JOHNSON COUNTY DERMATOLOGY

## PATIENT INFORMATION

*Last Name* *First Name* *MI* *Nick Name* *Gender* *DOB* *Age*

*Home Address* *City* *State* *Zip*

*Marital Status* *SSN* *Employer* *Occupation*

*Primary Care Doctor* *Primary Care Phone Number*

*Pharmacy* *Pharmacy Phone Number* *Pharmacy Address (or City and cross streets)*

## CONTACT INFORMATION

Home Phone: _____ Leave voicemail? ☐ YES ☐ NO

Cell Phone: _____ Leave voicemail? ☐ YES ☐ NO

Send text messages? ☐ YES ☐ NO

Email Address: _____

Would you like an invitation to sign up for our **Patient Portal** sent to the above email address? ☐ YES ☐ NO

## SURROGATE DECISION MAKER

Do you have someone that can make medical decisions on your behalf if you are unable to? ☐ YES ☐ NO

IF YES, name of surrogate: _____

IF THE PATIENT IS A MINOR, please provide the responsible party information below.

*Responsible party is the parent or legal guardian who completes and signs this form.*

*Last Name* *First Name* *DOB* *Relationship to patient*

*Home Address* *City* *State* *Zip*

INSURED INFORMATION If name on insurance card is someone *other than the patient*, please provide the following information

*First and Last Name of Insured* *DOB* *Relationship to patient*

*Home Phone* *Cell Phone* *Employer*

*Home Address* *City* *State* *ZIP*

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## PRIVACY NOTIFICATION

I have read and/or been offered a copy of the Notice of Privacy Practices for Johnson County Dermatology, PA. I understand that I may request a copy of the Privacy Notification in the future by contacting Johnson County Dermatology PA at (913) 764-1125 or by writing to 153 W 151st St, Suite 100, Olathe, KS 66061.

Signature Date

## CONSENT FOR RELEASE OF INFORMATION

Who can we speak with about your medical information, care, and/or billing information?

Name: Relationship: Phone:

Name: Relationship: Phone:

*If left blank, we will be unable to speak with anyone other than the patient OR parent/legal guardian of a minor patient.*
** If you need to make changes to the above preferences, please do so in writing.*

## AUTHORIZATION TO RELEASE MEDICAL BENEFITS

I authorize the release of all medical information necessary to process insurance claims and I hereby assign and authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance and other health plans, to Johnson County Dermatology for office visits, procedures or hospital charges.

I understand and agree that I am financially responsible for all charges incurred regardless of potential insurance benefits, including but not limited to Co-Payments, Co-Insurance, Deductibles, Pre-Existing and Non-Covered services. I understand that it is my responsibility to verify with my insurance company the physician treating me is covered under my insurance and to get referral(s) and/or authorization(s) for services prior to the service. Further, I understand that services cosmetic or not-medically necessary are not billable to insurance, and I am responsible for paying for those services. Should I have a cosmetic service in addition to medically necessary services during the same visit, I will pay for the cosmetic services, and medically necessary services will be billed to my insurance.

Signature Date

*The following provided information will only be used for government reporting purposes.

**RACE**
- ☐ White
- ☐ Black/African American
- ☐ Asian
- ☐ American Indian/Alaska Native
- ☐ Decline

**ETHNICITY**
- ☐ Hispanic/Latino
- ☐ Not Hispanic/Latino
- ☐ Decline

**LANGUAGE**
- ☐ English
- ☐ Spanish
- ☐ Indian
- ☐ Russian
- ☐ Decline
- ☐ Other_____

How did you hear about our office? _____

Please list any family members that are patients in our office: _____

## PATIENT HISTORY

*This is confidential medical information.*
*Accurate and complete medical information is needed to help us provide optimal care.*

**Patient's Name: _____ Todays Date: _____**

### TODAY'S VISIT

What is the reason for today's appointment?

_____

**PULL MEDICATION LIST ELECTRONICALLY?** ☐ **YES** ☐ **NO** _____
*SIGNATURE*

**IF NO, LIST CURRENT MEDICATIONS,** including injectables, herbals and over the counters, with dose and frequency

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

### MEDICAL HISTORY

**Have you ever had skin cancer?**

☐ Yes, on record at JCD ☐ No ☐ Unsure
☐ Yes, outside records: _____
*Please list date treated, type and location*

**Have you previously been diagnosed with any chronic skin conditions?**

☐ Psoriasis ☐ Eczema ☐ Other: _____

**Have you ever had the following? (Check all that apply)**

☐ AIDS/HIV
☐ Allergies
☐ Arthritis
☐ Asthma
☐ Bleeding disorder
☐ Cancer, type: _____
☐ Depression
☐ Diabetes
☐ Genetic disease, type: _____
☐ GI/bowel disease, type: _____
☐ Glaucoma
☐ Heart attack/disease
☐ Hepatitis, type: _____
☐ High cholesterol / triglycerides
☐ Hypertension
☐ Lupus
☐ Multiple sclerosis
☐ Organ transplant, type: _____
☐ Psychiatric disease
☐ Radiation, explain: _____
☐ Seizures
☐ Stroke
☐ Thyroid disease
☐ Tuberculosis

**Other chronic or current medical condition(s) not listed** _____

_____

**Do you have any of the following? (Check all that apply)**

☐ Pacemaker or defibrillator ☐ Prosthesis ☐ Artificial heart valve ☐ Joint replacement

Do you require antibiotics prior to surgical or dental procedures? ☐ Yes ☐ No

Are you currently pregnant? ☐ Yes Due: _____ ☐ No Are you planning pregnancy? ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

**Please complete front and back of form in its entirety (or both pages)**

## PATIENT HISTORY

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**Patient's Name**: _____

**ALLERGIES TO MEDICATIONS** (list medication and type of reaction):

_____ _____

_____ _____

**HOSPITILIZATIONS / SURGERIES**

Have you had any surgeries or been hospitalized in the last 12 months? ☐ No ☐ Yes, please list

_____.

_____

**FAMILY HISTORY** (please check all that apply)

| | mom | dad | sibling | child |
|---|---|---|---|---|
| Skin cancer (non-melanoma type) | ☐ | ☐ | ☐ | ☐ |
| Melanoma | ☐ | ☐ | ☐ | ☐ |
| Asthma | ☐ | ☐ | ☐ | ☐ |
| Allergies | ☐ | ☐ | ☐ | ☐ |
| Eczema | ☐ | ☐ | ☐ | ☐ |
| Lupus | ☐ | ☐ | ☐ | ☐ |
| Multiple Sclerosis | ☐ | ☐ | ☐ | ☐ |

**VACCINE HISTORY**

| Have you Received? | Approximate Date Last Received |
|---|---|
| Shingles Vaccine | |
| Influenza (Flu Shot) | |
| Pneumonia | |

**SOCIAL HISTORY**

Do you currently smoke? ☐ Yes ☐ No Do you currently use other tobacco products? ☐ Yes ☐ No

Are you a former tobacco user? ☐ Yes ☐ No

If former tobacco user, what year did you quit? _____

**SUNSCREEN USE**: ☐ Daily ☐ Occasional ☐ Rare or never

**Other sun safe habits (*check all that apply)*** ☐ Hat ☐ UPF rated clothing ☐ umbrellas ☐ other

Have you ever had a blistering sunburn? ☐ Yes ☐ No

Does your job require you to work in the sun? ☐ Yes ☐ No

Have you ever used tanning beds? ☐ No ☐ In the past ☐ Yes, Current frequent ☐ Yes, Current occasionally

**REVIEW OF SYSTEMS**

Please check any of the symptoms you are ***currently*** **experiencing**:

☐ Weight loss (unintentional)
☐ Fever
☐ Fatigue
☐ Nausea/vomiting
☐ Sore throat
☐ Abdominal pain
☐ Swollen lymph nodes
☐ Bleeding problem
☐ Changes in vision
☐ Cough
☐ Shortness of breath
☐ Muscle/Joint pain
☐ Chest pain
☐ Allergy symptoms
☐ Pain urinating
☐ Depression / Anxiety

☐ **PLEASE CHECK HERE IF YOU ARE IN YOUR USUAL STATE OF GOOD HEALTH**

**Please complete front and back of form in its entirety (or both pages)**

PATIENT NAME _____

We would like to thank you for choosing Johnson County Dermatology PA (JCD) as your medical provider. We are committed to providing you with the best possible care and service and would like to make you aware of our office policies. We require that you read and sign this document prior to receiving medical treatment.

## CANCELLATION POLICY & UNSCHEDULED APPOINTMENTS

Each missed appointment or last minute cancellation is a missed opportunity to serve another patient. *If you cannot make it to your appointment, please call our office by noon the preceding business day to cancel your appointment.* Failure to do so will result in a **$25 no-show fee for a routine office visit, $75 for patch testing appointments, $100 if your appointment was for a surgical or cosmetic procedure**. Such fees are not billable to insurance. Please do not call the on-call physician to cancel your appointment. Patients who repeatedly cancel late or no-show may be declined future appointments. If you arrive late for an appointment, you may be asked to see another provider or reschedule your appointment.

As a courtesy to our patients with scheduled appointments and for medicolegal reasons, **we cannot evaluate or treat anyone who does not have an appointment**. Sometimes we can accommodate additional same-day patient appointments, so please inquire at the front desk if interested.

## INSURANCE & SELF-PAY

JCD files both primary and secondary insurance claims as a courtesy to patients. *Current insurance cards and driver's license must be presented at each visit* – you have a responsibility to provide timely and accurate information to our office so a claim can be properly submitted on your behalf. You are financially responsible for all charges incurred regardless of potential insurance benefits, including but not limited to co-payments, co-insurance, deductibles, pre-existing and non-covered services. As the patient, it is your responsibility to verify with your insurance company that the physician treating you is covered under your plan and to obtain specialist referrals and/or authorization for services if required by your plan. JCD will not become involved in disputes between the patient and the insurance company. If your insurance company has not paid a claim on your behalf within 60 days because of information that you have not provided the balance will be transferred to your account and you will be responsible for payment. If your insurance company pays the claim at a later date, your account will be credited and a refund may be issued.

If you do not have insurance (and thus regarded as self-pay) we will be happy to provide care. Charges incurred will be consistent with our usual fee schedule and based on the services provided. We will do our best to estimate anticipated fees exceeding customary office-visit charges on a case-by-case basis.

## DELINQUENT ACCOUNTS

If your delinquent account is turned over to a collection agency by JCD, it will be at management's discretion to accept you back into the practice. If accepted back, the balance must be paid in full to the collection agency before any future treatments or appointments and future payment will be on a cash basis only. There will also be a $25 reinstatement fee applied to your account. The reinstatement fee and the full estimated amount of the upcoming visit are due at the time of service as a guarantee of payment. We will submit your claim to your insurance company and you will be reimbursed once your claim is processed.

## PROCEDURES THAT LACK MEDICAL NECESSITY

The nature of dermatology is such that very often physicians and physician assistants are asked to remove or treat skin lesions for cosmetic rather than medically necessary reasons. The providers at JCD are happy to provide such services if within their scope of practice. However, if medical necessity is not justifiable – whether determined as such by the insurance company or the treating practitioner – *the cost for such procedures is the responsibility of the patient*. Inquire about the expected cost of procedures that may be considered cosmetic in nature prior to treatment. Of specific note, *treatment of skin tags is almost always determined to lack medical necessity* and our charge is $134 for removal of 15 or fewer tags.

## MINORS AND DEPENDENTS

JCD will bill the insurance for both parents (if applicable). The parent who accompanies the child to his or her first appointment will be considered financially responsible for payment, regardless of the subscriber (parent) listed on the child's insurance card. We do not get involved in child custody issues.

JOHNSON COUNTY DERMATOLOGY

**NONCOMPLIANCE**

JCD has the right to discharge any patient from this practice at any time due to noncompliance with office policies. Failure to adhere to treatment plans in a manner that jeopardizes our ability to maintain standards of care may also be considered noncompliance and grounds for discharge. If this occurs, records will be released to a physician of your choice when a signed release of information is received in this office.

**PHONE CALLS**

Questions and requests received during business hours will be answered within 24 hours. Questions and requests made after 4 pm or over the weekend will be returned the following business day, unless in an emergent situation. Patients are encouraged to use the patient portal for communication with our office.

**PHOTOGRAPHY**

In some circumstances, the use of clinical photographs can be helpful in diagnosing or monitoring a skin condition. Clinical images may also enhance communication between clinicians (e.g. surgeons, pathologists) or may be used for the education of medical professionals. In most cases medical photographs will not include features that allow for patient identification. Verbal and/or written consent will be obtained at the time such photographs are requested. Such images may be retained as part of your medical record at the discretion of the physician or physician's assistant.

**PRESCRIPTIONS**

Prescription refill requests should preferentially be submitted to the pharmacy for reasons relating to medication accuracy. Please allow two clinic days for prescription refill requests made Monday – Thursday. Prescription requests received on Fridays or over the weekend may not be filled until the following Monday. Please encourage your pharmacy to submit *electronic* refill requests to minimize the processing time. Prescription refill requests may also be made through the patient portal.

**RETURNED CHECK FEE**

If JCD receives a returned check, you will be charged an additional $30 above the amount on the check and will be on a cash only basis thereafter.

**COMPLETION OF FORMS REQUESTED BY PATIENTS**

Effective January 1, 2014, there will be a charge of $25.00 for the completion of forms on behalf of our patients. Examples include but are not limited to forms relating to disability, FMLA, KSHSAA or similar athletic clearance forms, cancer policies, legal disputes and applications for insurance policies. Payment must be received at time of request.

**TOTAL BODY SKIN EXAMINATIONS**

Full skin examinations (aka skin cancer screening exams, mole checks) require a separate appointment and will be scheduled as such. Accordingly, other new concerns (e.g. acne, rashes, hair loss, nail disorders, etc.) should be introduced at a separate appointment. This is for your benefit so our full attention may be given to your screening examination and is critical to maintain clinic flow (i.e. minimize wait times), particularly if biopsies are required at the time of your exam.

***I have read and understand the policies outlined above and agree to accept responsibility as described.***

_____ Date: _____

Patient Name (Please Print)

_____ Patient date of birth: _____

Signature of Patient or Patient Representative