Pine Belt Dermatology & Skin Cancer Center

Patient Information			
First name	Last name	MI	DOB / /
Parent or Legal guardian, If Applicable:			
Address	City	State	Zip
Cell	Home	Work	
Social Security	Male/ Female	Marital Status S M D W	
Email:	Did your doctor refer you? ☐ Yes ☐ No		
Primary Care Physician	How did you hear about us?		
Emergency Contact Name	Phone number		
Race			
Do we have permission to leave a message on your voicemail? ☐ Yes ☐ No	Do we may permission to contact you at work? ☐ Yes ☐ No		

Insurance Information	
Primary Insurance	Secondary Insurance
Policy Holder's Name	Policy Holder's Name
Policy Holder's DOB / /	Policy Holder's DOB / /
ID#	ID#
Group #	Group #
Relationship to Policy Holder Self Spouse Daughter Son	Relationship to Policy Holder Self Spouse Daughter Son

By signing below, I acknowledge and consent that all information provided is true and correct.

_____ _____

Patient or Guardian Signature Date

Pine Belt Dermatology & Skin Cancer Center Medical History Form

Patient Name: _____ Date: _____
Current Weight_____ Current Height_____
What is the main reason(s) for your visit today? _____

Please circle if you currently have or have ever had any of the following?

Anxiety	Coronary Artery Disease	High Cholesterol	Eczema
Arthritis	Depression	Hyperthyroidism	Melanoma
Asthma	Diabetes	Hypothyroidism	Precancerous moles
Atrial fibrillation	Kidney Disease	Leukemia	Psoriasis
Bone Marrow Translation	GERD/Heartburn	Lung Cancer	Skin Cancer
Enlarged Prostate	Hearing Loss	Lymphoma	
Breast Cancer	Hepatitis	Prostate Cancer	
Colon Cancer	High Blood pressure	Radiation Treatment	
COPD	HIV/AIDS	Seizures	
		Stroke	

Please list surgical history (if applicable): ☐ **None**

_____

Do you have a family history of Melanoma? ☐ **Yes** ☐ **No** If so, who? _____
Do you have a family history of Skin Cancer? ☐ **Yes** ☐ **No** If so, who? _____

Please list any medications you are currently taking: ☐ **None** ☐ **No Changes**

_____

_____

Preferred Pharmacy name and location: _____
Do we have permission to reconcile your medications with your pharmacy? ☐ **Yes** ☐ **No**

Please list any allergies to medications: ☐ **None**

_____

Have you had the flu shot in the last 12 months? ☐ **Yes** ☐ **No** Pneumonia Vaccine? ☐ **Yes** ☐ **No**
Do you smoke? ☐ **Yes** ☐ **No** If yes, how many packs per day? _____
Do you drink alcoholic beverages? ☐ **Yes** ☐ **No** If yes, how many per day? _____
Do you use IV drugs? ☐ **Yes** ☐ **No**
Do you have any artificial/replaced joints? ☐ **Yes** ☐ **No**
Do you require antibiotics before a surgical procedure? ☐ **Yes** ☐ **No**
Do you have a prosthetic heart valve? ☐ **Yes** ☐ **No**
Do you have implantable devices that have been surgically put into your body? ☐ **Yes** ☐ **No**

Do you have a living will? ☐ **Yes** ☐ **No**
Do you have a power of attorney for healthcare? ☐ **Yes** ☐ **No**
If so please list name and relationship _____

Pine Belt Dermatology & Skin Cancer Center **Review of systems**

Patient name: _____ Date: _____

Please circle if you are currently experiencing any of the following:

Problems with healing	Muscle weakness	Shortness of breath
Problems with scaring	Neck Stiffness	Wheezing
Sore Throat	Headaches	Rash
Immunosuppression	Bloody Stool	Joint aches
Problems bleeding	Bloody Urine	Pregnant or trying to become?
Chest pain	Abdominal Pain	Breastfeeding
Fever or chills	Blurry vision	Seizures
Night sweating	Unintentional Weight Loss	Cough

Are you currently experiencing any pain at this time related to your visit with us today?

☐ **Yes** ☐ **No**

IF YOU ARE EXPERIENCING PAIN, please circle your pain level. Your level of pain on a scale of 0-10, with 0 being none and 10 being the highest level of pain.

0 1 2 3 4 5 6 7 8 9 10

PINE BELT DERMATOLOGY & SKIN CANCER CENTER

Financial & Office Policies

We would like to thank you for choosing Pine Belt Dermatology & Skin Cancer Center for all your dermatological needs. Pine Belt Dermatology & Skin Center is committed to providing you with the best possible medical care. The following outlines your financial responsibilities related to payment for professional services.

No Show Fee:
Please Kindly give a 48-hour notice if you are unable to keep your follow up appointment. Our office reserves the right to charge your account $20.00 in the event you do not show for your scheduled appointment.

No Show Surgical Appointment Fee:
Please Kindly give a 48-hour notice if you are unable to keep a surgical appointment. Please note there will be a fee in the amount of **$100.00** added to your account in the event you do not show for your surgical appointment.

For Our Patients with Medical Insurance Benefits:
We participate in most major health plans. We have contracts with many HMO's, PPO's Insurance companies and government agencies including Medicare and Medicaid. Our business office will assist you in any way reasonable we can to get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid.

Co- Payments:
Your insurance company required us to collect co- payments at the time of service. Waiver of co-payments constitutes fraud under state and federal law. For your convenience, we accept cash, checks or the following credit cards: Visa, MasterCard, Discover, American Express and Care Credit.

Additionally, you may have coinsurance and/ or deductibles, or other financial responsibility required by your insurance carrier. Any outstanding balance on your account, after adjusting for all of your insurance responsibilities, will be billed to you.

PINE BELT DERMATOLOGY & SKIN CANCER CENTER

Surgery sliding scale for those patient's needing financial Assistance:

In the event you need assistance paying for a surgery that has been discussed with your provider, our office has to set up guidelines in order to be able to legally assist our patients who may not have the means to cover their services entirely. Please see a staff member to discuss this matter privately.

Non- Covered and Out of Network Services:

Medical services that are considered by your insurance company to be non- covered, out of network, or not medically necessary will be your responsibility.

For Our Patients with no Medical Insurance:

If you do not have group or individual medical insurance, we do offer a self- pay rate. A minimum of $50.00 will be required on office visits and $100.00 on surgical procedures.

Payment Plan:

Please let us know If you are having difficulty paying your account. We are more than willing to make arrangements that will fit your budget.

Delinquent Balance Appointment:

If you have a balance more than 120 days old, you will be required to pay an additional amount towards the outstanding balance and a payment plan must be set up.

Collection Agency Fees:

All patient's balances that require placement with an outside collection agency will be assessed a fee of 35% for the total balance owed on the account.

Cosmetic Services:

Services for cosmetic procedures or any service deem non- medically necessary by the provider, are required to be paid in full at the time of service.

Waiver of Patient Responsibility:

It is the policy of the practice to treat all patients in an equitable fashion related to patient balances. The practice will not waive, fail to collect or discount co-payments, co –insurance, deductibles or other patient responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Charity/Free Care Policy.

PINE BELT DERMATOLOGY & SKIN CANCER CENTER

Photography:
Our Providers require the use of photography in your medical chart. In short, it is another way to identify the patient and the medical record. Our office **does not** sell or distribute your personal information including pictures to any outside source. The only exception to this is for payment of your medical claim, your consent and request or required by law enforcement.

HIPAA Consent:
It is the practice of the office not to release your medical information to anyone without your written authorization. **If you would like our office to discuss your confidential medical information with someone other than you such as, your primary care physician, spouse or family member, please list the person(s) and their relationship to you.**

We are required by law to provide you with a notice that explains our privacy practices with regards to your medical information and how we may use and disclose your protected health information, payment, for healthcare operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information as we describe them in our HIPAA policy. Please see the staff for a full copy of our HIPAA policy.

☐ **No**, I would not like to disclose any of my health information with anyone.

☐ **Yes**, I would like to disclose my health information with the following.

_____
Printed Name of Authorized Person(s) & phone number

_____
Printed Name of Authorized Person(s) & phone number

_____ _____
Patient or Guardian Signature Date