MIDTOWN DERMATOLOGY

Health History

Patient Name: _____ Date of Birth: _____

Reason for Today's Visit: _____

Past Medical History (Do you have or have you ever had the following? Check if Yes)

____None
____Anxiety
____Arthritis
____Hearing Loss
____Asthma
____Atrial fibrillation (Irregular heartbeat)
____BPH (Benign Prostatic Hyperplasia)
____Breast Cancer
____Cerebrovascular Accident (Stroke)
____COPD
____COVID-19
____Coronary Artery Disease / Heart Attack
____Colon Cancer
____Depression
____Diabetes
____End Stage Kidney Disease
____Epilepsy / Seizures
____GERD
____Hepatitis
____Hypertension (High Blood Pressure)
____High Cholesterol
____HIV / AIDS
____Hyperthyroidism
____Hypothyroidism
____Leukemia
____Lung Cancer
____Lymphoma
____Prostate Cancer
____Radiation Treatment
Other:_____

Past Surgical History

____None
____Knee Replacement (Both / Rt / Lt)
____Hip Replacement (Both / Rt / Lt)
____Pancreatectomy (pancreas removal)
____Coronary Artery Bypass Graft
____Prostatectomy (prostate removal)
____Splenectomy (spleen removal)
____Mastectomy (Both / Rt / Lt)
____Colectomy (removal of colon, partial or total)
____Cystectomy (bladder removal)
____Hysterectomy (uterus removal)
____Breast Lumpectomy (Both/ Rt / Lt)
____Oophorectomy (ovary removal)
____Kidney stone removal
____Nephrectomy (kidney removal)
____Orchiectory (testicle removal)
____Appendectomy (appendix removal)
____Cholecystectomy (gall bladder removal)
____Heart Valve Replacement (Tissue / Mechanical)
____Breast Biopsy
____Prostate Biopsy
____Kidney Transplant
____Heart transplant
____Liver transplant
Other: _____

Past Skin History

____ None ____ Basal Cell Carcinoma
____ Acne ____ Abnormal Mole(s)
____ Eczema ____ Severe Sunburn(s)
____ Itchy Scalp / Dandruff
____ Squamous Cell Carcinoma
____ Actinic Keratosis (pre-cancer)
____ Psoriasis
____ Melanoma
____ Dry Skin

Do you have a family history of Melanoma? Yes / No If yes, which relative?_____

Current Medications: (attach list, write on back for more)

_____ _____

_____ _____

Medication Allergies: Yes / No If yes, please list: _____

Any previous problems with procedures (Lightheadedness, fainting, etc.). Yes / No _____

Pharmacy Name: _____ Location (Cross Streets):_____

Social History:

Smoking Status: ☐ Never ☐ Current ☐ Former Start Date: _____ End Date: _____

Do you drink alcohol? ☐ None ☐ < 1 drink per day ☐ 1-2 drinks per day ☐ 3+ drinks per day

Have you ever used recreational drugs? Yes / No

Do you feel safe at home? Yes / No

For patients 9 – 13 years old:

Up to date on immunizations? Yes / No

For patients 65 years old or older:

Have you received the pneumonia vaccine? Yes / No Do you have an Advance Directive? Yes / No

If yes, who is appointed to make medical decisions on your behalf?

Name: _____ Phone: (_____)_____

Do you have a living will? Yes / No Do you have a DNR? Yes / No

MIDTOWN DERMATOLOGY

Patient Information

Patient Legal Name (First)_____(MI)_____(Last)_____

Date of Birth: _____/_____/_____ Age: _____ SSN: _____

Birth Gender: Male / Female Gender Identity: _____

Nickname/How would you like to be addressed? _____

Marital Status: Married / Divorced / Single Spouse's Name:_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Work Phone: (_____)_____

Email : _____

Are you employed? Yes / No Place of Employment: _____

Ethnicity: Hispanic / Non-Hispanic

Preferred Language: _____ Race: _____

Primary Care Physician: _____

Primary Care Phone #: (_____)_____

Referring Provider: _____

Referring Provider #: (_____)_____

Pharmacy: _____

Emergency Contact/ Patient Parent Information if Minor

Name: _____ Relationship:_____ Phone #:_____

Name: _____ Relationship:_____ Phone #:_____

MIDTOWN DERMATOLOGY

HIPAA PRIVACY AUTHORIZATION
Receipt of Notice of Privacy Practices

Confidential Communication Request

As required by the Health Information Portability and Accountability Act of 1996 (HIPAA) you have the right to request that communication concerning your personal health be made through confidential channels. This medical practice will not ask you why you are making your request and will try to accommodate all reasonable requests.

I, (print patient full name) _____, date of birth _____, hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment, or payment for services. **This request supersedes any prior request for confidential channel communication I may have made.**

Contact Information:

Home #: (_____)_____ ☐ Do ☐ Do Not Leave messages on my voicemail

Cell #: (_____)_____ ☐ Do ☐ Do Not Leave messages on my voicemail

☐ Do ☐ Do Not Send text messages (appointment reminders)

Work #: (_____)_____ ☐ Do ☐ Do Not Leave messages on my voicemail

☐ Do ☐ Do Not Leave message with any other person

Email: _____ (appointment reminders)

Please list other person(s) that may be contacted with confidential communications:

Name: _____ Name: _____

Relationship to patient: _____ Relationship to patient: _____

Phone #: (_____)_____ Phone #: (_____)_____

By signing this form, I acknowledge that I have received a copy of Midtown Dermatology's Notice of Privacy Practices.

Patient/Parent or Guardian Signature: _____ Date: _____

MIDTOWN DERMATOLOGY

POLICIES AND FINANCIAL RESPONSIBILITIES

Credit Card on File Policy:

Midtown Dermatology Credit Card on File policy is a convenient method to pay for the portion of the services that your insurance company deems to be the patient's responsibility, such as co-pay, deductible, co-insurance, No Show Fees, and Re-Billing Fees. At your appointment, your credit card information will be obtained and kept confidential and secure until insurance(s) have paid their portion and notifies Midtown Dermatology of the balance due, if any. At that time, the billing department will issue one statement via mail which the patient will have 30 days to pay or plan for other forms of payment. After 30 days, the debit/credit card on file will be automatically charged for any outstanding balance if it is less than $300. If your bill is more than $300, you will be notified by phone (including voicemail) prior to the charge being processed. In the case when a credit card has reached its maximum limit, the patient will have an additional 60 days to arrange payment before the bill is forwarded to a collection agency.

No-Show Fee Policy:

If you are unable to make your appointment, we require 24 hours' notice. If you cancel or reschedule with less than 24 hours' notice, you will be charged a No Show fee of $50 for a regular appointment and $150 for a procedure appointment.

Re-Billing Fee Policy:

Midtown Dermatology billing statements are sent out once a month and ask that the balance be paid in full within 30 days. If the balance is not paid in full or a payment plan is not set up within 30 days, a re-billing fee will be applied to your account in the amount of $25 for each monthly billing cycle.

In-Network and Medicare Patients:

If we participate in your insurance plan you will be responsible for paying for your co-pay, deductibles and or co-insurance at the time of service. You may also be responsible for payment of services related to conditions that are not covered by your plan. If you have not met your deductible, you will be responsible for the deductible and any amount the insurance company does not pay. If your insurance company denies payment or will only pay a portion of your medical bill, you are responsible for the remainder of services rendered. Please be aware that your insurance carrier does not guarantee accuracy of confirmation of coverage and benefits.

Pathology Policy:

If a biopsy is needed, the tissue sample will be sent to a pathology lab for microscopic evaluation. You and/or insurance may receive a separate bill for these services.

Failure to Pay Policy:

Any unpaid balance that exceeds 60 days will be sent to a collection agency and may incur additional fees or collections costs. The patient /or guarantor will be responsible for all associated costs.

All professional services rendered are charged to the patient. Necessary forms will be completed to expedite insurance claims. The patient is responsible for all fees, regardless of insurance coverages. It is our utmost concern that our patients' transactions are processed according to the highest security standards. Midtown Dermatology, LLC will safely and securely store your credit card information in Modernizing Medicine. Modernizing Medicine meets all PCI requirements and will prevent unauthorized access to full card information.

I hereby authorize Midtown Dermatology to provide information to insurance carriers concerning my diagnosis and treatments. I hereby assign to the doctor all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any charges not covered by insurance for myself or my dependents.

I have read the above disclaimer and fully understand my financial responsibilities to Midtown Dermatology, LLC.

Patient Name: _____ DOB: _____

Patient/Parent or Guardian Signature: _____ Date: _____