FOREST DERMATOLOGY, PA
PATIENT INFORMATION

Date:_____

PATIENT: _____
Last Name *First Name* *Middle Initial* *" Preferred Name "*

Mailing Address _____ Apt#_____

City_____ State_____ Zip_____

Email _____

Home #_____ Cell/Text #_____ Work #_____

Messages from Forest Dermatology may be left for me at the following locations:

❑ Home ❑ Cell/Text ❑ Work

Birth Sex ❑ M ❑ F Age_____ Date of Birth_____ Social Security #_____

Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Widowed

Preferred Language _____

RESPONSIBLE PARTY (if under 18)_____ Relationship to Patient_____

SS#_____ Date of Birth_____

CONSENT TO TREAT MINORS (if under 18)

I hereby authorize the person(s) listed below to bring my minor child to Forest Dermatology for diagnostic evaluation and treatment (other than parents):

Authorized Party_____ Parent Signature_____

PATIENT'S EMPLOYER_____ Occupation_____

PRIMARY INSURANCE: _____

Subscriber Name: _____

Date of Birth_____ SS#_____

Policy Number: _____

SECONDARY INSURANCE_____

Subscriber Name_____

Date of Birth_____ SS#_____

Policy Number: _____

MEDICARE PATIENTS ONLY

Forest Dermatology, PA accepts what is allowed and approved by Medicare.
Your co-payment and yearly deductible are your responsibility.

I request that payment of authorized Medicare benefits be made on my behalf to Forest Dermatology, PA for any services furnished me by that physician/supplier.

Signature:_____ Date:_____

Primary Care Physician: _____

Reason for your visit today: _____

MEDICAL HISTORY

(This is confidential medical information)

Patient's Past Medical History (please circle all that apply.)

Anxiety
Arthritis
Artificial Heart Valve/Joint
Asthma
Atrial Fibrillation
Bleeding Disorders
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hepatitis
High Blood Pressure
HIV/AIDS
High Cholesterol
Hyperthyroidism
Hypothyroidism
Pace Maker
Problems Healing/Scarring
Radiation Treatment
Seizures
Stroke
Cancer: _____
Psychiatric Care
Pregnant/Breast Feeding: _____
Trying to become pregnant
Other:_____

Patient's Skin Disease History (please circle all that apply.)

Acne
Actinic Keratoses
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
Other:_____

Patient's Family History:

Do you have a family history of Melanoma?_____ If yes, which relative?_____

PREFERRED PHARMACY: _____

Location: _____

Medications: (Please enter all current medications)

_____
_____
_____
_____

Allergies to medications (Please enter all allergies & describe reaction (i.e. hives, anaphylaxis, ETC.)

_____
_____
_____
_____

Social History:

Tobacco use: ❑ non-smoker ❑ current smoker ❑ former smoker

Drug use: ❑ yes ❑ no

Alcohol use: ❑ none ❑ less than 1 drink/day ❑ 1-2 drinks/day ❑ 3+ drinks/day

PATIENT CONSENTS:

1. List anyone with whom we may discuss your personal, medical or financial information (i.e. family members or friends). The identity of these designated parties will be verified prior to the release of any information:

   Name:_____ Relationship:_____

   Name:_____ Relationship:_____

2. Emergency Contact:

   Name:_____ Relationship:_____

   Phone 1:_____ Phone 2:_____

3. Patient Consent for Medical Photography:

   I give my consent for medical photographs to be made of me (or for the person for whom I am the legal guardian). I understand that these images will be stored in my/their private medical record with strictly controlled access as mandated by the Department of Health and Human Services' "Privacy Rule."

   Name of Patient:_____

   Name of Patient's Guardian:_____ Signature:_____

4. Patient Information Consent:

   I have read and understand Forest Dermatology's Notice of Information Practices. I understand that Forest Dermatology will use and/or disclose my personal health information (PHI) for the purposes of carrying out treatment, obtaining payment, evaluating the quality of services provided and any administrative operations related to treatment, payment. I understand that I have the right to restrict how my PHI is used for treatment, payment, or administrative operations if I notify the practice of my wishes.

   I understand that Forest Dermatology will consider requests for restriction on a case-by-case basis, but is not legally bound to comply with requests for restrictions.

   I understand that Forest Dermatology does not allow the use of PHI for the purposes of marketing, fund-raising, solicitation, or research studies.

   I hereby consent to the use and disclosure of my personal health information for the provision of treatment facilitation of payment, evaluation of service quality, or administrative operations.

5. Patient Information Consent:

   You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or the use of an automatic dialing device, as applicable.

Patient Name: _____ Signature: _____ Date: _____

Forest Dermatology, PA Financial Policy

We have adopted the following financial policy. If you have any questions about this policy, please discuss them in advance of your visit with our front office personnel.

Please be prepared to pay in full charges for your portion of services you receive on the date of your treatment. We accept cash, checks and debit cards as well as MasterCard, Visa and Discover credit cards. If you choose to pay by check, and your check is returned to our office for any reason, the amount of the dishonored check will be added to your existing balance, along with a service charge of $25.00. Payment of these amounts must be made immediately in the form of cash or money order.

We have made prior arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with whom we have an agreement, and will only require you to pay the authorized co-pay and co-insurance at the time of service. Please be aware, however, that if you have a high deductible insurance plan, you may be responsible for more than your co-pay at the time of your visit. As a courtesy to our patients, our office will file your claim with your insurance company, even if we do not participate with your particular insurance plan. For this reason, we will need to see your insurance information at the time of your visit.

Note: Failure of the insurance company to pay does not excuse the patient's responsibility. It is the patient's responsibility to know what is covered by their policy, and what is not covered.

MEDICARE PATIENTS: Our office is required by law to file your Medicare claims for you. We accept assignment for services rendered to Medicare patients. This means that we have agreed to accept Medicare approved amounts as full payment. However, Medicare only pays 80% of the approved amount, leaving a 20% co-insurance to be paid by the patient. A yearly deductible may also be due, if the patient has not met their Medicare deductible at the time of service. We will file secondary insurance claims, if relevant, upon the receipt of Medicare payment.

Medicare will not pay for a list of services they have deemed not medically necessary. For those services, Medicare requires Forest Dermatology to have you sign a waiver acknowledging that you have been informed that Medicare will not pay, and that you will be solely responsible for payment of that service. Payment is expected at the time of service for these non-covered services.

MEDICAID PATIENTS: We do accept Medicaid. It is the patient's responsibility to bring a signed, valid card with you to all visits. If you do not have a valid card with you at each visit we will reschedule your appointment to a time when you can bring it with you. For adults on Medicaid, a $3.00 copay is expected at the time of the visit.

RETIRED FEDERAL EMPLOYEES: We are required to file claims for those patients who are of Medicare age (65 and older) who don't have traditional Medicare coverage.

SURGERY PATIENTS: We will file a claim with your insurance company for surgery. All surgery patients will also receive a separate billing statement from Pathology.

COSMETIC PROCEDURES: With all cosmetic procedures, payment arrangements must be made prior to receiving treatment or products.

MINOR PATIENTS (Under age 18): For all services rendered to minor patients, we will look to the adult accompanying the patient for payment. We are unable to know the financial responsibility of divorced parents. Please notify us of the responsible party at the time of check in. The child's legal guardian must accompany them to their first appointment.

MISSED APPOINTMENTS: Forest Dermatology requests a 24-hour advance notice to cancel or reschedule appointments. Please call us as early as possible if you know you will need to reschedule your appointment. Please note that any patient who misses more than 2 appointments may be charged $25.00.

PLEASE NOTE: Overdue accounts will be sent to our collection agency.

I have read and understand and will abide by Forest Dermatology, PA's Financial Policy:

Print patient name: _____ Date of Birth: _____

Signature of patient, parent, or guardian: _____ Date: _____