SOUTH LYON DERMATOLOGY

MEDICAL HISTORY FORM

PATIENT NAME: _____ **TODAY'S DATE**: _____

PRIMARY CARE PHYSICIAN (NAME): _____

LOCATION: _____

PHARMACY NAME: _____

LOCATION: _____

EMERGENCY CONTACT (Name): _____

PHONE NUMBER: _____*RELATIONSHIP TO YOU:* _____

DO YOU HAVE A LIVING WILL? ❑ YES ❑ NO

ALLERGIES (List all known allergens)

_____

_____

DO YOU RECEIVE THE FOLLOWING: Annual Flu Shot? ❑ YES ❑ NO
Pneumonia Vaccine? ❑ YES ❑ NO

MEDICAL HISTORY ~ Select any of the following medical conditions that you currently have.

- ❑ None
- ❑ Anxiety
- ❑ Arthritis
- ❑ Asthma
- ❑ Atrial Fibrillation
- ❑ Bone Marrow Transplant
- ❑ Benign Prostate Hyperplasia
- ❑ Breast Cancer
- ❑ Colon Cancer
- ❑ COPD
- ❑ Coronary Artery Disease (Heart Disease)
- ❑ Depression
- ❑ Diabetes
- ❑ Renal Disease
- ❑ GERD
- ❑ Hearing Loss
- ❑ Hepatitis
- ❑ Hypertension
- ❑ HIV/AIDS
- ❑ High Cholesterol
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Leukemia
- ❑ Lung Cancer
- ❑ Lymphoma
- ❑ Prostate Cancer
- ❑ Radiation Treatment
- ❑ Seizures
- ❑ Stroke
- ❑ Other _____

SURGICAL HISTORY
Select any of the following surgical procedures that you have had.

- ❑ None
- ❑ Appendix (Appendectomy)
- ❑ Bladder (Cystectomy)
- ❑ Breast: Breast Biopsy
- ❑ Breast: Lumpectomy (*Which breast?* _____)
- ❑ Breast: Mastectomy (*Which Breast?* _____)
- ❑ Colon: Colectomy (*Reason?* _____)
- ❑ Colon: Colostomy (*Reason?* _____)
- ❑ Gallbladder (Cholecystectomy)
- ❑ Heart: Valve Replacement/Repair
- ❑ Heart: Coronary Artery Bypass Surgery
- ❑ Heart: Heart Transplant
- ❑ Heart: Pacemaker
- ❑ Joint Replacement (*Which Joint?* _____)
- ❑ Kidney: Kidney Biopsy
- ❑ Kidney: Kidney Stone Removal
- ❑ Liver Removal / Hepatectomy
- ❑ Liver Transplant
- ❑ Liver Shunt
- ❑ Ovaries (*Reason:* _____)
- ❑ Ovaries: Tubal Ligation
- ❑ Pancreas / Pancreatectomy
- ❑ Prostate Biopsy
- ❑ Prostate Removal (*Reason?* _____)
- ❑ Rectum
- ❑ Skin Cancer (*Which type?* _____)
- ❑ Spleen (Splenectomy)
- ❑ Testicles (Orchiectomy)
- ❑ Uterus/Hysterectomy: (*Reason?* _____)
- ❑ Other _____

SKIN HISTORY
Have you had any of the following skin conditions?

- ❑ None
- ❑ Acne
- ❑ Actinic Keratoses
- ❑ Asthma
- ❑ 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 _____

Do you wear Sunscreen? ❑ YES ❑ NO
Do you tan in a tanning salon? ❑ YES ❑ NO

Do you have a family history of Melanoma? ❑ YES ❑ NO If yes, which relative? _____

MEDICATIONS

_____ _____
_____ _____
_____ _____
_____ _____

SOCIAL HISTORY Check all that apply

- ❑ Current Smoker
- ❑ Former Smoke (What year did you quit? _____)
- ❑ Drink Alcohol (# of drinks per day _____)
- ❑ Street drugs/IV drug use

Patient Financial Responsibilities

The following is a statement of our financial policy, which we request you read and sign prior to your treatment. Due to the ongoing changes in healthcare, South Lyon Dermatology may make periodic updates or modifications to our financial policy. In the event there are changes to the financial policy, we will require each patient to have an updated, signed copy in their chart.

1. We ask that you present your insurance card and photo identification at each visit.
2. All co-payments are due at the time of service. If the co-pay is not paid at the time of service, you will be assessed a $25 late fee. Co-payments, co-insurance, and deductibles are a contract responsibility between you and your insurance plan. We are unable to negotiate or reduce these amounts. We accept cash, check, debit and credit cards (Visa, MasterCard, American Express, and Discover.) If you are not able to pay in full at the time of service, payment arrangements must be made prior to seeing the doctor. There will be a $35.00 fee for any check returned to us.
3. Any time you are seen by one of our providers there will be a charge for their services. There are limited exceptions to this rule, such as cosmetic consultations.
4. HMO patients are responsible for obtaining the required referral/note prior to their office visit. Failure to provide a referral/note when necessary may result in your appointment being canceled or rescheduled, or the responsibility for payment in full prior to seeing the physician.
5. Our office will submit claims to your insurance company as a service to you. We will only accept assignment of benefits for insurance plans which we participate with. Please check with your carrier for coverage limitations. It is very important that you understand the provisions of your policy. If you do not provide us with the correct insurance information in a timely manner, you will be responsible for the entire balance. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim.
6. We consider any patient who is uninsured, or who is electing not to utilize their insurance benefits, as self-pay. With our self-pay patients, we still follow insurance guidelines for our billing and coding to ensure we are consistent in our billing practices. Charges for these services must be paid in full at the time of service.
7. Responsibility of payment for services rendered to a child of divorced/separated parents, rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved without including our facility. We will not send duplicate statements.
8. You will receive a statement/explanation of benefits (EOB) from your insurance carrier, as well as from our office, stating your financial responsibility. If the balance remains unpaid after the statement from our office has been issued, you will receive a final notice before your account becomes delinquent. We reserve the right to refer delinquent accounts to a collection agency that reports to credit bureaus. Each account turned over to a collection agency will assess a fee equal to 25% of the unpaid balance on the account.
9. Due to the specialized nature of our practice, we provide some cosmetic services that are not covered by insurance carriers. The staff will review these additional fees and all patients will be required to sign a waiver prior to receiving these additional services. These services must be paid for in full at the time of service.
10. For your safety we have personally selected the Dermatopathologist for the reading of your skin specimens/biopsies. Be advised that laboratory charges are completely separate from our office charges.
11. Any patient that fails to show up for their scheduled appointment or fails to cancel their appointment within 24 hours in advance of their scheduled appointment will have a “No Show Fee” charged to their account. The “No Show Fee” is $35 for medical visits and $75 for cosmetic and surgical appointments. We reserve the right to dismiss you from the practice for non-compliance.
12. Payment on File Policy: Regardless of insurance coverage, all patients are required to have a valid credit card, HSA or e-check on file with South Lyon Dermatology. Credit cards are securely stored in a PCI-compliant payment gateway and card numbers are not visible to staff. South Lyon Dermatology will notify patients via email statement 1 week prior to charging the card on file. By signing this policy, you authorize South Lyon Dermatology to charge the payment on file for balances due. For patients who do not have an email, your balance will be notified by paper statement. Payment on file will be charged 7 days from notification. If your payment method is declined, you will be notified by phone. Declined credit cards may be subject to an office fee.

Your signature below acknowledges that you have read and have a full understanding of South Lyon Dermatology’s Patient Financial Responsibilities.

Signature:_____ Date:_____

Print Patient Name:_____ Patient Date of Birth: _____

SOUTH LYON DERMATOLOGY

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HIPAA Acknowledgement and Consent Form

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **For treatment:** This includes the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another.
- **For payment:** This includes any activities we must undertake in order to get reimbursed for the services provided to our patients, including such things as organizing PHI and submitting bills to insurance companies (either directly or through a third party), management of billed claims for services rendered, medical necessity determinations and reviews, utilization review and collection of outstanding accounts.
- **For health care operations:** This includes quality assurance activities, licensing and training programs to ensure that our personnel meet our standards policies and procedures, obtaining legal and financial services, conducting business planning, processing grievances and complaints, creating reports that do not individually identify you for data collection purposes, fundraising and certain marketing activities.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge a clear understanding of the Privacy Practices. I understand that South Lyon Dermatology has the right to change the terms of this Notice at any time, and the changes will be effective immediately and will apply to PHI that has been maintained by South Lyon Dermatology. Any material changes to the Notice will be promptly posted in the office or on the South Lyon Dermatology' website. I will be given a copy of the latest version of this Notice at my next visit or I can contact South Lyon Dermatology at the address above.

I understand that I may request in writing that South Lyon Dermatology restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. However, if the information is needed to provide emergency treatment, then South Lyon Dermatology may use or disclose my PHI to a healthcare provider to provide me with emergency treatment. I understand that I may restrict the right to disclose my PHI to a health plan for payment if I pay in full for the services and items provided at the time of the visit.

I understand that South Lyon Dermatology will protect my health information in accordance with HIPAA. Having knowledge of the privacy practices, **I willingly give the following persons or organizations the ability to receive my personal health information.**

Name (Person able to receive my information): _____

Phone Number: _____ Relationship to patient: _____

Dates of which the listed above are authorized to receive personal health information: _____

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already taken action relying on this consent.

_____ _____

Patient's Name **DOB (mm/dd/yyyy)**

_____ _____

Signed (Patient or Legal Representative for Patient) **Date**

_____

Legal Representative's Relationship to Patient

PATIENT NAME: _____ BIRTH DATE: _____ PHONE: _____

EMAIL (For Statements & Communication): _____

***** If the patient is a minor, please include all parent/guardian information *****

Parent/Guardian Name: _____
Relationship to Patient: _____
Parent/Guardian Date of Birth: _____
Phone: _____

Parent/Guardian Name: _____
Relationship to Patient: _____
Parent/Guardian Date of Birth: _____
Phone: _____

Electronic Communication Consent

I consent that South Lyon Dermatology can communicate with me via mobile phone, text messages, email, and any kind of online communications, provided that these communications comply with privacy regulations.

Appointment Reminders, Reschedules and Cancellations: I understand that South Lyon Dermatology can reach me any time to remind me of my appointments or let me know of any change about my appointments. I also understand that South Lyon Dermatology can employ and use a third-party automated system to reach out me for the purpose of "confirm", "reschedule" or "cancel".

Telemedicine: I understand telemedicine appointments will be held via electronic environments.

Contact Information Change: I accept that I am responsible of notifying South Lyon Dermatology when my contact information changes.

Consent for Examination and Treatment

I understand that medical treatment may be necessary for the patient by Dr. Angela Clay and her assistants and/or associates. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not Dr. Angela Clay and her assistants and/or associates. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. I hereby release my examiner from all responsibility in connection with the examination.

For patients less than 18 years old, a parent or legal guardian must accompany them to the initial visit, and must sign our parental consent form, giving Dr. Angela Clay and her assistants and/or associates permission for continuing ongoing medical treatment if a parent or legal guardian will not be present. The adult accompanying a minor will be held responsible for the payment of any services that are rendered.

Your signature below acknowledges that you have read and have a full understanding of South Lyon Dermatology's Consent for Examination and Treatment. Your signature consents to the use of mobile, text message, email communications, electronic statements, and payment with South Lyon Dermatology.

Patient Name (Print) _____

Signature:_____ Date:_____