKIN AND VEIN CENTER
NEW PATIENT INFORMATION

Date _____

Name _____ Date of Birth _____ Age _____ Sex : M F

Address _____ Apt # _____ City _____ ST _____ Zip Code _____

Daytime Phone _____ Evening Phone _____ Cell/Alternate Phone _____

Social Security # _____ Emergency Contact _____ Phone _____

(Circle One) MINOR SINGLE MARRIED (if married name of spouse) _____

May we discuss medical / billing information about you with your spouse? YES NO

Employer _____ Occupation _____

Primary Care Physician _____ Referred by _____

RESPONSIBLE PARTY

[Who is responsible for the account if different than above]

check if SELF

Name _____ Relationship _____

Date of Birth _____ Drivers License # _____ Social Security # _____

Address _____ Apt # _____ City _____ ST _____ Zip Code _____

Employer _____ Occupation _____

Daytime Phone _____ Evening Phone _____ Alternate Phone _____

INSURANCE INFORMATION

PRIMARY INSURANCE (circle one)

MEDICARE BCBS PPO BCBS HEALTHSELECT HUMANA PPO OTHER NO INSURANCE

If OTHER is circled, please give insurance carrier name _____

Policy Holder's Name _____ SS# _____

Policy Holder's Date of Birth _____ Employer _____ Relationship to Patient _____

SECONDARY / SUPPLEMENTAL INSURANCE—YES NO

Insurance Company Name _____ ID# _____ Group # _____

Policy Holder's Name _____ Date of Birth _____ Relationship to Patient _____

DISCLOSURE STATEMENT

If we are in network with your insurance all co-pays, co-insurance and deductibles are due at the time of service. If we are not in-network, then all charges are due and you will be reimbursed directly by your insurance company based on your out-of-network benefits. All cosmetic or non-covered services are also due at time of visit and likely won't be covered by you insurance.

All Medicare claims are filed with Medicare but the 20% that Medicare does not cover will be collected at the time of service until we know that your secondary insurance accepts claims from Medicare directly. If Medicare files your claim with your secondary and they do not pay within 60 days then you will be billed for the balance on the claim. You may pursue reimbursement for these services directly from your insurance carrier.

If you have Blue Cross Blue Shield Health Select, you must have a referral from your Primary Care Physician for every office visit. If one is not obtained by the time of the office visit, you will be required to sign a waiver and pay for 100% of charges as the insurance company will deny coverage without a referral.

I have read and understand the above disclosure and have filled out my insurance information accurately.

Patient / Responsible Party Signature _____ Date _____

Clinic Representative _____ Date _____

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ASSIGNMENT / RELEASE

- I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me/my child during the period of such medical care to third party payers including Medicare.
- If my insurance is in network, I assign my medical insurance to pay the billed charges. I understand that my medical insurance company may pay less than the billed charges. I agree that I may be responsible for payment of services rendered on my behalf or my dependents.
- I understand I may be billed from an outside laboratory for pathology or lab charges. These services are separate from any procedures done in this office.

FINANCIAL POLICY

- We accept CASH, CHECKS-with valid driver's license, MASTERCARD, VISA and AMERICAN EXPRESS. **There will be a \$25.00 return check fee assessed to patients account for each returned check.*
- If copies of your medical records are needed, we require patients to sign a medical record release. The fee for record copying is \$25.00.
- If you have any balance due from deductibles, co-insurance etc., statements will be sent out monthly. Payment is considered due for the full amount when you receive your statement. Sometimes the insurance companies give us incorrect benefit information in which we don't find out until the claim has been filed. You will be responsible for any payment due in this case. Payment plans are not available.
- We require a 24-hour notification prior to cancellations for all appointments. The following are the cancellation fees.

<OFFICE VISIT	\$30
<SURGERY	\$200
<AESTHETIC or COSMETIC TREATMENT	The cost of the procedure.

As a courtesy, we call to remind you of your appointment 48-72 hours in advance. You are still responsible for your appointment, even if we are unable to contact you. Please make sure have updated the numbers where you can be reached.

I have read and understand the above Authorization/Release and Financial Policy.

Patient Name (print) _____ Date _____

Patient / Responsible Party Signature _____ Date _____

Clinic Representative _____ Date _____

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PHARMACY NAME: _____ **PHONE:** _____

PAST MEDICAL HISTORY—Please complete entire section

Do you have, or have you ever had any of the following? (If yes, please check box and explain in line provided.)

- | | |
|----------------------------------------------------------------------------------|--------------------------------------------------------|
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> High Cholesterol _____ |
| <input type="checkbox"/> Blood Clots/Phlebitis _____ | <input type="checkbox"/> Irregular Heartbeat _____ |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Joint Replacement _____ |
| <input type="checkbox"/> Defibrillator _____ h/r _____ | <input type="checkbox"/> Kidney problems _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Pacemaker _____ h/r _____ |
| <input type="checkbox"/> Emphysema _____ | <input type="checkbox"/> Psychological disorders _____ |
| <input type="checkbox"/> Glaucoma _____ <input type="checkbox"/> Cataracts _____ | <input type="checkbox"/> Stomach problems _____ |
| <input type="checkbox"/> Headaches/Seizures _____ | <input type="checkbox"/> Thyroid problems _____ |
| <input type="checkbox"/> Heart disease/Heart Attack/Bypass _____ | <input type="checkbox"/> Tuberculosis _____ |
| <input type="checkbox"/> Heart Murmur _____ h/r _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hepatitis B/C _____ | |
| <input type="checkbox"/> High Blood Pressure _____ | |

Females: Pregnant—**IF NO**, Date of Last Period: _____
 If **NOT**, planning pregnancy, then list method of Birth Control: _____

Have you ever had any Skin Cancer, Melanoma, Atypical or Dysplastic Moles or Pre-cancerous lesions? (If yes, explain location, diagnosis and when treated) _____

Are you **ALLERGIC** to any medications? If so, please list _____

What medications are you currently taking? (Include all over the counter medications, herbs and/or vitamins)

SOCIAL HISTORY—Please complete entire section

- Do you drink alcohol? If yes, how many drinks per day/week _____
 Do you smoke or use tobacco products? If yes, how long and how many packs per day _____
 Where did you grow up? _____
 Hobbies / Leisure activities that keep you outdoors _____
 Have you had more than 3 sunburns before age 18? Yes No
 Have you had a sunburn in the last 10 years? Yes No If yes, where on body? _____
 Have you had any blistering or peeling sunburns? Yes No If yes, where on body? _____
 Have you tanned in a tanning bed? Yes No If yes, what age(s) and # of uses. _____

FAMILY HISTORY—Please complete entire section

(Check any medical condition(s) that have occurred in your family)

- | | |
|------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Cancer (other than skin cancer)
Family Member(s) _____
Type of Cancer _____ | <input type="checkbox"/> Skin Cancer
Family Member(s) _____
Type of Skin Cancer _____ |
| <input type="checkbox"/> Atypical /Dysplastic Moles <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malignant Melanoma |
| <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis | Family Member(s) _____ |
| <input type="checkbox"/> Lupus <input type="checkbox"/> Varicose Veins | _____ |
| <input type="checkbox"/> High Cholesterol | _____ |

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REVIEW OF SYMPTOMS—Please complete entire section

Have you had any problems related to the following organ systems that you have not discussed with another physician?

(Please circle answer. If yes, explain in line provided.)

Allergic/Immunologic	YES	NO	_____
Arthritis/Muscles/Joints	YES	NO	_____
Blood/Bleeding disorders	YES	NO	_____
Ears/Nose/Throat/Mouth	YES	NO	_____
Eyes	YES	NO	_____
Headaches/Seizures	YES	NO	_____
Heart	YES	NO	_____
Kidneys	YES	NO	_____
Lungs	YES	NO	_____
Skin	YES	NO	_____
Stomach/Bowel	YES	NO	_____
Thyroid/Diabetes	YES	NO	_____

Patient / Responsible Party Signature _____ Date _____

Clinic Representative _____ Date _____

Physician Signature _____ Date _____

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HIPAA PRIVACY CONSENT FORM

By signing this consent form, you consent to our use and disclosure of Protected Health Information. Protected Health Information may be used or disclosed in order to treat a patient, obtain payment for service, or to carry out healthcare operations.

Examples:

- **Treatment:** sending a specimen to an outside laboratory
- **Payment:** filing to an insurance company
- **Healthcare Operations:** pulling a chart or confirming an appointment.

Signing this consent does not allow the practice to obtain or disclose records from other physicians without a signed authorization for each request. Please refer to Brykerwood Skin and Vein Center’s Notice of Privacy Practices for a more complete description of such uses and disclosures. This Notice contains a Patient Rights section describing your rights under law. You have the right to review our Notice before signing the consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. Brykerwood Skin and Vein Center provides this form to comply with the Health Insurance Portability and Accountability Act of 1996(HIPAA).

The patient understands the following:

- The practice has a Notice of Privacy Practices and the patient has the right to review the Notice prior to signing the consent.
- The practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the practice is not required to agree to those restrictions.
- The patient may revoke this consent in writing at anytime. However, such a revocation shall not affect any disclosures we have already made.
- The practice may condition receipt of treatment upon the execution of this consent.

Patient Name _____

Patient/Responsible Party Signature _____ Date _____

Clinic Representative _____ Date _____