Maragh Dermatology

( ) New Patient ( ) Name Change ( ) Address Change

Today's Date _____

Patient Name: Last_____First_____MI____ Male ( ) Female ( )

DOB____/____/_____ Marital Status ( ) Married ( ) Single ( ) Other Spouse_____

Address_____City_____State_____Zip_____

Home Phone_____ Cell** _____

Email_____ Social Security #_____

Emergency Contact:_____Relationship_____Phone_____

Who is your Primary Care Physician?_____Phone_____

Who may we thank for referring you?_____

Complete the following only if patient is a minor

Responsible Party Name_____Relationship_____

Responsible Party Home #_____Work or Cell#_____

****

Insurance Information: Please allow us to photocopy your Insurance Card(s)

Primary Insurance Company Name_____( ) *HMO ( ) *POS ( ) PPO

Policy Holder Name_____DOB_____SS#_____

ID Number_____Group Number_____

Patient relationship to Policy Holder/Insured Party: ( ) Spouse ( ) Child ( ) Other

***Please be aware that when Insurance requires a patient to obtain a written referral to see a specialist it is the patient's responsibility to bring this to the appointment *or* confirm with our office that your Primary Care Physician office has done this for you, prior to your appointment. If you are not sure if a referral is required please contact your Insurance Company.**

Secondary Insurance Company Name_____( ) *HMO ( ) *POS ( ) PPO

Policy Holder Name_____DOB_____

ID Number_____Group Number_____

If you have a secondary or supplemental Insurance we will file for you after your primary has processed the claim. However, in the event that the secondary does not pay within 60 days, patients will be billed the balance due.

*In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

**** Used for Text Message appointment reminders!**

HIPAA Consent & Financial Policy

Patient Name:_____

(*Please Print*)

****

HIPAA: The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. By signing below the patient understands:

* Protected health information may be disclosed or used for treatment, payment or health care operations.

* The patient has the right to review and request a copy before signing. (Please ask our staff if you wish to review or obtain a copy of our Privacy Practices.)

* The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions

* The Practice may condition receipt of treatment upon the execution of this consent

* The Patient may revoke this consent in writing at any time and all future disclosures will then cease.

Release of Information:
Besides myself, I authorize this practice to discuss personal medical information with the following

person(s): _____and/or _____

Messages may be left: (regarding appointments and call back information only) ❒ Yes ❒ No

Messages may be left: (regarding my personal medical information, i.e. test results) ❒ Yes ❒ No

Check all that are authorized: _____ Home Answering machine ____ Email _____Cell _____Work

Insurance and Assignment of Benefits:

I hereby authorize this practice and its providers to apply for benefits on my behalf for covered services rendered. I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier (or in the case of Medicare Part B benefits, to the Social Security Administration and Health Care Financing Administration) A copy of the authorization may be used in place of the original. This authorization may be revoked by either me or my insurance carrier at any time in writing.

I hereby authorize payment of all medical insurance benefits to be paid directly to this practice and/or its providers for services rendered. I understand and agree that I am financially responsible for charges not paid by insurance company. I understand that in certain instances my insurance may decide that medical services are not medically necessary and that payment may be denied for these services. I agree to be personally and fully responsible for payment of any denied charges. **If I have Medicare I understand that I may be asked to sign an advanced notice/waiver for certain services or procedures**.

I hereby certify that the information I have provided is correct**. I hereby certify that I have read, understand and agree with the above HIPAA and Financial policies.** I further agree to pay bank charges for insufficient funds, finance charges and or collection fees assessed to my account for any overdue balances.

Patient Signature _____Date_____

(Or responsible party if patient is a minor)

Patient Name:_____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Artificial joints	End Stage Renal Disease	Lymphoma
Asthma	GERD	Pacemaker
Atrial fibrillation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Bone Marrow Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None
Coronary Artery Disease	Hypothyroidism	

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy (Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy (Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy
Coronary Artery Bypass	Basal Cell Cancer Surgery
PTCA	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	None

Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	None

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

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

Cautions: (please circle all that apply)

Have you ever had difficulty stopping bleeding? Yes No
Do you require antibiotics prior to a surgical procedure? Yes No
Have you had an artificial joint replacement? Yes No
If yes, when and what body locations? _____
Do you have an artificial heart valve? Yes No
Do you have a pacemaker? Yes No
Do you have a defibrillator? Yes No
Are you pregnant or currently trying to get pregnant? Yes No

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Currently Smoke Has smoked in the Past

Drug Use None

Other : _____

Review of Systems: Are you currently experiencing any of the following?
(please check yes or no for the following)

Symptom	Yes	No
Abdominal Pain		
Anxiety		
Bleeding Problems		
Bloody Stool		
Bloody Urine		
Blurry Vision		
Changing Mole		
Chest Pain		
Cough		
Depression		
Fever or Chills		
Headaches		
Hay Fever		
Joint Aches		
Muscle Weakness		
Neck Stiffness		
Night Sweats		
Rash		
Seizures		
Shortness of Breath		
Sore Throat		
Thyroid Problems		
Unintentional Weight Loss		
Wheezing		

Other Symptoms: _____

Preferred Language: _____

Race:

- ☐ Caucasian
- ☐ American Indian or Alaskan Native
- ☐ Asian
- ☐ Black or African-American
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Other Race

Ethnic Group:

- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Unknown

Preferred Pharmacy: _____

_____

_____

_____

OFFICE POLICIES

No-show Policy

If you are unable to keep your scheduled appointment, please notify us at least 24 hours in advance so we can accommodate our other patients. You may also reschedule your appointment at that time. Our no-show policy is as follows: ***a 24-hour notice is required****. You will be charged $50 for the time slot we were not able to fill when you were a no-show.*

Medical Record Policy

Each patient has a complete record of all medical care received at our office.
Your personal medical record provides a history of treatment, medication, and diagnostic information that enables your health care team to make comprehensive medical evaluations. We consider your record to be confidential. Therefore, information will not be released without your written consent, unless required by law. Copies of your medical record will be released to you or transferred to another physician upon written consent. There will be a $25 - $50 copying fee for this service.

Completion of Forms *(Workman's compensation, disability forms, etc.)*

A $25-50 charge will be assessed for the completion of forms outside of an office visit. The charge varies on the length of the form and the time taken to complete.

Collection Policy

In case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect this amount or any future outstanding account balances.

Referral Waiver

Your signature below signifies that you clearly understand that:

- *Our Office will file a claim to your insurance carrier.*
- *Certain plans will not reimburse any money if:*
    1. *The patient request and seeks services from a physician that is not part of the plan or network,*
    2. *The patient request and seeks services from a physician without the proper referral.*

Signature of Patient: _____ Date: _____

FINANCIAL AGREEMENT

Date: _____

I/We hereby agree as follows:

1. **Guaranty of Payment**. Medical care has been / will be provided to the patient whose name appears below. I/We shall be fully responsible for the patients' physician bill, based upon the physician's posted charges, which I/we agree are fair and reasonable. The physician may demand full payment of the patients' bill at any time, but the physician is not required to do this. Even if the physician doesn't demand immediate payment, my/our obligation to make such payment remains the same.
2. **When the patients' insurance coverage is insufficient**. If any insurance coverage which the patient may have such as Anthem Healthkeepers Direct Access, Anthem Healthkeepers POS Bronze/Silver/Gold, Medicare, Medicaid, compensation or other coverage, rejects the patients' claim, or allow only part of the claim, I/we shall be responsible for immediate payment of the balance due, as determined by the physician.
3. **This agreement**. I/we have read and understood this agreement, and have received a copy as well.

_____
Name of Patient

_____
Name of Person Guaranteeing Payment (If different from above)

_____
Signature of person guaranteeing Payment

Witness/Staff _____