

HARRIS DERMATOLOGY

FINANCIAL POLICY

Patient Name _____ Today's Date ____ / ____ / ____

A. RELEASE OF INFORMATION:

I authorize the release of medical information to other physicians or qualified health care professionals and as necessary to insurance companies to process insurance claims, insurance applications and other administrative medical requests. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____

B. OTHER INSURANCE:

- 1. Participating Plans (BC/BS and Aetna):** Patients are responsible for paying an estimated deductible, copayment, coinsurance and any non-covered and/or cosmetic service, at the time of service. Once the insurance company has processed the claim, the patient may still have an outstanding balance requiring immediate payment.
- 2. Non-Participating Insurance Carriers:** Patients who are covered by private and/or commercial plans for which Harris Dermatology health care professionals are not providers will be required to pay an estimated balance at the time of service. You will be provided with a properly coded statement for you to submit to your insurance company for reimbursement. It is recommended to keep a copy for your files. You are responsible for any remaining balance due regardless of your insurance company's reimbursement to you.

Patient or Responsible Party Signature: _____

C. COLLECTION COSTS:

- 1.** I further understand I am fully responsible for providing Harris Dermatology with new insurance information immediately, and realize I may be billed in full for any medical services if I fail to report changes of insurance coverage.
- 2.** I hereby assume responsibility to pay the cost of all services provided by Harris Dermatology; realizing the initial quote and payment is only an estimate of my total costs.

The undersigned agrees to pay charges arising from the medical treatment of the above patient, as well as any and all costs of collection for any charges. This cost includes attorney fees, court costs, collection agency fees and any and all expenses occurred in the collection of any monies due.

Patient or Responsible Party Signature: _____

HARRIS DERMATOLOGY

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I, _____, have reviewed and been given an opportunity to obtain a copy of Harris Dermatology's Notice of Privacy Practices. I understand that copies of the Notice of Privacy Practices are posted at the offices of Harris Dermatology and that I may, at any time, request a copy of the notice.

Signature of Patient/Legal Representative

Date

If you are the legal representative of the patient, please provide the following information:

Your Name: _____

Your Address: _____

Your Phone #: _____

Nature of legal
Relationship: _____

(i.e. parent or legal guardian of patient under the age of 18, legal guardian, have power of attorney for patient, etc.)

CONSENT TO DISCLOSE OR DISCUSS PROTECTED HEALTH INFORMATION WITH OTHERS

Harris Dermatology will maintain the privacy of your Protected Health Information as required by law and by the Notice of Privacy Practices currently in effect. Are there other people besides yourself and in addition to those allowed by law to whom you authorize Harris Dermatology to disclose Protected Health Information or with whom you authorize Harris Dermatology to discuss your Protected Health Information? If so, please provide the following information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Please state any limitations or restrictions on your Consent to Release Protected Health Information to the above-named individuals: _____

Please note that you may modify or revoke this consent in writing at any time unless Harris Dermatology is acting or has acted in reliance on an existing consent from you.

Signature

Date

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

Signature: _____

Date: _____

HARRIS DERMATOLOGY

Medical History

Patient: _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If YES, list: _____

List all Medications with dosage you are currently taking including over the counter medications, vitamins and supplements:

None Not Available See List

LUNGS:

| | YES | NO |
|------------------------------|--------------------------|--------------------------|
| Emphysema | <input type="checkbox"/> | <input type="checkbox"/> |
| Asthma | <input type="checkbox"/> | <input type="checkbox"/> |
| O ₂ Dependent/Use | <input type="checkbox"/> | <input type="checkbox"/> |

VASCULAR:

| | | |
|-------------------------|--------------------------|--------------------------|
| High Blood Pressure | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Attack | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> |
| Irregular Heartbeat | <input type="checkbox"/> | <input type="checkbox"/> |
| Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> |
| Defibrillator | <input type="checkbox"/> | <input type="checkbox"/> |
| Phlebitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Mitral Valve Prolapse | <input type="checkbox"/> | <input type="checkbox"/> |
| Heart Valve Replacement | <input type="checkbox"/> | <input type="checkbox"/> |

Other, Systemic:

| | YES | NO |
|--|--------------------------|--------------------------|
| Diabetes | <input type="checkbox"/> | <input type="checkbox"/> |
| Dialysis (Past or present) | <input type="checkbox"/> | <input type="checkbox"/> |
| Kidney _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Thyroid _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Bladder _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Stomach _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Bowel _____ | <input type="checkbox"/> | <input type="checkbox"/> |
| Hepatitis | <input type="checkbox"/> | <input type="checkbox"/> |
| Glaucoma | <input type="checkbox"/> | <input type="checkbox"/> |
| Arthritis/Joint Deformity | <input type="checkbox"/> | <input type="checkbox"/> |
| Convulsions, Epilepsy, or Seizures | <input type="checkbox"/> | <input type="checkbox"/> |
| Fainting | <input type="checkbox"/> | <input type="checkbox"/> |
| Cold Sores/Fever Blisters/Herpes Simplex Virus | <input type="checkbox"/> | <input type="checkbox"/> |
| If Yes, Frequency _____ | | |

List any other disease or condition we should know about including malignancies/cancer: _____

List surgical procedures you have had in the last 6 months: _____

Have you been told you need to take antibiotics before routine dental cleanings or surgical procedures? Yes No

If yes, what do you take and why? _____

Who is your Primary Care Physician: _____ Pharmacy of Choice: _____

Did a physician refer you to our practice? Yes No If yes, whom? _____

Do you see any specialist? Oncologist Allergist Cardiologist Nephrologist
 Rheumatologist Orthopedic Surgeon Other: _____

Skin: When you are exposed to sun do you: Tan only Tan and burn Burn
 Have you ever had skin cancer? Yes No
 Has anyone in your family had skin cancer? Yes No If YES, Who? _____
 Do you have a history of any specific skin diseases? Yes No
 If yes, please list: _____

Please answer the following questions:

A. Tobacco use: Current Smoker (how much) _____ Former Smoker (when quit) _____ Never Smoker

B. Do you drink alcohol? Yes No If Yes, _____ drinks per day

C. Do you bleed easily? Yes No

D. Do you have artificial joint(s) Yes No If Yes, which joint _____ When _____

E. (Women) Are you pregnant? Yes No

F. (Women) Are you breast feeding? Yes No

G. What is your occupation? _____

H. What are your hobbies? _____

Completed by: Patient
 Caregiver _____
 Medical Assistant Initials

Signed by Physician _____ Date _____

Reviewed by _____ Date _____

HD CL 010 10/14 Chart # _____

HARRIS DERMATOLOGY

Additional Medical History

Patient: _____ Date: _____

Have you had the Flu Vaccine? Yes No If yes, when: _____

Have you had the Pneumonia Vaccine? Yes No If yes, when: _____

Do you have Diabetes? Yes No If yes, when was your last:

Primary Care Physician exam, date _____

Endocrinologist exam, date _____

Podiatrist exam, date _____

Eye exam with dilation, date _____

Men and women (65 years old and older): Have you had a fall or difficulty with walking or balance within the past year?

Yes No

Do you have an Advance Care Plan such as; Living will, DNR orders, Durable Power of Attorney, or health care proxy?

Yes* No *If yes, please provide a copy for our records.

Do you have a surrogate decision maker (someone you would like to have make decisions on your behalf if you do not have decision-making capacity) Yes No If yes, who: _____

If you drink alcohol: How many times in the past year have you had:

Men (64 years old or younger) 5 or more drinks per day? _____ times.

Men (65 years old or older) 4 or more drinks per day? _____ times.

Women (of all ages) 4 or more drinks per day? _____ times.

When was your last:

Men and women (50-75 years old) Colonoscopy, date _____ Never

Men and women (50-75 years old) Sigmoidoscopy, date _____ Never

Women (21-64 year old) Pap smear, date _____ Never

Women (50-74 years old) Mammogram, date _____ Never