RIVERCHASE DERMATOLOGY

Patient Information Form

Please complete both sides of this form in ink and sign where indicated.

Date: ____/____/_____

Patient Name (last, first, middle initial):_____

Date of Birth: ___/___/_____ Social Sec. #:_____ Gender: Male / Female

Race: _____Ethnicity: _____ Language: _____ □ Decline

Mailing Address: Street _____

City_____ State_____ Zip_____

Alternate Address: _____

Home Phone: (____)- _____ Mobile Phone: (____)- _____

Email Address: _____

(We will never give out your email address or send personal medical information via email without your permission)

Please check yes or no to authorize Riverchase Dermatology to contact you via email for appointment reminders, practice updates and informational promotions.

_____ Yes _____ No

Primary Care Physician: _____ Referring Physician: _____

Marital Status (circle one): Single Married Divorced Widowed Separated

Parent, Spouse or Responsible Party (if different from patient)

Patient Name (last, first, middle initial):_____

Date of Birth: ___/___/_____ Social Sec. #:_____ Gender: Male / Female

Mailing Address: Street _____

City_____ State_____ Zip_____

Alternate Address: _____

Home Phone: (____)- _____ Mobile Phone: (____)- _____

Email Address: _____

Insurance Coverage- Primary

Insurance Company Name: _____

Name of Policy Holder (Insured): _____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other: _____

Employer: _____ Employer Address: _____

Insurance Coverage- Secondary (if applicable)

Insurance Company Name: _____

Name of Policy Holder (Insured): _____ Date of Birth: _____

Relationship to Insured: Self Spouse Child Other: _____

Employer: _____ Employer Address: _____

RIVERCHASE
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How did you learn about Riverchase Dermatology?

- □ Newspaper _____
- □ Magazine _____
- □ Physician Referral _____
- □ Family/ Friend _____
- □ Phone Book _____
- □ TV Network _____
- □ Website/ Search Engine _____
- □ Social Media _____
- □ Other _____

Emergency Contact Information

Name of Friend or Relative: _____

Relationship to Patient: _____

Address: _____

_____

Home Phone: _____

Mobile Phone: _____

Release of Information and Assignment of Benefits

I authorize the release of medical information to my primary care or referring Physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the Riverchase Physician/ Provider if applicable.

Responsible Party Signature: _____ **Date:** _____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization

I request that payment for authorized Medicare benefits be made on my behalf to Riverchase Dermatology (RCD) for any services furnished to me by providers of RCD. I authorize RCD to release to the CMS and its agents any information needed to determine these benefits payable for related services.

Medicare is not always the Primary insurance. Federal regulations REQUIRE that we obtain information to determine if another insurer may be primary to Medicare:

Yes	No	
□	□	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job?
□	□	Are you covered by an HMO/PPO which makes Medicare secondary?
□	□	Is this illness/ injury covered by the VA (Veterans Administration)?
□	□	Is this illness/ injury covered by the Federal Black Lung or End Stage Renal Disease Program?
□	□	Is this illness/ injury due to an automobile accident?
□	□	Is this illness/ injury due to work related causes?

Patient Signature: _____ **Date:** _____

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Patient Name: _____ Date: _____ DOB: _____

Past Medical History: (Please circle all that apply)

Anxiety	Depression	Hyperthyroid
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial Fibrillation	GERD	Lymphoma
Bone Marrow Transplant	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV/AIDS	Stroke
COPD	High Cholesterol	
Coronary Artery Disease	Hypothyroid	**NONE**

Other: _____

Past Surgical History: (Please circle all that apply)

Appendix Removed (Appendectomy)	Liver Transplant
Bladder Removal (Cystectomy)	Liver: Shunt
Mastectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Ovarian Cancer
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Cyst
Colon/ Colectomy: Colon Cancer Resection	Ovaries: Tubal Ligation
Colon/ Colectomy: Diverticulitis	Pancreas: Pancreatectomy
Colectomy: IBD	Prostate: Biopsy
Colectomy: Colostomy	Prostate: Cancer
Gallbladder Removed (Cholecystectomy)	Prostate: TURP (Prostate Removal)
Heart: Biological Valve Replacement	Rectum: APR
Heart CABG (Bypass)	Rectum: Low Anterior Resection
Heart: Transplant	Skin: Basal Cell Carcinoma
Heart: Mechanical Valve Replacement	Skin: Melanoma
Heart: PTCA (Angioplasty)	Skin: Skin Biopsy
Joint Replacement, Knee (Right, Left, Bilateral)	Skin: Squamous Cell Carcinoma
Joint Replacement, Hip (Right, Left, Bilateral)	Spleen
Kidney: Biopsy	Testicles Removed (Right, Left, Bilateral)
Kidney: Stone Removal	Uterus: (Hysterectomy) Fibroids
Kidney Transplant	Uterus: (Hysterectomy) Uterine Cancer
Kidney: Nephrectomy (Right, Left)	Uterus: (Hysterectomy) Cervical Cancer
Liver: Hepatectomy	**NONE**

Other: _____

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Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/ Allergies	Squamous Skin Cancer
Blistering Sunburns	Melanoma	**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 list all current medications & dosages)

_____
_____
_____

Allergies: (Please enter all drug allergies)

_____
_____
_____

Social History:

Cigarette Smoking:	**Alcohol Use:**
Never Smoked	None
Currently Smokes	Less than 1 drink per day
Has smoked in the past	1-2 drinks per day
Former Smoker	3 or more drinks per day

Family History: (Significant diseases & illness, skin or otherwise. Only first degree biological relatives- mother, father, brother, sister and children)

CONDITION **RELATIVE**

_____
_____
_____
_____
_____

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Review of Systems: Are you currently experiencing any of the following? (Please check "YES" or "NO")

SYMPTOM	YES	NO	SYMPTOM	YES	NO
Abdominal Pain			**Muscle Weakness**		
Anxiety			**Neck Stiffness**		
Bloody Stool			**Night Sweats**		
Bloody Urine			**Problems with bleeding**		
Blurred Vision			**Problems with healing**		
Chest Pain			**Scarring (Hypertrophic/ Keloids)**		
Depression			**Seizures**		
Fever or Chills			**Shortness of breath**		
Hay Fever			**Thyroid Problems**		
Headaches			**Unintentional weight loss**		
Immunosuppression			**Wheezing**		
Joint Aches			**Other:**		

Alerts: (please check all that apply)

□ Allergy to Adhesive
□ Blood Thinners
□ Defibrillator
□ Hepatitis B
□ Hepatitis C
□ History of Melanoma
□ HIV/ AIDS
□ Iodine Allergy
□ Lactating/ Breastfeeding
□ Latex Allergy
□ Lidocaine Allergy
□ Medication Allergy- PLEASE MAKE SURE ALL ALLERGIES ARE LISTED ON THE PREVIOUS SHEET
□ Pacemaker
□ Polysporin Allergy
□ Pregnant
□ Planning Pregnancy
□ Preoperative Antibiotics

Pharmacy:
Pharmacy Name: _____
Location (crossroads): _____
Phone: _____
Fax: _____
City or Zip Code: _____

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RIVERCHASE DERMATOLOGY FINANCIAL POLICY

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co- payment, co-insurance and/or deductible at the time services are rendered as required by your insurance carrier. You will be billed in full for any services that your health plan deems as "not a benefit" or a "non-covered service".

Secondary/Supplemental Insurance Plans
We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become patient responsibility 30 days after that claim is filed.

Non-Contracted Insurance Plans
If we do not participate with your insurance carrier, payment in full will be required by you at the time services are rendered. Our billing department will file a claim to your insurance company as a courtesy to you upon request.

Medicaid
We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over the age of 18 will be held financially responsible for all charges incurred.

Missed Appointments
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a fee.

Medical Records
Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees
Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department at (239) 313-2517. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees including court costs, attorney fees and collection agency charges.

Returned Check Fee
A $25 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

Pathology Fees
Riverchase Dermatology has an on-site lab and pathologist who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider.

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Riverchase Dermatology providers reserve the right to send their patients' specimens to the most qualified dermatopathologist of his or her choosing. Therefore, **if your insurance requires the use of a specific lab, it is your responsibility to provide us with that information prior to being seen. Failure to do so may result in additional out-of-pocket costs to you. Name of required lab (if applicable) _____**

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures. For more detailed information, please see one of our cosmetic coordinators.

My signature below indicates that I have read, understand and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

_____ _____
(Signature of Patient or Guardian) **Date**

For Office Use Only:
SIGNED COPY TO CHART **Staff Initials_____** **Date _____**

RIVERCHASE DERMATOLOGY
15051 S. TAMIAMI TRAIL, SUITE 203
FORT MYERS, FL 33908

HIPAA Notice of Privacy Practices Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

MAY WE CALL YOUR HOME AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? ☐ YES ☐ NO

MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK? ☐ YES ☐ NO

DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBER & RELATION TO YOU:

Name:_____ Phone:_____ Relation: _____

Name:_____ Phone:_____ Relation: _____

Name:_____ Phone:_____ Relation: _____

By signing this form, I acknowledge that I have received or have been given the opportunity to receive a copy of the Riverchase Dermatology Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

SIGNATURE:_____ **DATE:**_____

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Patient Communication Consent Form

Text Message Account Alerts

As part of the implementation of a new Practice Management system, Riverchase Dermatology and Cosmetic Surgery now have the advantage of communicating appointment reminders via text message with our patients.

I authorize Riverchase Dermatology and Cosmetic Surgery to send text messages appointment reminders to me on my provided cell phone number. I understand that I may reply with various commands to receive account information. By accepting these terms, I agree to receive text messages from the practice. Text charges from your cell phone provider may apply.

My signature below indicates that I represent and warrant that I am the person legally responsible for use of the account, and that I agree to the terms and conditions for the use of the text messaging services. I understand that I may opt out of text message communication at any time.

□ Accept

□ Decline

_____
Mobile Phone Number

_____ _____
Patient Signature Date

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Riverchase Dermatology offers comprehensive services and plans of treatment that may include care from multiple providers (Physicians, Physician Assistants or Nurse Practitioners). Some insurance policies may dictate that an additional copay be collected or higher out of pocket costs than anticipated.
Ultimately it is the policy holder's responsibility to know and understand the terms, guidelines, and limitations of the individual plan they have selected with their chosen Health Insurance Carrier.

Should any questions arise regarding the specific terms of the selected policy you purchased, or any additional fees determined to be "member responsibility," please contact the Member Service line, set in place by your Health Insurance Carrier.

Riverchase Dermatology Pathology Notice

Please note: Additional pathology charges may be incurred in the event specialized testing is required to make a definitive diagnosis. Often this decision is determined by the dermatopathologist at the time of processing the lab specimen. These additional tests or staining procedures are done to ensure the most complete and accurate diagnosis is achieved.

A final bill from our office will not be determined until all pathology results and reports are completed.

_____ _____

Patient Signature Date