DERMATOLOGY ASSOCIATES. LLC

Name____ Today's date__________
Last First Middle

Address____
Number, Street, Apartment Number City State Zip

Home Phone__________________________ Cell Phone__________________________

Date of Birth ____________________Sex________ SS#__________________________

Employer's Name ______________________________Employer's Telephone Number__________

Name of Pharmacy you use:______________________________ Pharmacy Phone:__________

Primary Care Physician______________________________________Phone:______________

Who referred you to our office:____

Do we have permission to: Leave a message on your home answering machine: **Y N**
Leave a message for you at work **Y N** Discuss your medical condition with another person **Y N**

If yes, whom___________________________________ Relationship to Patient____________

GUARANTOR (RESPONSIBLE PERSON) INFORMATION

Guarantor Name________________________________Relationship to Patient____________

Address____
Number, Street, Apartment Number City State Zip
Date of Birth:________________________________ Home Phone__________________________

Employer's Name ________________________Employer's Telephone Number______________

EMERGENCY CONTACT

Name: _________________________Phone____________ Relationship to Patient________

INSURANCE INFORMATION

Insurance Company Name:______________________________ Policy #__________________

Address:____

Subscriber's Name: ______________________________Relationship to Patient______________

PLEASE PRESENT INSURANCE CARDS TO THE RECEPTIONIST

Your signature authorizes the doctor to release medical information necessary to process your insurance claims.Payment is expected at the time of services for your portion of the charges. We accept Visa, MasterCard or American Express for your convenience.

____ ____________________
PATIENT, PARENT OR GUARDIAN SIGNATURE Date

MEDICAL HISTORY

Patient Name ______________________________ Today's Date __________

Primary Care Doctor / Other Doctors you see ______________________________

Referring Doctor ______________________________

Are you Pregnamt Y N
Are you trying to become pregnant Y N
Are you nursing Y N

Please list all allergies	Please list all Medications you take

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING:

Mitral Valve Prolapse	Y	N	Rheumatic Fever	Y	N
Do you need antibiotics prior to having dental work?	Y	N	Epilepsy, Seizures, Fainting Spells	Y	N
Heart Murmur	Y	N	High Blood Pressure	Y	N
Pacemaker	Y	N	Heart Attack	Y	N
Heart Disease	Y	N	Abnormal Bleeding/Hemophilia	Y	N
Asthma	Y	N	Skin Allergies	Y	N
Hay Fever	Y	N	HIV/Aids	Y	N
Arthritis	Y	N	Liver Disease	Y	N
Kidney Disease	Y	N	Diabetes	Y	N
Thyroid Disease	Y	N	Glaucoma	Y	N
Drug/Alcohol Dependency	Y	N			
Cancer If yes, what type	Y	N	Specific Skin Diseases If yes, what type?	Y	N
Personal History of Skin Cancer If yes, what type?	Y	N	Family History of Skin Cancer If yes, what type? Which Relative?	Y	N
Do you smoke? Number of packs per day:___	Y	N	Do you drink alcohol? Number of drinks per week: _____	Y	N

1. Date__________Comments______________________________Initials__________

2. Date__________Comments______________________________Initials__________

3. Date__________Comments______________________________Initials__________

CONSENT FOR TREATMENT

I consent to necessary treatment, including drugs, medicine, performance of operations and conduct of studies that may be used by Dr Sullivan, and her nurses or staff.

Signature______________________________

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MEDICARE PATIENTS

Do you or your spouse work in a company that has more than 20 employees and have coverage through insurance at that job? Yes No

Are you covered by any other insurance that makes Medicare secondary? Yes No

I authorize release of information needed to process any claim that is filed. I request payment be made to Dermatology Associates, L.L.C.

I request that payment of authorized Medicare benefits be made either to the or on my behalf to Dermatology Associates, L.L.C. for any services or items furnished to me by the physician. I authorize any holder of medical information about me to release to Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or benefits payable for related services.

Signature______________________________

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature______________________________

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ALL OTHER PATIENTS

I authorize Dermatology Associates, L.L.C. to furnish any medical information requested by insurance companies with whom I have coverage, any public agency which may be assisting in payment of my care, or my employer who is providing payment of my medical bills due to an on the job injury. I request payment to be made to Dermatology Associates, L.L.C. for all claims filed, if any.

Signature______________________________

PATIENT FINANCIAL POLICY

DERMATOLOGY ASSOCIATES LLC

This office has contracts with Medicare, State of Mississippi, and Blue Cross Blue Shield. We also accept Medicare crossover and Medigap carriers as secondary payors to Medicare.

If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible any deductibles, co pays, percentages or non covered services is required at the time of service.

If you do not have one of the above plans, the total cost of your visit is required at the time of service. You will be given all of the necessary paperwork before you leave the office so you can file a claim with your insurance company.

If at any time you are concerned about the cost of a procedure proposed by the doctor, someone in the business office will be happy to discuss the cost with you.

For your convenience, the office accepts, MasterCard, Visa, Discover and American Express, in addition to checks and cash.

I certify that I have read the financial policy of Dermatology Associates, LLC, and agree to abide by the policy.

Signature____ Date_______

PRIVACY NOTICE

The Health Insurance Portability Accountability Act of 1 HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we have prepared an explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. This explanation is described fully in our Notice of Privacy Practices. This Notice is posted in the reception room of the Clinic or you may request a copy from the office by phone or in person.

By signing below, you acknowledge that a Notice of Privacy Practices has been made available to you.

____ __________________

Patient's Signature Date

Do we have permission to leave a message on your answering machine? Yes No