A & G Dermatology: Patient information and Intake Form

Patient name: _____ DOB: ___/___/____ First visit here? Yes / no

Primary care provider: _____ Pharmacy: [name, street, city]_____

I am here to see: Dr. Berne / Dr. Adams Insurance Carrier:_____

Reason for today's visit ?:_____

Referred by: [which physician, family or friend]:_____

****

Please circle all that apply in each column:

Past Medical History	Past Surgery	Review of Symptoms {are you now or have your recently experienced any of the following?}
Anxiety disorder	Cosmetic [type:_____]	Changed or bleeding skin mole / lesion
Arthritis	Mastectomy [reason:_____]	Rash [chronic or recurring]
Asthma / COPD	Colon [reason:_____]	Fever or chills
Bone marrow transplant	Gallbladder	Diarrhea
Cancer: [type:_____]	Heart [bypass, angioplasty]	Unintentional weight loss
Lupus / Raynauds	Heart [valve]	Night sweats
Coronary artery disease	C-section	Muscle weakness
Depression	Transplant [organ:_____]	Joint aches
Diabetes [insulin??]	Joint replacement [_____]	Neck stiffness
Kidney disease	Kidney removal	Headaches
Gastric reflux [GERD]	Ovaries	Seizures
Seizures	Prostate	Blurry/double vision
HIV /// IMMUNOSUPPRESSED	Skin Cancer:[BCC / SCC / MELANOMA]	Chest pain
Mitral valve prolapse	Appendix	Shortness of breath
Hyperthyroidism	Spleen removal	Cough
PCOD [cystic ovary]	Uterine removal [hysterectomy]	Abdominal pain/nausea/vomiting
Radiation	NO SURGERY IN PAST	Depression

Name:_____

ALERTS: Important info to know about you / please circle any that apply:

- defibrillator /pacemaker
- **artificial joint placed in the last 2 years**
- artificial heart valve
- **abnormal scarring or healing**
- organ transplant recipient
- **immunosuppressed**
- pregnant or planning
- **Antibiotic prophylaxis needed**
- history of passing out
- **allergy to adhesive**
- breast feeding
- **on blood thinners**
- allergy to Lidocaine
- **HIV/AIDS**
- Hepatitis
- **MRSA**

DO YOU SMOKE? circle one

- **yes, daily**
- **yes, but not daily**
- **no, I quit**
- **no, never**

Preferred method of contact:

[circle]

- **Cell**
- **Home**

Phone # : _____

SKIN HISTORY:

circle any that apply

- **Melanoma**
- **Basal cell skin cancer**
- **Squamous skin cancer**
- acne
- AK [pre-cancers]
- blistering sunburns
- eczema
- Pre-cancerous moles
- Use of a tanning bed

Occupation and hobbies:

Occupation : _____

Hobbies?: _____

Racial / ethnic group: [circle]

- White,
- African American or Black
- Asian
- Hispanic or Latino
- other:_____

FAMILY HISTORY OF MELANOMA? [circle]

- **YES : [Who?:_____]**
- **NO**
- **unknown**

MEDICATIONS:

Please list [**NAMES only**] of medications including prescription, supplements and over the counter. No dosages please.

1. _____
2. _____
3. _____
4. _____

If More? please provide staff with a written list

ALLERGIES: [circle]

- **NKDA " I have no known medication allergies"**

or

- "I am allergic to: [reaction : i.e. rash, swelling...]

1. _____ [_____]
2. _____ [_____]
3. _____ [_____]

More ? : please provide staff with written list

Assignment and Release: Though we certainly will assist you in obtaining payment for medical services from your insurance carrier, the ultimate responsibility for payment of any bills incurred at our office lies with the patient. **I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required to process my claim. All HIPAA regulations will be followed.**

Signature: _____ **Date:** _____ / _____ / _____

Patient Name _____ SS# - -
Last Name First Name Middle Initial

Birthdate / / Gender Male Female Marital Status Married Single Other _____

Address _____
City State Zip

Billing Address *(if different from mailing address)* _____
City State Zip

Any other family or friend we have seen as a patient or referred you here? _____

Phone Numbers **IN CASE THE DOCTOR NEEDS TO REACH YOU**

Home ( )	May we call your home?	Yes	No	May we leave a message at home?	Yes No
Work ( )	May we call your work?	Yes	No	May we leave a message at work?	Yes No
Cell ( )	May we call your cell?	Yes	No	May we leave a message on cell?	Yes No

May we leave messages with members of your household? Yes No Who may we leave message with _____
In case of Emergency, who can we contact? _____ Phone Number _____

PERSON RESPONSIBLE FOR PAYMENT OF ACCOUNT
If same as patient, write SAME

_____ SS# - -
Last Name First Name Middle Initial

Address _____
City State Zip

Relationship to Patient _____ Birthdate___/___/_____ Married Single Other_____
Party Employed By: _____ Address _____
City _____ State _____ Zip _____

PLEASE PROVIDE A COPY OF YOUR INSURANCE CARD(S)

Primary Insurance _____ Secondary Insurance _____

A & G Dermatology Financial Policy

Welcome and thank you for choosing A & G Dermatology for your dermatologic care. We are committed to providing you with the highest quality medical care possible in a cost effective manner. Our professional fees have been determined through careful consideration in addition to being reasonable and customary within our geographical area. We are pleased to discuss with you any questions you may have concerning a bill.
Payment in full is due at the time services are rendered. As a courtesy to our patients, we accept cash, personal check, money order, Debit, Visa, MasterCard, Discover, and American Express.

We also provide our patients the ability to pay for their accounts over the phone at local: **(773)237-7546**.
In order to achieve our goal of providing you with the best care possible, we need your assistance and your understanding of our financial policy:

Our Office Hours are:
- Mon and Wed: 10am-5pm
- Tues: 10am-7pm
- Thurs: 10am- 7pm
- Fri: 10am- 3:30pm
- Our answering service is available after hours for emergencies

Things to bring with you to EACH appointment:
- Health Insurance Card(s)
- Drivers License
- Method of Payment

Appointments:
- Please arrive for your appointment 10 minutes early.
- If more than 15 minutes late for your appointment, you will be marked as a *No Show* and will need to reschedule your appointment.
- It is your responsibility to verify that the physician is currently under contract with your insurance plan and that you have obtained all necessary referrals BEFORE your scheduled appointment. (Failure to confirm this may result in your responsibility for any and all charges.)
- Please inform the receptionist of any demographic changes (phone number, address, insurance information, etc.). Failure to notify us immediately of changes in demographic information, financial status and/or insurance coverage may result in you being responsible for any services not covered by your insurance carrier.

Missed or Cancelled Appointments and other fees:
- All co-pays are due at the time of service.
- There will be a fee of $25 for any returned checks to our office.
- All balances are due prior to any further service provided by our office.
- Extended appointments require 48 hour notice of canceling, or $75.00 deposit required to reschedule.

"In Network" vs. "Out Of Network" Insurance

- Your insurance coverage and benefits are a contract between you and your insurance company and therefore all disputes must be handled between you and your insurance company.
- Remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment.
- Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. The extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's record.
- We are contracted with multiple insurers to accept assignment of benefits.
- If you have insurance coverage under a plan with which we do not have a contract, you will be treated as a *self pay* patient.
- We are required to file with your primary insurance carrier only. As a courtesy to our patient, we will file a claim with your secondary insurance.

Payment in full is due at the time services are rendered:

- Co-pays and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are due during the check-in process. Failure to produce payment at check-in may result in your appointment being rescheduled.
- Any amount not covered by the insured/patient's insurance is due within 15 days of the time of service.
- Any outstanding balance may incur a $10 statement late fee in addition to the initial balance.
- As a courtesy to our patients, we gladly accept cash, check, money order, Debit, Visa, MasterCard, Discover, or American Express.
- Failure to pay balances may result in discharge from the practice.

Keeping a credit card on file:

- Please sign our Patient Pay Easy Consent form in order to keep a credit card number on file (the same process you would go through for hotels, rental cars, etc.) to be used for any unpaid balances. (Optional)

Medicare Patients:

- Please make sure you have a full understanding of your benefits and what might be your responsibility if not covered by your insurance plan.
- Medicare requires that we provide patients with a written notification whenever it is likely that you will be responsible for a bill.

Minor Patients:

- The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as the payment in full for services provided.
- Parent(s) or guardian(s) must have an Authorization for Medical Treatment form signed each time a minor arrives unaccompanied for an appointment.
- In compliance with HIPAA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient, parent/guardian unless otherwise documented.
- Both parents/legal guardian(s) are responsible for payment for services rendered to the minor patient. A copy of this financial policy and all statements will be provided to each parent if living in separate residences.

Lab/Hospital Charges:

- Any service(s) provided by a lab or hospital is a contract between you and that lab or hospital. Any dispute with that lab or hospital should be handled with that lab or hospital and is not the responsibility of our practice.
- It is your responsibility to know which procedures your insurance will and will not cover at these facilities and to request an Explanation of Benefits (EOB) from your insurance carrier.

Collections and Outstanding Balances:

- The provider reserves the right to add a $10 statement late fee on any account that has an unpaid balance.
- Any outstanding balance after 60 days of the date of service may be referred to an outside collection agency. If this account is assigned to an attorney for collection and/or suit the prevailing party shall be entitled to reasonable attorney's fee and costs of collection.
- Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from our practice.

Payment Plans:

- Our office will be happy to work with you in order to pay any balance due to our practice.
- Please contact our billing department to work out a payment plan with our practice.
- Please allow 5 mail days prior to each due date for each payment to be received by our practice.
- Please mail all payments to our office: Or over the phone:

1733 N. Harlem Ave (773)237-7546
Chicago, IL 60707

Refunds:

- Refunds are issued to the appropriate party.
- Patient refunds will not be processed until all active or past due charges are paid in full.

Medical Records:

- Your medical records will be held in the strictest confidence. If you request a copy of your records to be sent to another physician or to yourself, a written authorization will be required, a professing fee, and additional costs may apply. Only the records requested will be forwarded.

Cosmetic/Elective Procedure

- By definition, these procedures are not covered by insurance companies; and this office does not submit claims on their behalf. Payment **in full** is required on the day of the scheduled procedure.
- We fully comply with the federal standards regarding privacy and security of your personal health information. (HIPAA)

Signature_____Date_____

A and G Dermatology
Patient Medical Information

Last Name_____First Name_____Middle Initial_____
Reason for Today's Visit_____
Were you referred to us by your doctor?_____
Current Medications_____
Any Known Allergies_____
Current Tobacco Use_____
Current Alcohol Use_____
Are you currently pregnant or nursing?_____
Past Surgical Procedures_____
Do you have any artifical stents/joints/heart valves?_____
Have you had any bad reaction or poor response to anesthesia?_____

(Please Circle Yes or No to the questions below)

Patient Past Medical History			**Family Past Medical History**			**Are you currently experienceing any of the following concerns?**		
Y	N	Skin Disease	Y	N	Skin Disease	Y	N	Fever, chills, weight loss
Y	N	Eczema	Y	N	Eczema	Y	N	Eye Pain or Discharge
Y	N	Skin Cancer	Y	N	Skin Cancer	Y	N	Headaches
Y	N	Melanoma*	Y	N	Melanoma*	Y	N	Light headedness
Y	N	Severe Sunburn	Y	N	Severe Sunburn	Y	N	Nasal Congestion
Y	N	Blood Clots	Y	N	Blood Clots	Y	N	Chest Pain
Y	N	Bleeding Tendency	Y	N	Bleeding Tendency	Y	N	Leg/Ankle Swelling
Y	N	Bruise easy	Y	N	Bruise easy	Y	N	Shortness of Breath
Y	N	Cancer	Y	N	Cancer	Y	N	Nausea
Y	N	Defibrillator/Pacemaker	Y	N	Defibrillator/Pacemaker	Y	N	Constipation
Y	N	Diabetes	Y	N	Diabetes	Y	N	Diarrhea
Y	N	High Blood Pressure	Y	N	High Blood Pressure	Y	N	Irregular Menses
Y	N	Glaucoma	Y	N	Glaucoma	Y	N	Genital sores/Discharge
Y	N	Heart Disease	Y	N	Heart Disease	Y	N	Skin Rash
Y	N	Stroke	Y	N	Stroke	Y	N	Itching
Y	N	Asthma	Y	N	Asthma	Y	N	New Skin Lesions
Y	N	Breathing Problems	Y	N	Breathing Problems	Y	N	Change in existing lesions
Y	N	Ulcers	Y	N	Ulcers	Y	N	Loss of Balance
Y	N	Hepatitis	Y	N	Hepatitis	Y	N	Numbness in fingers/toes
Y	N	Colitis	Y	N	Colitis	Y	N	Joint pain or swelling
Y	N	Liver diease	Y	N	Liver diease	Y	N	Anxiety/ Confusion
Y	N	Epilepsy/seizures	Y	N	Epilepsy/seizures	Y	N	Frequent Illness/Infection
Y	N	Cataracts	Y	N	Cataracts	Y	N	Other_____
Y	N	Organ Transplant	Y	N	Organ Transplant			
Y	N	Lupus	Y	N	Lupus			
Y	N	Fainting Spells	Y	N	Fainting Spells			

Pharmacy Name_____ Pharmacy Address_____
Pharmacy Phone #_____ City State Zip

ASSIGNMENT AND RELEASE

Though we certainly will assist you in obtaining payment from your insurance carrier, the ultimate responsibility for payment of any bills incurred at our office lies with the patient.

I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for any balance due. I authorize the doctor or Insurance company to release any information required to process my claim.

Signature:_____Date_____/_____/_____