DERMATOLOGY of capecod
Affiliate of Northeast Dermatology Associates

Patient Name: _____ **Date of Birth:** _____

Height (19 & younger): _____ **Weight (19 & younger):** _____

PHARMACY: _____

MEDICAL HEALTH

Do you NOW, have you EVER had, or are you CURRENTLY taking medication for:

YES	NO	Heart disease (heart attack, high blood pressure, irregular heartbeat)
YES	NO	Blood disorder (anemia, iron deficiency, etc)
YES	NO	Bleeding disorder (blood clots, DVT, Factor V, etc)
YES	NO	Lung disease (asthma, COPD, bronchitis)
YES	NO	Kidney disease (Please specify)
YES	NO	Liver disease (hepatitis)
YES	NO	Digestive problems (nausea, vomiting, diarrhea, colitis, ulcer, etc.)
YES	NO	Thyroid disease
YES	NO	Diabetes
YES	NO	Lupus
YES	NO	Arthritis (osteo, rheumatoid, or psoriatic)
YES	NO	Internal cancer (please specify)
YES	NO	Immunosuppression (HIV, lymphoma, etc)
YES	NO	STDs (genital warts, syphilis, etc)
YES	NO	Neurological disease (epilepsy, seizures, migraines)
YES	NO	Parkinson's disease
YES	NO	Psychiatric disorder (depression, anxiety, bipolor, ADD, etc)
YES	NO	Dementia (Alzheimer's, senile)
YES	NO	Visual problems (other than far/near sightedness)
YES	NO	Psoriasis
YES	NO	Hives
YES	NO	Eczema
YES	NO	Skin cancer (basal cell, squamous cell, melanoma)

Any other skin problems:

Any other health conditions:

MEDICATIONS

Please list any medications you are currently taking and their dosages (supplements included):

NAME:	DOSE:	FREQUENCY

ALLERGIES

Please list any allergies you may have to MEDICATIONS:

Have you EVER had surgery OR been hospitalized? (please be specific)

Surgery/Hospitalization	Date

Do you wear sunscreen?	**YES**	**NO**
Do you have a pacemaker/defbrillator?	**YES**	**NO**
Do you take any blood thinners (ie. Aspirin, coumadin, xarelto, etc.?	**YES**	**NO**
Have you had a artifical joint replaced in the last 2 years?	**YES**	**NO**
Do you have a artificial heart value?	**YES**	**NO**
Do you have family history of skin cancer (ie. Basal Cell Carcinoma, Squamous Cell Carcinoma, or Melanoma?	**YES**	**NO**

The Practice will not disclose patient information to anyone other than the people listed below.
***** If no names are given, no patient information will be discussed with anyone other than the patient.*****

Name: _____ **Relationship:** _____

Please answer the following questions to the best of your ability.

Please note that the United States Federal Government REQUIRES us to ask these questions!

SOCIAL HISTORY

Do you now or have you ever smoked tobacco? **YES** **NO** **FORMER**

If YES, are you aware of the resources available to help you quit? **YES** **NO**

ADULTS 65 AND OVER:

Do you have a healthcare proxy? **YES** **NO**

If you answered YES, please list your designee's name and phone number below:

Do you have a living will? **YES** **NO**

If you answered YES, please list your designee's name and phone number below:

☐ **DO NOT INTUBATE**

The patient does NOT wish to have a breathing tube, even if it's required for life-saving measures

☐ **DO NOT RESUCITATE**

In the event the patient's heart were to stop, the patient does NOT wish to have chest compressions or any automated external defibrillator to restate the heart, even if it's required for life-saving measures.

☐ **FULL CARDIOPULMONARY RESUCITATION**

The patient wishes to have FULL cardiopulmonary resuscitation to be made.

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Northeast Dermatology Associates [NEDA] may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Northeast Dermatology Associates' **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 this consent. Northeast Dermatology Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Northeast Dermatology Associates' Chief Privacy Officer at [*280 Merrimack St, #311, Lawrence, MA 01843*].

With my consent, Northeast Dermatology Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Northeast Dermatology Associates 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.

CHECK ONE

○ With my consent, I hereby give Northeast Dermatology Associates permission to discuss/ share my PHI pertaining to my treatment and/or diagnosis with _____

[Relationship to patient:_____] Contact Phone # _____

Please initial: _____

○ I choose not to give consent to NEDA to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Northeast Dermatology.

By signing this form, I am consenting to Northeast Dermatology Associates use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Northeast Dermatology's Notice of Privacy Polices.

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, Northeast Dermatology Associates may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Printed Name of Legal Guardian (if applicable)

_____ ____/____/_____ _____

Patient's Name Patient DOB Date Signed

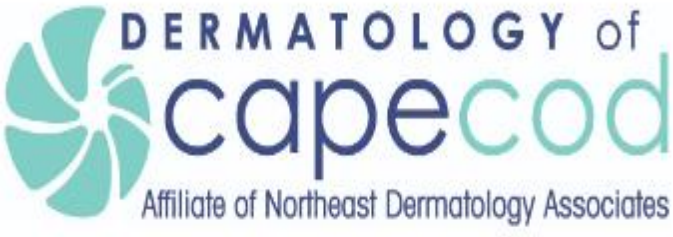
Emergency Contact Information

Emergency Contact Name: _____

Phone Number: _____

Relationship to patient: _____

Today's Date: _____



PATIENT FINANCIAL POLICY

Thank you for choosing us for your health needs. As your physician, we are committed to providing you with the best possible care. Please read our financial policy and, if you have any questions, please ask one of our associates for assistance or call our billing office at (844) 733-1400

You will be asked to show the front office staff your current insurance card at each visit. Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

PATIENTS WITH INSURANCE POLICIES:

For insurance companies that we participate with:

We are pleased to bill your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at time of service. In addition, you will be responsible for any amount the insurance plan deems not covered, up to the entire amount.

If we do not hear from your insurance company

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsbility. We request your assistance in following up with your isnurance company to resolve any non-payment issues.

For insurance companies that we DO NOT participate with:

If your insurance has an out of network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. PhyNet reserve that right to collect any unmet deducitble or coinsurance at the time of service. It is ultimately the patients' responsbility to

Referrals

If your insurance requires that you have a current referral to be seen at Dermatology of Cape Cod, our policy is that you obtain one prior to your visit, otherwise you will be responsbile for the full cost of your visit contract with your insurance company. Signature: _____ Date: _____

SELF PAY PATIENTS

If you do not have sinruance or are seeking care outside of your insurance plan benefits, payment is full is required preior to the service. For your convenience, we accept cash, check, visa, mastercard, discover and american express. A returned check fee $35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card

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COPAYMENTS

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are note prepared today your co-pay, your appointment will be rescheduled.

COINSURANCE

Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example, your may have an 80/20 plan, meeting the insurance will consider and pay on 80% of the charges and the remaining 20% is your responsibility. It is very important to review your coverage to determined your level of coinsurance

NO SHOW FEES

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a $100 fee for an visits missed with Dermatology of Cape Cod

PAST DUE ACCOUNTS

In the event a a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fee associated with collecting the outstanding balance.

We will gladly discuss your proposed treatment and will do our best to answer any questions relative to your insurance. You must realize that: A.) your insurance is a contract between you, your employer, and the insurance company. B.) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As a medical provider, our relationship and concern is with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, **all charges are your responsibility from the date of services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY

Signature: _____ Date: _____

Patient Name: _____ DOB: _____