Patient Information

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_\_Sex: \_\_ Male \_\_ Female

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please select preferred daytime phone #: \_\_ Home phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Cell phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Work phone: ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is it okay for us to leave a detailed voicemail? \_\_\_Yes \_\_\_No

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you learn about our office? \_\_ Google \_\_ Flyer \_\_ Radio \_\_ Website

\_\_ Friend \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_ Physician Referral \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Care Physician or Pediatrician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently working: \_\_Yes \_\_No Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_

Preferred Language: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Race:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ethnic Group:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred pharmacy Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City or Zip code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Carrier Information**: Please complete responsible party if you are **not** the policy holder

Primary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Secondary Insurance Carrier: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party: \_\_ Parent \_\_ Spouse \_\_Guardian \_\_Domestic Partner

(Payment policy – The adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.)

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_\_/\_\_\_\_\_\_

Address (if not same as patient address): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact Name and Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you give our office permission to discuss your medical information with family members?

\_\_ Yes \_\_ No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please sign so we may have your insurance authorization on file

I, the patient listed above, authorize and agree to the terms stated in the Consent for Exam and Treatment Policy, provided by Greater Michigan Dermatology. I acknowledge all patient responsibilities and have reviewed these terms. Only services that are considered medically necessary will be billed to my current health insurance. It is my responsibility to keep this informed of any changes to my health insurance coverage, and to obtain a referral for all medical services, if applicable. I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Signature of patient or guardian (if minor): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_\_\_\_

New Patient History and Intake Form

**What brings you in today: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Past Medical History**: (please circle all that apply)

Anxiety

Arthritis

Asthma

Atrial fibrillation

Bone Marrow Transplantation

Breast Cancer

Colon Cancer

COPD

Coronary Artery Disease

Depression

Diabetes

End Stage Renal Disease

GERD

Hearing Loss

Hepatitis

High Blood pressure

HIV/AIDS

High Cholesterol

Thyroid Problems

Leukemia

Lung Cancer

Lymphoma

Prostate Cancer

Radiation Treatment

Seizures

Stroke

NONE

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently pregnant, breast feeding, or trying to get pregnant? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_

Did you receive the flu vaccine this year? Yes \_\_\_\_ No \_\_\_\_

**Past Surgical History**: (please circle all that apply)

Appendix Removed

Mastectomy (Right, Left, Bilateral)

Colectomy

Gallbladder Removed

Coronary Artery Bypass

Mechanical Valve Replacement

Biological Valve Replacement

Heart Transplant

Hysterectomy

Joint Replacement, Knee (Right, Left, Bilateral)

Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years

Kidney Removed (Right, Left)

Kidney Transplant

Ovaries Removed

Prostate Removed: Prostate Cancer

Prostate Biopsy

TURP (Prostate Removal)

Spleen Removed

Tubal ligation

NONE

Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Skin Disease History**: (please circle all that apply)

Acne

Actinic Keratoses

Basal Cell Skin Cancer

Blistering Sunburns

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Melanoma

Precancerous Moles

Psoriasis

Squamous Cell Skin Cancer

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)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**: (Please enter all current medications and dosage)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**: (Please enter all allergies and type of reaction i.e. rash, itching, breathing problem)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History**: (Please circle all that apply)

**Cigarette Smoking:**

Currently Smokes

Has smoked in the past

Never smoked

Former Smoker

**Alcohol Use:**

EtOH- None

EtOH- less than 1 drink per day

EtOH -1-2 drinks per day

EtOH -3 or more drinks per day

IV Drug Use? Yes No

IV Drug Use in the last 12 months? Yes No

How many times a day in the past year have you had 5 or more drinks in a day for men, 4 or more drinks a day for women, or any adult older than 65? \_\_\_\_\_\_\_\_\_\_\_\_

Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**For patients 65 and older:**

Have you received a pneumonia vaccination? Yes No

Do you have a health care proxy in the event you are unable to make your own medical decisions? Yes No

Do you have a living will? Yes No

Which statement(s) best reflects your wishes on advanced care recommendations?

\_\_ Do not intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

\_\_ Do not resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it’s necessary to save my life.

\_\_ Full cardiopulmonary resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

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Do you have any implantable devices? Yes No

If yes, please list: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Review of Systems**: Are you **CURRENTLY** experiencing any of the following?

(Please check yes or no for the following)

|  |  |  |
| --- | --- | --- |
| **Symptom** | **Yes** | **No** |
| **Problems with bleeding** |  |  |
| **Problems with healing** |  |  |
| **Problems with scarring** |  |  |
| **Rash** |  |  |
| **Immunosuppression** |  |  |
| **Fever or chills** |  |  |
| **Night sweats** |  |  |
| **Unintentional weight loss** |  |  |
| **Thyroid problems** |  |  |
| **Blurry vision** |  |  |
| **Joint aches** |  |  |
| **Headaches** |  |  |
| **Seizures** |  |  |
| **Cough** |  |  |
| **Shortness of breath** |  |  |

Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALERTS**: (please circle all that apply)

Allergy to Adhesive

Allergy to lidocaine

Allergy to topical antibiotics

Artificial heart valve

Artificial joint replacement? \_\_\_\_\_\_ When?\_\_\_\_\_\_\_

Blood thinners

Defibrillator

MRSA

Pacemaker

Require antibiotics prior to a surgical procedure

Rapid heart beat with epinephrine

Are you pregnant or currently trying to get pregnant?

West Africa: Travel or Contact?

Ebola Risk?

Family History (Only first degree relatives)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Acknowledgement of Notice of Privacy Practices (HIPAA)

Greater Michigan Dermatology, in an effort to comply with HIPAA, has a Notice of Privacy Practices available to all patients in the reception area with the receptionist.

**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Dr. Kelsey Lawrence, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Greater Michigan Dermatology’s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Greater Michigan Dermatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to: Kelsey Lawrence, MD

849 Health Park Blvd

Grand Blanc, MI 48439

With my consent, Dr. Lawrence, associates and staff, may send a text message, email or may call my home or other designated location and/or leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items or any call pertaining to my clinical care.

With my consent, Dr. Lawrence, associates and staff, may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Dr. Lawrence, associates and staff, may e-mail to my home or other designed location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Lawrence restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Kelsey Lawrence use and disclosure of my Protected Health Information to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dr. Lawrence may decline to provide treatment to me.

I have read the above authorizations, acknowledgements, and policies. I understand them and agree to this as outlined.

Signature of Patient or Guardian \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guardian’s Name (print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_



Patient Financial Responsibilities

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial agreements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines. The following is a state of our financial policy, which we request you read and sign prior to your treatment. Due to ongoing changes in healthcare, Greater Michigan Dermatology (“the office”), 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. I agree to furnish the office with a copy of my current health insurance card(s). I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
2. I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to the office for services provided to me.
3. I understand that co-pays are due at the time of service, as required by my insurance company. Co-payments, co-insurance, and deductibles are a contract responsibility between me and my insurance plan. Unfortunately, the office is unable to negotiate or reduce these amounts. We accept cash, check, debit and credit cards.
4. I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
5. 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 payment will be expected prior to being seen by the physician.
6. I understand that the office will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient). The office will submit claims to my insurance company as a service. My insurance carrier will not be billed unless I provide the necessary documentation.
7. I understand that the office will consider any patient who is uninsured 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.
8. Responsibility for payment for services rendered to the child(ren) of divorced or separated parents rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved without including our facility. The office will not send duplicate statements.
9. I will receive a statement/explanation of benefits (EOB) from my insurance carrier, as well as from the office, outlining my financial responsibility. If the balance remains unpaid after statement(s) from the office, I understand I will receive a final notice before my account becomes delinquent. We reserve the right to defer 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.
10. I understand that my account will be charged $35 when a check I presented for payment is returned and marked “non-sufficient funds” (NSF). Returned checks over $500 will be assessed a fee of 5% of the amount of the check.
11. I understand the office allows 30 days for the processing of my claim by the insurance company. In the event the office does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
12. I will notify an Insurance Specialist at the office if I am aware of a payment delay by my insurance company. It is my understanding that Insurance Specialists at the office will provide me with assistance in resolving the claim.
13. For your safety we have have hand selected the following facilities based on the expertise of their dermatopathologist for the reading of your skin specimens; Pinkus/Aurora Diagnostics. Be advised that any laboratory charges are completely separate from our office charges. For skin cultures our office sends specimens to Ascension Genesys and Quest diagnostics.
14. I understand that if I fail to show up for my appointments without canceling with a call to the office 24 hours in advance; I will be charged a $50 fee.
15. If I plan to pay privately for services, I understand that it is the policy of Greater Michigan Dermatology to collect payment in full at the time of service. If I am unable to make payment in full at the time of service, my appointment will be rescheduled to a more convenient time, or payment arrangements can be established.

Consent for Examination and Treatment

I understand that medical treatment may be necessary for the patient by Dr. Kelsey Lawrence 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 any abnormalities found and treated, lies with me and not Dr. Lawrence and their 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 examined 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 by signing this form, give Dr. Kelsey Lawrence 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.

*I have read, understand, and agree to the insurance assignment and Financial Policies and Consent for Examination and Treatment stated above. I also agree that I have had the opportunity to discuss any questions or concerns regarding the above with the Insurance Specialists or Provider at the office.*

**Your signature below acknowledges that you have read and have a full understanding of Greater Michigan Dermatology’s Patient Financial Responsibilities and Consent for Examination and Treatment.**

Signature of patient or guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

Print Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_

Guardians Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_