BRECKSVILLE DERMATOLOGY

Welcome to Brecksville Dermatology. Please provide the following information.

Last Name	First Name	Middle

Sex (circle one) M F	Date of Birth / /	Marital Status (circle one) Single Married Divorced Separated Widowed	Social Security #

Address	City	State	Zip Code

Home Phone Number	Cell Phone Number	Email Address

Occupation	Employer	Work Phone Number

How did you hear about us / who referred you to us? (CIRCLE ONE)

Family Member Friend/Co-Worker Internet Signage Yellow Pages/Printed Ad Physician:_____

Name_____ Name _____

Pharmacy Name, Location, Phone Number	Primary Care Dr.

Insurance Subscriber / Policy Holder Name	Subscriber Relationship to Patient	Subscriber Date of Birth

Emergency Contact	Relationship to Patient	Phone Number

I ☐ ALLOW ☐ DO NOT ALLOW test results and other specific health information to be left on my answering machine or voicemail.

PROTECTED HEALTH INFORMATION RELEASE

Concerning matters of my health, lab results, and appointments, I, the patient/legal representative give permission for Brecksville Dermatology to speak to and share my information with:

Name(s)_____ Relationship(s) to Patient: _____

☐ I do not want to share my health information with anyone. (Initial) _____

SIGNATURE ON FILE

The completed information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Brecksville Dermatology. I understand that I am financially responsible for any balance or services not covered by my insurance. I also authorize Brecksville Dermatology or my insurance company to release any information required to submit my claims.

Signature:_____

CONSENT FOR MEDICAL TREATMENT

I give my consent for Brecksville Dermatology to administer diagnostic and therapeutic treatment and to perform operative procedures as deemed necessary by the physician for the purpose of diagnosis and treatment. I consent to physical examination to diagnose and treat my condition or injury. (Initial)_____

HIPPA ACKNOWLEDGEMENT

I have been given, I have reviewed, and I consent to all practices/policies explained in the Notice of Privacy Practices.

Signature:_____

FINANCIAL POLICY

Due to many recent changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible, as they can sometimes happen day-by-day. Therefore, we urge you, as the patient, to please check with your insurance company prior to any medical office visits, procedures, or surgeries being performed. It is your responsibility to know your individual coverage. Failing to comply with our suggestion could result in you, the patient, being responsible for all costs of services rendered.

I agree to pay all copays, **in full**, in advance of seeing the physician.
I agree to pay**, in full**, for all cosmetic services on the date of service, prior to checking out.
I understand that **I am financially responsible for all services rendered by Brecksville Dermatology**, in the event of any of the following:

- **I have not met my deductible.**
- **I have given incorrect, invalid or incomplete insurance information.**
- **My insurance company denies the claim.**
- **Certain services / diagnoses are not covered by my insurance, due to plan exclusions OR if my insurance company deems the service/diagnosis as *not medically necessary.***
- **My insurance is out of network with Brecksville Dermatology. I, the patient, am responsible for verifying my coverage and network status with Brecksville Dermatology prior to my visit.**

I agree to pay any outstanding balances, **in full**, before any continuation of care or any new care is rendered.
If my insurance does not remit payment within 60 days, I agree to pay the **full amount billed.**

I understand that **Brecksville Dermatology does not submit claims to secondary insurances**, and I will be responsible for submitting claims to my secondary insurance on my own. (This does not apply to patients who have Medicare as their primary insurance, as Medicare is responsible for forwarding the claims on to the secondary payers, unless your secondary payer is UFCW. Unfortunately, Medicare and UFCW do not have an agreement for forwarding claims.)

I understand that I may receive a separate bill from the pathology lab (Dermatopathology Laboratory of Central States/ Cleveland Skin Pathology) or microbiology lab (University Hospitals) for processing of tissue specimens from procedures. It is my responsibility, as the patient, to verify my insurance coverage and network status with the above listed labs prior to my visit. For any blood or urine tests, you may visit any outside lab or your choice, with a lab requisition provided by our medical staff.

I understand that Brecksville Dermatology is a specialty medical practice, and therefore, **preventative screening codes will not be submitted** to insurance. I understand that all services provided will be submitted under my specialist benefits.

I understand that balances 90 days past due (from the date of visit) will be turned over to a third-party credit reporting collection agency, and a **25% late fee will be added to my balance**. The collection agency is a business associate of Brecksville Dermatology and they may contact me using all the information provided on page 1 of this registration form. Failure of my insurance company to pay does not excuse my financial responsibility.

By signing this financial policy, I am acknowledging that I have read and understand the financial policy fully.

Patient (or financially responsible guardian/POA) Signature: _____ Date _____

FOR PATIENTS UNDER 18 YEARS OLD

Patient Name: _____
Name of legal guardian authorizing patient to receive care: _____
As the legal guardian, I am responsible for the above named patient and I assume all financial responsibility for the services provided.
Signature of Legal Guardian: _____

CONSENT TO TREAT A MINOR WITHOUT A LEGAL GUARDIAN PRESENT (optional)

As the legal guardian, I, _____ give permission to the stall and providers of Brecksville Dermatology to provide medical care to _____without my being physically present during the office visit. I understand that I may contact the office at 440-792-4802, should I have any questions regarding his/her care.
Parent/Legal Guardian Signature: _____

MEDICAL HISTORY

Name: _____ Preferred Name (Nickname):_____

Race/Ethnicity: _____ Natural Hair Color: _____ Natural Eye Color: _____

DRUG ALLERGIES: (list medication AND reaction):

(**Write NONE**, if you have no allergies)

_____

_____

ALLERGY to LATEX, IODINE, BETADINE?

□ No □ Yes

MEDICATIONS: (Include Prescription, Over-The-Counter, Vitamins, Herbal Supplements, and **dosages for each**)

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

TOPICAL MEDICATIONS: (Include Prescription, Over-The-Counter, Vitamins, and Herbals)

_____ _____ _____

_____ _____ _____

Dermatology:	**Personal History**	**Family History**	**(WHO? WHAT TYPE?)**
Malignant Melanoma?	□ No □ Yes	□ No □ Yes	_____
Other Types of Skin Cancer?	□ No □ Yes	□ No □ Yes	_____
Cancer of any kind?	□ No □ Yes	□ No □ Yes	_____

- Do you have a history of atypical/ unusual moles? □ No □ Yes _____
- Have you had any moles removed? □ No □ Yes _____

(If pathology results are known, please indicate)

- Do you sunburn easily? _____ Have you ever had blistering sunburns? _____
- Do you wear sunscreen? □ No □ Yes If so, what SPF? _____

Other Skin Conditions: _____

- Do you need to take antibiotics prior to any surgical procedures? □ No □ Yes
- Current tobacco use? □ No □ Yes_____ # of packs per week
- Former tobacco use? □ No □ Yes
- Alcohol consumption? □ No □ Yes_____# of drinks per week
- High blood pressure? □ No □ Yes
- Artificial / damaged heart valve? □ No □ Yes

- Metal plate / Artificial joint / implants? ☐ No ☐ Yes _____
  (Please Specify)
- Pacemaker or Defibrillator ☐ No ☐ Yes
- Use of blood thinners (aspirin, Coumadin, Plavix) ☐ No ☐ Yes
- History of organ transplant? ☐ No ☐ Yes _____
  (Please Specify)
- Kidney disease? ☐ No ☐ Yes
- Diabetes? ☐ No ☐ Yes
- Seizure / Stroke / Black-out? ☐ No ☐ Yes
- Asthma / Emphysema / Lung disease? ☐ No ☐ Yes
- History of Hepatitis A, B, or C? ☐ No ☐ Yes
- History of HIV/AIDS? ☐ No ☐ Yes
- History of "staph" skin infections? ☐ No ☐ Yes
- **Female patients:** Are you currently pregnant? ☐ No ☐ Yes
- **Patients over 65 yrs:** Have you had a flu shot this year? ☐ No ☐ Yes
- **Patients over 65 yrs:** Have you had the pneumonia vaccine? ☐ No ☐ Yes

OTHER MEDICAL CONDITIONS: (not listed above) _____

_____

_____

PAST SURGERIES / HOSPITALIZATIONS: (including cosmetic surgeries) _____

_____

_____

RECENT ABNORMAL SYMPTOMS: (please circle any you have experienced in the past months)

Problems with Bleeding
Problems with Scarring (keloids or hypertrophic scars)
Rash
Immunosuppression (low immune system)
Hay Fever (seasonal allergies)
Fevers/Chills
Night Sweats
Unintentional Weight Loss
Thyroid Problems
Sore Throat
Bloody Stool or Urine
Joint Aches
Muscle Weakness
Headaches
Cough
Shortness of breath
Anxiety/Depression

PATIENT (OR LEGAL GUARDIAN/POA) SIGNATURE (all info is correct):_____