Dermatology Associates

History and Intake Form

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

Name I prefer to be called:_____

Past Medical History: (please check all that apply)

_____ Anxiety
_____ Arthritis
_____ Asthma
_____ Atrial fibrillation (irregular heartbeat)
_____ BPH
_____ Bone Marrow Transplantation
_____ Breast Cancer
_____ Colon Cancer
_____ COPD
_____ Coronary Artery Disease
_____ Depression
_____ Diabetes
_____ End Stage Renal Disease (Kidney)
_____ GERD
_____ Hearing Loss
_____ Hepatitis
_____ Hypertension (High Blood Pressure)
_____ HIV/AIDS
_____ High Cholesterol
_____ Hyperthyroidism (High)
_____ Hypothyroidism (Low)
_____ Leukemia
_____ Lung Cancer
_____ Lymphoma
_____ Prostate Cancer
_____ Radiation Treatment
_____ Seizures
_____ Stroke

Other_____

Past Surgical History: (please check all that apply)

_____ Heart: Coronary Artery Bypass
_____ Heart: PTCA (Angioplasty/Stent)
_____ Heart: Mechanical Valve Replacement
_____ Heart: Biological Valve Replacement
_____ Joint Replacement, Knee __ Right ___Left
_____ Joint Replacement, Hip ___ Right ___Left
_____ Ovaries Removed –Reason:_____
_____ Transplant Type: _____
_____ Uterine: Hysterectomy -Reason: _____

Other _____

Skin Disease History: (please check all that apply)

_____ Actinic Keratoses
_____ Basal Cell Skin Cancer
_____ Eczema
_____ Hay Fever/ Seasonal Allergies
_____ Melanoma _____ (location/year)
_____ Atypical Moles
_____ Psoriasis
_____ Squamous Cell Skin Cancer

Other _____

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?
_____

Any other family history: _____

PLEASE NOTE: Patients under 18 must be accompanied by a parent or legal guardian.

TURN OVER TO COMPLETE

History and Intake Form

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

MEDICATIONS: Please list any prescription and non-prescription medications including pain relievers you are currently taking. Please include medication name, dosage and frequency. If you are taking more medications than space provides, please continue on a separate sheet of paper.

Medication	Dosage	Frequency	Medication	Dosage	Frequency

Allergies: (Please enter all medications you are allergic to)

_____

_____

Social History: Please check all that apply:

Alcohol Use:
_____None _____less than 1 drink a day _____1-2 drinks per day _____3 or more per day

Smoking:
_____Never smoked _____ Former smoker _____ Current smoker

Please check all that currently apply:

Alerts:
_____ Allergy to adhesive
_____ Allergy to lidocaine
_____ Allergy to topical antibiotic ointments
_____ Artificial heart valve
_____ Artificial joints within the past two years
_____ Blood thinners
_____ Defibrillator
_____ MRSA
_____ Pacemaker
_____ Rapid heartbeat with epinephrine
_____ Do you require antibiotics prior to a surgical procedure?
_____ Are you pregnant or currently trying to get pregnant?
_____ Allergy to Latex
_____ Allergy to Iodine

Review of Systems:
_____ Problems with bleeding
_____ Problems healing
_____ Abnormal scarring
_____ New or changing moles
_____ Swollen glands

Pharmacy Name: _____ **Phone #** (____)_____

Pharmacy Street: _____ **City:** _____

May we obtain a history of prescriptions directly from your pharmacy? Yes No

Signature: _____ **Date:** _____

CENTER FOR SURGICAL DERMATOLOGY
&
CENTER FOR SURGICAL DERMATOLOGY AMBULATORY SURGERY CENTER

Patient Demographics
(Please print)

Patient's Name:_____ Name I Preferred to be Called: _____

Home Address: _____

City: _____ State:_____ Zip:_____

Home Phone: _____ E-mail: _____

Cell Phone: _____ May we send you information via e-mail regarding cosmetic specials? ☐ Yes ☐ No

Work Phone: _____

Date of Birth: _____ Social Security #: _____

Race: ☐ African American ☐ American Indian ☐ Asian ☐Caucasian ☐ Hispanic

Marital Status: ☐ Married ☐ Single ☐ Widow/Widower ☐ Divorced Sex: ☐ Male ☐ Female

Employer: _____ Occupation: _____

Employer Address: _____

City: _____ State: _____ Zip:_____

Spouse's Name if applicable:_____ Date of Birth: _____

Emergency Contact: _____

Phone Number: _____ **Relationship:** _____

How were you referred to our office?

☐ Physician
☐ RSVP Mailer ☐ Ad in Suburban News ☐ Friend ☐ Yellow Pages
☐ Skin Cancer Screening ☐ Family ☐ Self ☐ Other

Primary Care Physician:_____ Referring Physician:_____

Address: _____ Address: _____

City: _____State:_____ Zip: _____ City: _____State: _____ Zip: _____

Phone Number: _____ Phone Number: _____

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

Fiscally Responsible Party Information (If Other Than Patient)

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Home E-mail: _____

Insurance Information

Is a referral required for this appointment? ☐ Yes ☐ No

Primary Insurance: _____

Policy #: _____ Group #: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Parent

If subscriber other than patient, please complete the following information:

Subscriber Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security# _____

Secondary Insurance (If Applicable)

Secondary Insurance: _____

Policy #: _____ Group#: _____

Relationship to Patient: ☐ Self ☐ Spouse ☐ Domestic Partner ☐ Parent

Subscriber Name (if other than patient): _____

Date of Birth: _____ Social Security# _____

I certify that as the patient or responsible party I assign all insurance benefits to the Center for Surgical Dermatology (CSD) and/or Center for Surgical Dermatology Ambulatory Surgery Center (CSD ASC) and its physicians otherwise payable to me. I understand and agree that I am financially responsible for all charges whether or not paid by my insurance. My signature further authorizes CSD/CSD ASC to release information necessary to obtain payment of benefits.

_____

Signature of Patient Date
(or Responsible Party & Relationship to Patient)

CENTER FOR SURGICAL DERMATOLOGY
&
CENTER FOR SURGICAL DERMATOLOGY AMBULATORY SURGERY CENTER
PATIENT PRIVACY INSTRUCTIONS

I hereby acknowledge that I have been provided an opportunity to receive a copy of the Notice of Privacy practices for Center for Surgical Dermatology (CSD) and/or Center for Surgical Dermatology ASC. (CSD ASC).

I have: ❒ received ❒ declined the Privacy Notice and, I understand my rights as a patient with regard to privacy of health care information.

Can CSD/CSD ASC call with results and leave a message on your . . .

Question ?	Yes	No	Write Number if Yes
Home Phone?			
Work Phone?			
Cell Phone?			
Other Phone?			

Is there anyone else we may speak to regarding your medical information by phone or in person? Yes ❒ No ❒

If you answered **Yes**, please print persons' name, relationship to you and phone number.

_____	_____
PRINTED NAME	PRINTED NAME
_____	_____
RELATIONSHIP TO YOU	RELATIONSHIP TO YOU
_____	_____
PHONE NUMBER	PHONE NUMBER

It may be necessary to better treat your disease to review your medical records, path report and pathology slides. Do you authorize CSD/CSD ASC to obtain any necessary medical records, pathology report and slides?
Yes ❒ No ❒

Patient Signature (or Guardian): _____

Printed Patient (or Guardian) Name: _____

Date: _____

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GENERAL DERMATOLOGY BILLING POLICY

Dear Patient:

We are committed to providing you with the best possible care. With health care policy changing so rapidly, we do not have the ability we once did to know if you are approved for your visit. We wish to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our financial policy.

1. Your insurance is a contract between you and the insurance company. We are not a party to that contract.
2. We are contracted with many insurance companies and if you have a question regarding whether or not we are contracted with your plan, please contact your insurance company as they can best answer your questions. In order to be able to file your insurance claims, we must have a copy of your insurance cards as well as a picture I.D. We will submit to your primary and secondary insurances. When there is a change in your insurance plan, coverage or if at any time you receive a new/updated card, please notify us as soon as possible. Without this information, we may be unable to submit your claim to your insurance for payment.
3. Because our doctors are specialists, some insurance companies require a referral from your primary care physician. These can be faxed to us at 614-761-0849. If this is not done by the time of your appointment, you will be asked to either reschedule your appointment and contact your PCP, or pay for the services at the time you are seen. Any payments made at the time of service will be promptly refunded upon receipt of payment by the insurance company.
4. Your visit may generate two or more different bills. Depending on what you need to have done, you may receive statements from the following:
    a. Professional charges for DA has 11 providers including 8 physicians and 3 certified nurse practitioners (CNP**). All of our CNP's are board certified and have subspecialty training in dermatology.
    **CNP billing: Please note that your bill following a visit with a CNP may or may not show the name of that practitioner. More commonly it will show the name of one of our DA physicians, and it may or may not be one you have seen before. Which provider gets listed is determined by your insurance company rules (third-party carrier or Medicare) and not by us. This is often a confusing point so please keep it in mind.
    b. Pathology charges—professional fees from the pathologist for the reading of your biopsy.
    Many insurance policies carry differing levels of coverage for in-network and out-of-network physicians. Again, you must clarify with your insurance that our physicians are a participating provider with your particular plan. It is also your responsibility to contact your insurance company prior to your procedure to clarify your own benefit levels, copays, deductibles, etc. as you are primarily responsible for the charges.
5. Mohs surgery procedures are approved by Medicare and need no prior authorization.
6. We are required by the state of Ohio to explain to patients the method of billing, including charges, for pathology services. If your physician performs a biopsy or excision, your specimen will be sent to a Board Certified Dermatopathologist (skin pathologist) for interpretation whenever possible. The Center for Surgical Dermatology/Dermatology Associates (CSD/DA) maintains contracts with multiple pathology labs to insure the highest quality of patient care and also to accommodate as

- OVER –

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many of our patients' insurance companies as possible. In most cases, preparation of the skin biopsy for the pathologist is done here in the Center for Surgical Dermatology Pathology lab. You are billed for the preparation work from CSD ($90) and billed for the physician's reading from the outside pathology lab. If the skin pathologist requires additional studies on your tissue (special stains, immunochemistries) to help with making your diagnosis, those will appear on their bill whether to your insurance company or you. Occasionally we subcontract the pathology work. The amount CSD is charged for this service ranges from $30.00 - $38.00. When CSD is able to bill your insurance directly or you directly instead of the pathology company doing the billing, we (CSD) can bill it for somewhat less than the approximate $110.00 - $170.00 the pathology company would normally charge for the service. Please note that this policy applies to only some insurances.

7. Certain payments are due at the time when services are rendered including copays, outstanding balances, cosmetic procedures or products. We accept cash, personal checks, Visa, MasterCard, Discover and American Express.
8. If you do not have insurance, please call the billing office as soon as possible. Billing representatives are available Monday-Friday 7:30 am to 4:30 pm at 614-339-1360, to answer any questions related to the above or to set up a payment plan if necessary. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate such problems so that we can assist you in the management of your account.
9. Cancellation Policy: As a courtesy to our other patients, please call at least 24 hours in advance to cancel or reschedule your appointments. We reserve the right to charge $25 for any appointment which is not cancelled with proper notice.

We are pleased to have you as our patient. Your assistance as well as your patience with the above issues is appreciated as this will help make your overall visit with us go very smoothly. If you have <u>any</u> questions, please feel free to contact our office.

I HAVE READ THE ABOVE FINANCIAL ARRANGEMENTS AND INSURANCE STATEMENT AND I REALIZE THAT PAYMENT IS MY OBLIGATION FOR COVERED AND NON-COVERED SERVICES REGARDLESS OF INSURANCE OR THIRD PARTY INVOLVEMENT. I AUTHORIZE THE PHYSICIAN TO FURNISH MY INSURANCE COMPANY WITH ANY INFORMATION REQUIRED AND MY INSURANCE BENEFITS TO BE PAID TO THE PHYSICIAN.

_____ _____

Patient (Guarantor) Signature | Patient Name Printed

_____ _____

Patient DOB | Date

Q:Forms/CSD/GD Patient Billing Info Sheet
Updated 11/2013

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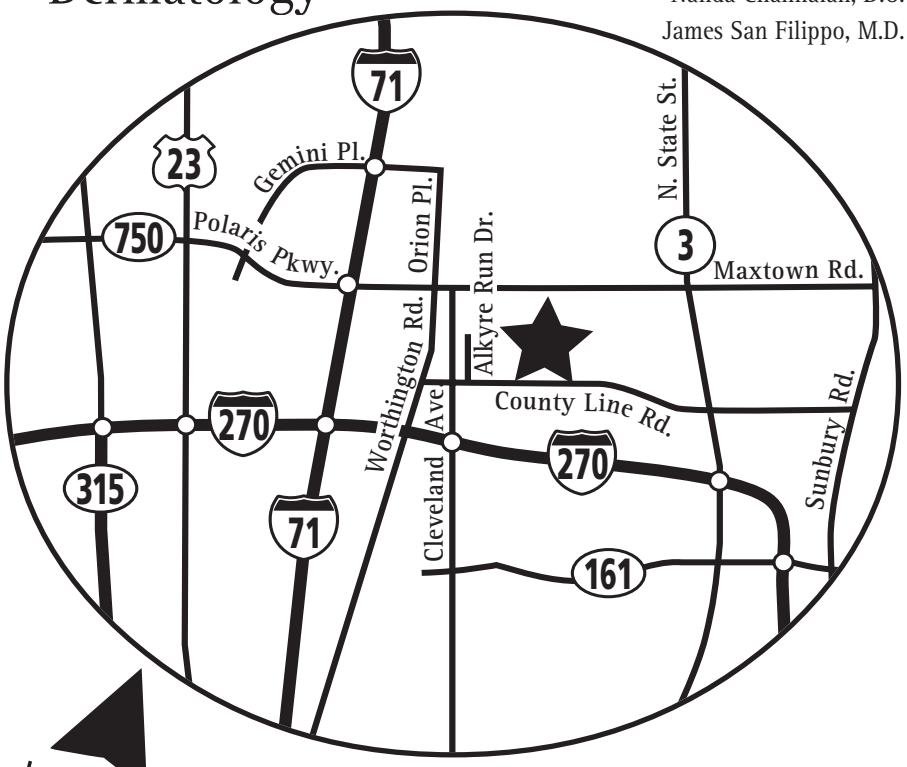
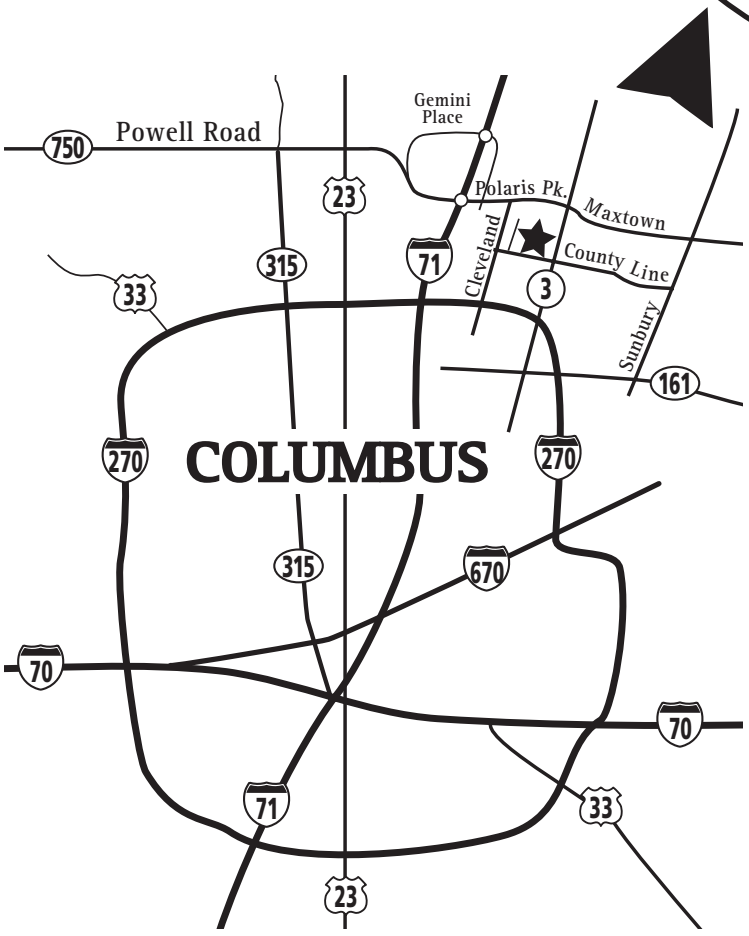
It's easy to find the Center for Surgical Dermatology & Dermatology Associates

428 County Line Road West
Westerville, Ohio 43082-7027
TEL: 614-847-4100 | FAX: 614-430-1601





We are located north and east of the I-71 & I-270 Interchange about 15 miles north of downtown Columbus.

FROM THE NORTH, exit I-71 at Gemini Place/Polaris Parkway and turn left (East) at the light. Cross over the highway and turn right (South) on Orion Place to Polaris Parkway (0.3 miles). Turn left (East) on Polaris Parkway and go one mile to Cleveland Avenue. Turn right (South) on Cleveland Avenue and go 1/2 mile. Turn left (East) on County Line Road West. Immediately turn left on Alkyre Run Drive and turn right into our parking lot.

FROM THE SOUTH, you have two options.

- The most direct would be to exit I-270 at Cleveland Avenue and go North 2 miles. Turn right on County Line Road West and take the immediate first left onto Alkyre Run Drive and turn right into our parking lot.
- A second option is to stay on I-71 north until Polaris Parkway. Turn right (East) on Polaris Parkway to Cleveland Avenue (Just over 1 mile). Turn right and go 1/2 mile south on Cleveland Avenue. Turn left on County Line Road West. Immediately turn left on Alkyre Run Drive and turn right into our parking lot.

If you are coming from the north side of Franklin County or southern Delaware County it may be helpful to know that Powell Road (Route 750) coming from the west is continuous with Polaris Parkway which as you go east is continuous with Maxtown Road.

CALL US IF YOU NEED DIRECTIONS.
614-847-4100

Specializing in Mohs Surgery • Skin Cancer Treatment • Dermatologic and Cosmetic Surgery • Liposuction • Laser Surgery •
• Sclerotherapy • Skin Rejuvenation • Skin Care Products •