PATIENT INFORMATION

Patient Name: _____ DOB: _____
(Last) (First)

Mailing Address: _____
(Street) (City / State) (Zip)

Telephone Number: Cell: _____ Home: _____

E-Mail Address: _____

Employer: _____ Emp. Phone #: _____

SS#: _____

(Circle) Sex : Male / Female Marital Status: Single / Married / Divorced / Widowed

Ethnic Origin: African American / Asian / Hawaiian / Native American / White / Other

RESPONSIBLE PARTY INFORMATION

Name: _____ DOB: _____

SS #: _____ Phone: _____

Mailing Address: _____
(Street) (City) (State) (Zip)

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____ Group #: _____

Insured's Name: _____ Insured's DOB: _____

Secondary Ins: _____ Policy #: _____ Group #: _____

Insured's Name: _____ Insured's DOB: _____

Relationship to Insured: _____

Referring Physician: _____ Primary Care Phy: _____

How did you hear about our clinic? _____

Emergency Contact: _____ Phone: _____

The above information is true to the best of my knowledge. I give consent for treatment at Price Skin Care Clinic and authorize my insurance benefits to be paid directly to the provider(s). I understand I am financially responsible for any portion of payment not covered by my insurance company.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I was provided the opportunity to review the Notice of Privacy Practices of Price Skin Care Clinic on display in the office building.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

AUTHORIZATION FOR TREATMENT: I do hereby grant my authorization and consent for Richard M. Price, M.D. or Taylor D. Kane, NP-C to administer treatment of my skin conditions. I acknowledge that there are risks to any procedure even though they are unlikely. I hereby authorize the above-mentioned providers to to provide treatment, which may require diagnostic procedures that require further pathological testing. I also agree to assume the cost of any care provided by Price Skin Care Clinic.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

FINANCIAL POLICY:

All co-pays, co-insurance and deductible amounts are due at the time of services rendered. Any other amount that your insurance does not cover is due at time of service. I agree to make the most recent insurance card available on the date of service to ensure that the proper insurance is filed.

Patients who are interested in cosmetic procedures need to be aware that **this is *NOT* a service covered by insurance. You are required to pay 100% of the payment on the day of service.** I understand that I am responsible to keep my account up to date. Past due bills will be pursued, including but not limited to, use of outside collections agencies. I understand that I am responsible for all collection fees.

Failure to cancel or reschedule a missed appointment within 24 hours of the appointment date will be assessed a "no show" fee. This will be added to my account.

Patient Signature: _____ **Date:** _____

Witness Signature: _____ **Date:** _____

NON-COVERED SERVICES MEDICAL CONSENT FORM

I understand that some services may not be considered eligible benefits by my health insurance provider(services and/or supplies may be determined to not be medically necessary, non-covered and/or investigational).

I understand that my health insurance coverage has certain restrictions and limitations, such as prior authorization requirements and non-covered services. Examples of these non-covered items include, but are not limited to, report writing, filling out various insurance forms or medical paperwork, and/or cosmetic services and supplies.

I agree to be financially responsible for all related charges if they are not covered by my health insurance company.

Patient Signature: _____ **Date:** _____

Price Skin Care Clinic

HIPAA (Health Insurance Portability and Accountability Act) Release

I, _____ (*Please Print - **Patient's name or specified patient agent(s)***, intend for any agent named in this release to be treated as I would be treated with respect to my rights regarding the use and disclosure of my individually identifiable health information and other medical records. This release authority applies to any information governed by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. 1320d and 45 C.F.R. 160-164.

I authorize the disclosure of any information governed by HIPAA to be provided to the following persons*:* _____

_____

_____

_____ ***(name, address, and relationship, if any, to patient)***

Accordingly, I hereby authorize any physician, health-care professional, dentist, health plan, hospital, clinic, laboratory, pharmacy or other covered health-care provider, any insurance company and the Medical Information Bureau Inc. or other health-care clearinghouse that has provided treatment or services to me, or that has paid for or is seeking payment from me for such services, to give, disclose and release to any agent who is named herein and who is currently serving as such, without restriction, all of my individually identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

This authority given to any named agent shall supersede any prior agreement that I may have made with my health-care providers to restrict access to or disclosure of my individually identifiable health information. The individually identifiable health information and other medical records given, disclosed, or released to any named agent may be subject to redisclosure by a named agent and may no longer be protected by HIPAA. The authority given to any named agent herein has no expiration date and shall expire only in the event that I revoke this HIPAA Release in writing and deliver it to my health-care provider. There are no exceptions to my right to revoke this HIPAA Release.

I understand that it may take up to one month to prepare the medical records that were requested. I further understand that the physician has the right to redact any information that he feels could be harmful for the patient to view. While this is a rare occurrence, there may be an instance where this may be necessary for the wellbeing of the patient.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Patient Name: _____ **Date of Birth:** _____

Medical History: (Circle)

None Anxiety Arthritis Asthma Atrial Fibrillation Bone Marrow Transplant

BPH Breast Cancer Colon Cancer COPD Coronary Artery Disease Depression

Diabetes End Stage Renal Disease GERD Hearing Loss Hepatitis Hypertension

HIV/AIDS High Cholesterol Hyper/Hypothyroidism Leukemia Lung Cancer

Lymphoma Prostate Cancer Radiation Treatment Seizures Stroke

Other: _____

Past Surgeries: (Circle)

None Appendix Bladder Breast- Biopsy/Lumpectomy/Mastectomy/Left/Right/Both

Colectomy- Cancer Resection/Diverticulitis/Inflammatory Bowel Disease, Gallbladder

Kidney- Stone Removal/Transplant/Nephrectomy Liver- Hepatectomy/Transplant/Shunt

Ovaries- Endometriosis/Cancer/Cyst/Tubal Ligation/Hysterectomy

Prostate Biopsy/Removal Joint Replacement: Hip (R, L) Knee (R, L)

Heart: pacemaker/defibrillator, valve replacement, bypass

Other: _____

Skin Conditions: (Circle)

None Acne Actinic Keratosis Basal Cell Skin Cancer Blistering Sunburns Dry Skin

Eczema Flaky/Itchy Scalp Hay Fever/Allergies Melanoma Poison Ivy Psoriasis

Precancerous Moles Squamous Cell Skin Cancer Other: _____

Family History of MELANOMA: (Circle) No / Yes _____

Medications: (List names of Rx only)

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Medication Allergies: (List) _____ _____ _____

_____ _____ _____ _____

Social History: (Circle)

Do you smoke cigarettes: Y / N **Do you drink alcohol:** Y / N **How often?** _____

Single/Married/Divorced/Other

Name of Pharmacy/Location: _____

Have you had the Flu vaccination? Y / N

Have you had the Pneumonia vaccination? Y / N