VANGUARD DERMATOLOGY

Patient Information

Name _____ Date of Birth: _____

Address _____

City, State and Zip _____

Male · Female ·

Home Tel #: _____ Mobile Tel# _____

E-mail Address _____

Pharmacy Name and Tel # _____

Race _____ Ethnicity _____ Language _____

Emergency Contact _____ Relationship _____

Home #: _____ Mobile # _____ Work # _____

Payment Agreement

Medicare Patients: I request that payment of authorized Medicare benefits be made on my behalf for any services furnished by the physicians and staff of vanguard Dermatology. I authorize any holder of my medical information to release to the Centers of Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services.

All Patients: PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED FOR "YOUR PART" OF THE CHARGES INCURRED. I agree to pay my deductibles, co-payments, and payments at the time services are rendered. We accept cash, checks, and Visa/MasterCard Your signature below indicates that you understand and accept this policy. Furthermore, your signature authorizes your Doctor to release such medical information necessary to process your insurance claims (if any). I herein authorize payment of medical benefits to Vanguard Dermatology when an assigned claim is submitted.

Signature of Patient / Legal Guardian - X _____

Date _____ Patient Relationship to Policy Owner: · Self · Child · Spouse

Acknowledgement of Receipt of Notice of Privacy Practices

I have been presented with a copy of Vanguard Dermatology's Notice of Private Practices (effective July 1, 2005) detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction (if any) concerning the use of my personal information:

X Signature _____ Date _____

VANGUARD DERMATOLOGY

Medical Information

Name: _____

Reason for visit: _____

Started when: _____

Status: **Improving** **Worsening** **About the same**

What makes it better?

What makes it worse?

Symptoms: Circle any below that you are currently experiencing on your skin or due to the reason you have come in.

Itching Pain Dry Skin Oozing/Crusting Sore Bleeding Irritation Redness Swelling Regrowth

Increasing in number Increasing in size Change in color Other: _____

_____

Current Medications: List your medications or provide a written list we can copy – thank you!

Medication Allergies: If Yes, please list:

Medical History: Do you have any chronic syndrome, illness, or disease?

Family history of malignant melanoma: No ☐ Yes ☐ in Father ☐ Mother ☐ Brother ☐ Sister ☐ Grandparent ☐

Surgical History: Malignant melanoma ☐ BCC ☐ SCC ☐ Other ☐ (describe below)

Have you had any procedures on your skin, such as Mohs or excisions? If yes, please list where on the body and what year.

Have you had any procedures on your heart?

Social History: Do you smoke? How many pack(s) per day? Marital status:

Occupation:

VANGUARD DERMATOLOGY

Consent for Treatment / Authorization for Release of Medical Information

I authorize Vanguard Dermatology to treat me and/or provide medical services for me, or for the minor in my care. I authorize Vanguard Dermatology to release information requested by my insurance company or any of its agents.

I also authorize Vanguard Dermatology to furnish my primary care physician, referring physician or other treating medical professional any and all information that may be requested regarding my physical or mental condition, treatment rendered by my physician at Vanguard Dermatology, or any records or results. This authorization shall remain in force until revoked in writing by the undersigned. Signed (Patient or Responsible Party)

X _____ Date_____

_____ Date_____

Consent for Communication of Information

In addition to release of information as authorized above (Authorization for Release of Medical Information), and in the interest of confidentiality and compliance with HIPAA (Health Insurance Portability and Accountability Act), I authorize the release of information as it pertains to my care to the following individuals:

Name _____Relationship _____Tel#_____

Name _____Relationship _____Tel#_____

For the purpose of communicating test results, prescription refill requests, and other information, please provide us with acceptable ways of reaching you: Vanguard Dermatology may leave messages only: (please check all that apply)

- On my home answering machine #_____
- On my cell phone voicemail #_____

I have the right to revoke and change my consent options as listed above. When circumstances change regarding me response, In order to make changes to my communication options, I will submit written changes, revocations, limitations, and restrictions to Vanguard Dermatology, at main office address. Without a written letter that makes changes to the acceptable methods of communicating information, Vanguard Dermatology Doctors nor Staff will not be held liable for leaving messages or test results on the methods of communication listed above.

Signed (Patient or Responsible Party)

X _____ Date_____

Internal use only: If the Patient or Responsible Party refused to sign any of the above acknowledgements, please document the date and time the patient was presented with the above material and sign below: Information presented on (date) _____ Time _____

Staff Name _____ Signature_____

VANGUARD DERMATOLOGY

Informed Consent for Biopsy

Patient_ X _____

I hereby authorize the physicians of Vanguard Dermatology, PC to perform the following procedure on me: **Biopsy**

I recognize that, during the course of the biopsy, unforeseen conditions may necessitate additional or different procedures than those set forth above. I further authorize that the above named doctor or his assistant perform such procedures that are, in his or her professional judgment, necessary and desirable.

I consent to administration of local anesthesia to be given by or under the direction of the above doctor. I am aware of the risks of this procedure include the following:

-bleeding, infection, scarring (including keloid formation) -darkening or lightening of pigmentation which can be temporary or permanent -temporary (rarely permanent) loss of sensation / numbness to the area -pain or discomfort -possible need for additional procedures

I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of the operation of procedure.

After this procedure, I agree to cooperate with the above doctor in my own care until completely discharged.

By signing below, I understand and agree that laboratory and pathology services are covered by Vanguard Dermatology's INSURANCE INFORMATION AND FINANCIAL POLICY and that I am entitled to a copy of this policy upon request.

Patient Signature X _____ Date: _____

Physician's or Medical Assistant's Signature _____

Patient Financial Policy

Thank you for choosing us for your healthcare 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 responsibility. We request your assistance in following up with your insurance 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 reserves the right to collect any unmet deductible or coinsurance at the time of service. It is ultimately the patient's responsibility to verify if we are in your network and what the out-of-pocket costs in using an out-of-network provider will be.

SELF PAY PATIENTS

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required prior to the service. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express. A returned check fee of $35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card.

COPAYMENTS

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are not prepared to pay 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, you may have an 80/20 plan, meaning 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 determine your level of coinsurance.

NO SHOW FEES

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a $50 fee for an office visit, a $100 fee for a missed surgery/ASC appointment and a $75 fee for a cosmetic appointment.

PAST DUE ACCOUNTS

In the event 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 fees associated with collecting the outstanding balance.

DISABILITY AND OTHER SPECIAL FORMS

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time-consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete these forms at the following rates:

- FMLA - $25
- Disability/Physician Attestation - $25
- Miscellaneous Forms - $25
- Medical Records - $35

Payment of the form filing fee is due at the time of request and a medical release form must be signed.

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 your 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 services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature:_____ Date:_____

Patient Name:_____