Patient Intake Form

Personal Information:

First Name: _____ Last Name: _____ Middle Initial: _____

Date of Birth: _____ Gender: _____ Social Security _____

Address:

_____

City: _____ State: _____ Zip Code_____

Email address: _____

Home Phone: _____ Mobile Phone: _____

Emergency Contact Name: _____ Phone # _____

Pharmacy:

Local Pharmacy Name: _____ Local Pharmacy Phone # _____

City: _____ Zip Code: _____

Specialty Pharmacy Name: _____ Specialty Pharmacy Phone # _____

City: _____ Zip Code: _____

Mail Order Pharmacy Name: _____ Mail Order Pharmacy Phone # _____

City: _____ Zip Code: _____

Insurance Name:

Primary Insurance Carrier: _____ Policy Holder's Name: _____

Policy Number: _____ Group Number: _____

Specialty Pharmacy Name: _____ Specialty Pharmacy Phone # _____

Insurance Phone #: _____

Derrington Dermatology

Patient Intake Form

Medical History:

Primary Care Physician: _____ Phone Number: _____

List any allergies (medications, food, latex, etc.):

_____

Current Medications (Include dosage):

_____

_____

Tobacco History: _____

Past Medical History:

_____

_____

Past Dermatological History (conditions, treatments, surgeries):

_____

_____

Family History of Skin Conditions (if applicable):

_____

_____

Skin Concerns:

Reason for Visit (briefly describe your skin concern or condition):

_____

Additional Information:
Have you had any recent exposure to new chemicals, plants, or environmental factors? _____ Y _____N
Do you use sunscreen regularly? _____ Y _____N
Do you tan or use tanning beds? _____ Y _____N
Are you currently pregnant or breastfeeding? _____ Y _____N

Authorization and Consent: I authorize Derrington Dermatology to release any information required to process insurance claims and request payment of benefits. I understand that I am responsible for any charges not covered by insurance.

Signature: _____ **Date:** _____

Derrington Dermatology

Patient Financial Policy

Insurance Coverage:

1. We accept most major insurance plans. It is your responsibility to provide accurate insurance information at each visit.
2. Co-payments and deductibles are due at the time of service. This may include any estimated portion of charges not covered by your insurance plan.
3. If we are not contracted with your insurance plan, full payment is expected at the time of service.

Self-Pay Patients:

1. For patients without insurance coverage or with services not covered by insurance, full payment is due at the time of service unless other arrangements have been made in advance.
2. We offer discounted rates for self-pay patients who qualify based on income guidelines. Please inquire at the front desk for more information.

Billing and Payments:

1. You will receive a statement for any balance remaining after your insurance has paid its portion. Payment is due upon receipt of the statement.
2. We accept cash, checks, and major credit cards for payments.
3. If you are unable to pay your balance in full, please contact our billing office to discuss payment plan options.

Missed Appointments:

1. We require at least 24 hour notice for appointment cancellations. A fee of $100 may be charged for missed appointments without sufficient notice.

Financial Responsibility:

1. You are financially responsible for all charges incurred for services rendered at our office, regardless of your insurance coverage.
2. It is your responsibility to understand your insurance benefits, including any co-payments, deductibles, or non-covered services.

Collections:

1. Unpaid balances over 90 days may be subject to collection efforts. You will be responsible for any fees associated with the collection of unpaid balances.

Agreement: By signing below or by accepting treatment at Derrington Dermatology, you acknowledge that you have read, understood, and agree to abide by our financial policies.

Signature: _____ **Date:** _____

Derrington Dermatology

Credit Card Payment Policy

It is Our Policy to keep a method of payment on file, whether it be your debit or credit card, to be used for the portion of services that your insurance does not cover, but for which you are financially responsible. You will receive a courtesy call informing you of any outstanding balance and pending charge to your card.

Please choose an option below:

Credit/Debit Card used at today's visit:

Last four digits of card_____ **Zip Code**_____ **CVV**_____

OR

Amex ____ Visa ____ MasterCard ____ Discover ____

Card number:_____

Expiration Date:_____ CVV_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

I, _____, authorize and request Derrington Dermatology to charge my credit card, indicated above, for balanced due for services rendered that my insurance company identifies as my financial responsibility.

Patient Name (PRINT)_____

Patient/Guarantor Signature_____

Derrington Dermatology

Appointment Policy

Please review and initial below:

This Appointment Policy will be **strictly enforced.**

_____You **must confirm** your appointment at least **48 hours prior** or **it will be given to someone on the waitlist.**

***** **We have a 3 month wait for visits.** Please be courteous to others by responding to the appointment reminders that are sent **by email 5 days before, by phone 3 days before or by text 2 days before.**

_____ **NO SHOW and SAME DAY cancellations will be charged $100.**

Derrington Dermatology

HIPAA Notice of Privacy Practices

Introduction: Derrington Dermatology is dedicated to protecting your medical information. We are required by law to maintain the privacy of your health information, to follow the terms of this Notice, and to provide you with this Notice of our legal duties and privacy practices with respect to your health information.

Uses and Disclosures of Protected Health Information (PHI): We may use and disclose your PHI for treatment, payment, and healthcare operations. For example:

- **Treatment:** We may use your health information to provide you with medical treatment or services.
- **Payment:** We may use and disclose your health information to obtain payment for services provided to you.
- **Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations, such as quality assessment and improvement activities.

Authorization Requirements: Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke this authorization at any time, except to the extent that we have already relied upon it.

Patient Rights: You have the following rights regarding your health information:

- **Right to Inspect and Copy:** You have the right to inspect and obtain a copy of your PHI.
- **Right to Amend:** You have the right to request an amendment of your PHI if you believe it is incorrect or incomplete.
- **Right to Request Restrictions:** You have the right to request restrictions on certain uses and disclosures of your PHI.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Paper Copy:** You have the right to obtain a paper copy of this Notice upon request.

Breach Notification: We will notify you if there is a breach of your unsecured PHI.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. To file a complaint with us, contact [Contact Information].

Changes to this Notice: We reserve the right to change this Notice and to make the revised or changed Notice effective for medical information we already have about you as well as any information we receive in the future. The current Notice will be posted in our office and on our website.

Contact Information: If you have any questions about this Notice or would like further information concerning your privacy rights, please contact Diana Cornman at 843-459-8400.

By signing below or by accepting treatment at Derrington Dermatology, you acknowledge that you have received and understand our Notice of Privacy Practices.

Signature: _____ **Date:** _____

Derrington Dermatology