

LEXINGTON DERMATOLOGY & LASER CENTER, PSC

448 Lewis Hargett Circle, Suite 240
Lexington, KY 40503
859-226-0206

PATIENT INFORMATION					
NAME (Last First Middle)		SSN#	BIRTH DATE	AGE	SEX
ADDRESS			CITY, STATE, ZIP		
HOME PHONE	WORK PHONE	ALTERNATE PHONE (CELL)	PREFERRED PHONE: <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> AII/Cell		
MARITAL STATUS (Circle One) MARRIED SINGLE WIDOWED DIVORCED SEPARATED					
Who may we discuss your health information with? <input type="checkbox"/> NO ONE OTHER THAN SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> PARENT <input type="checkbox"/> VOICEMAIL (Cell/Home) <input type="checkbox"/> OTHER (Name): _____					
May we leave detailed personal health information on your contact phone number voice mail? This information may include pathology results, lab results, appointments, etc. HOME PHONE: <input type="checkbox"/> Yes <input type="checkbox"/> No ALT/CELL PHONE: <input type="checkbox"/> Yes <input type="checkbox"/> No BUSINESS PHONE: <input type="checkbox"/> Yes <input type="checkbox"/> No Can we notify you of specials and events via email? <input type="checkbox"/> Yes <input type="checkbox"/> No EMAIL ADDRESS: _____ PHARMACY OF CHOICE: _____ How did you hear about our practice? <input type="checkbox"/> PHYSICIAN <input type="checkbox"/> FRIEND <input type="checkbox"/> OTHER: _____					
PRIMARY EMPLOYER		ADDRESS	CITY, STATE, ZIP		
EMERGENCY CONTACT NAME			EMERGENCY CONTACT PHONE NUMBER		
REFERRING PHYSICIAN		PRIMARY CARE PHYSICIAN			
RESPONSIBLE PARTY INFORMATION (for minor patients)					
NAME (Last First Middle)		SSN#	BIRTH DATE	AGE	SEX
ADDRESS			CITY, STATE, ZIP		
HOME PHONE	DAY PHONE	MARITAL STATUS	RELATIONSHIP TO PATIENT		
INSURANCE INFORMATION					
Primary Insurance		NAME OF INSURANCE COMPANY	ID#	GROUP#	
EFFECTIVE DATE	NAME OF INSURED (POLICYHOLDER)		RELATIONSHIP TO PATIENT		
Secondary Insurance		NAME OF INSURANCE COMPANY	ID#	GROUP#	
EFFECTIVE DATE	NAME OF INSURED (POLICYHOLDER)		RELATIONSHIP TO PATIENT		
MEDICARE PATIENTS ONLY (required by Medicare Program)					
• ARE YOU OR YOUR SPOUSE COVERED BY ANY EMPLOYER GROUP HEALTH BENEFIT PLAN?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• ARE YOU OR YOUR SPOUSE WORKING FOR AN EMPLOYER WITH MORE THAN 20 EMPLOYEES?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• DO YOU RECEIVE BLACK LUNG BENEFITS?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• DO YOU RECEIVE WORKERS COMP BENEFITS?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
• ARE YOU BEING SEEN FOR AN INJURY OR ILLNESS FOR WHICH AN OTHER PARTY COULD BE HELD LIABLE OR IS COVERED UNDER AUTOMOBILE NO FAULT INSURANCE?			<input type="checkbox"/> Yes	<input type="checkbox"/> No	

I hereby give my permission to Lexington Dermatology & Laser Center, PSC for the evaluation and treatment of the presented dermatological condition.
 I hereby authorize the above physician(s) to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.
 I hereby authorize the physician(s) indicated above to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.
 I have read the financial and privacy policy statements for Lexington Dermatology & Laser Center, PSC on the reverse of this page and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

Patient or Responsible Party

Date

Lexington Dermatology & Laser Center, PSC

Financial Policy

Thank you for allowing Lexington Dermatology & Laser Center, PSC to be your healthcare provider. We are committed to providing you with the best possible care. We wish to avoid any misunderstandings about our billing and payment procedures, so we ask you to please review this policy. If you have any questions, please do not hesitate to speak to our office staff. We may also direct your questions to our billing consultants, MD/BS.

Insurance: We will be happy to process your insurance claims if you have an insurance that we participate with. We must emphasize that our relationship is with you and not your insurance company. All charges are your responsibility at the time of service (this excludes any amount due from your insurance company that we have agreed to accept payment from). Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by their insurance. *Initials* _____

Demographic Information & Insurance Cards: It is extremely important that we have updated demographic information as well as a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to "timely filing" requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for "timely filing" by your insurance and those claims would become your financial responsibility. *Initials* _____

Network Providers: It is your responsibility to know if your physician is considered "in-network" by your insurance. Please call your insurance to verify and contact our Business Office, if there are any questions regarding network eligibility. *Initials* _____

Co-Pays, Co-Insurances, Deductibles, HSA, HRA & Flexible Spending Accounts: I understand that any co-payments, deductibles and co-insurances are due from me at the time of service. This also applies to HSA, HRA and Flexible Spending Accounts. We will collect up front an estimated allowable for the services provided. Failure to produce payment at check-in may result in your appointment being rescheduled. I understand that I am responsible for any balance not covered by my insurance. *Initials* _____

Surgical Services: Co-insurance, co-pays and deductibles are due on the day that surgical services are rendered. Our office will contact your insurance company to determine the amount due and will contact you prior to your procedure to discuss this obligation. *Initials:* _____

Cosmetic Services and Product purchases: Payments for cosmetic services are due in full at the time of the service. We do require a \$75.00 deposit for some cosmetic services that is due at the time of scheduling your appointment. You must provide our office with 2 business days' notice to cancel a cosmetic procedure, or you may forfeit the amount of your deposit. The purchase of laser packages and skin care products are non-refundable. If you develop a reaction to a product you may return the product within 10 days and receive a credit for the full amount which may be applied to any other cosmetic procedure or service. *Initials* _____

Annual Skin Cancer Exams: Please note that annual skin cancer exams will be subject to your deductible and/or copay. "Preventive visit" codes are most often not recognized by insurance companies for dermatology visits. *Initials* _____

Laboratory Services: Some services, such as biopsies or surgery, require specimens be sent to a laboratory for processing. The patient may receive a separate bill from the laboratory. I understand that I am responsible for payment for all laboratory services not covered by insurance. *Initials* _____

Missed Appointment Fees: Lexington Dermatology and Laser Center, PSC will charge a \$50.00 fee for missed office visits, surgical and laser appointments when the patient fails to give appropriate notification. A cancellation notice must be received 24 business hours in advance of a scheduled office visit appointment and a cancellation notice of 48 business hours in advance is required for a scheduled surgical or laser appointment. I understand that I will be charged a \$50 cancellation fee if I do not give proper notice. *Initials* _____

Returned Check Policy: I understand that I will be charged a \$25.00 fee for any check returned by my bank for non-sufficient funds. *Initials* _____

Disability/FMLA/Other Forms/Medical Records: Lexington Dermatology and Laser Center, PSC will charge a \$25.00 fee per form which is due in advance. Should you need a copy of your medical records, a signed authorization is required. You will be provided your first copy at no charge after that you will be charged \$25.00 for the first 50 pages, and \$.10 per page for each additional page, plus any postage charges. *Initials* _____

Minor Patients: The parent or guardian accompanying a minor are responsible for providing current insurance information for the minor as well as the payment at the time of service. The parent or guardian must sign an Authorization for Medical Treatment Form anytime a minor arrives unaccompanied for an appointment. Without this completed form, we are unable to see a minor not accompanied by a parent or guardian. *Initials* _____

Payment: As a courtesy to our patients, we gladly accept cash, check, money order, visa, mastercard, discover, or care credit. Any outstanding balances more than 90 days past due will be sent to a professional collection agency and may result in dismissal from the practice. If your account is assigned to the collection agency you will be responsible for any and all fees associated with the collection effort of the account, to include reasonable attorney fees, court costs, collection charges and interest. In the event that my account is not resolved, I understand that my account may be turned over to a collection agency and I may be dismissed from the practice as a patient. *Initials* _____

I have read the above financial policy, and I understand my financial obligations in exchange for medical care provided by Lexington Dermatology and Laser Center, PSC.

Print Name

Signature

Date

HIPAA PATIENT CONSENT FORMS

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:

Printed Name – Patient or Representative

Signature

____/____/____
Date

Relationship to Patient
(if other than patient):

Witness:

Printed Name – Practice Representative

Signature

____/____/____
Date

Dermatology Medical History

Patient: _____ **Date of Birth:** ___/___/___ **Today's Date:** ___/___/___

Reason for Today's Visit:

Occupation:

Hobbies:

Medications: Include over the counter medications/supplements

Medication Allergies:

Alcohol Use:

None

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

Cigarette Smoking:

Never Smoke

Quit: Former Smoker

Smokes less than daily

Smokes daily

Any History of Drug Abuse or Dependency: YES NO

Past Medical History:

NONE (or circle all that apply)

Arthritis	Asthma	Irregular Heartbeat	Bone Marrow Transplant
Breast Cancer	Colon Cancer	COPD	Coronary Artery Disease (Heart Attack)
Depression	Diabetes	End Stage Renal Cancer	Acid Reflux
Hearing Loss	Hepatitis	Hypertension	High Cholesterol
Hyperthyroidism	Hypothyroidism	Lung Cancer	Prostate Cancer
Seizures	Stroke	Dementia	Ulcerative Colitis Crohn's disease
Lupus	Blood Clots	Any other cancer-please list	

Surgical History:

Heart Surgery Skin Cancer Surgery Other Surgery-please list

Joint Replacement Other Cancer Surgery

Patient: _____ **Date of Birth:** ___/___/___ **Today's Date:** ___/___/___

Skin Disease History: None (or circle all that apply)

Basal Cell Carcinoma

Squamous Cell Carcinoma

Melanoma

Acne

Actinic Keratosis ("pre cancer")

Asthma

Blistering Sunburns

Dry Skin

Eczema

Flaking or Itchy Scalp

Hay Fever/Allergies

Abnormal Moles (that needed further treatment)

Psoriasis

Do you have a family history of Melanoma? YES NO

 If Yes, which relative(s) _____

Do you have a family history of other skin cancers? YES NO

 If yes, which relative(s) _____

Alerts: Do you have any of the following:

Allergy to Lidocaine	YES	NO
Allergy to Epinephrine	YES	NO
Allergy to Latex	YES	NO
Allergy to adhesive	YES	NO
Allergy to topical antibiotic ointments	YES	NO
Pacemaker	YES	NO
Defibrillator	YES	NO
Currently taking blood thinners or aspirin	YES	NO
Need antibiotics prior to dental procedures	YES	NO
Artificial Heart Valve	YES	NO
Artificial Joint	YES	NO
History of HIV/AIDS	YES	NO
Hepatitis B or C	YES	NO
Active Tb	YES	NO
Convulsions, Epilepsy, Seizures or Fainting	YES	NO
Fever Blisters	YES	NO
Keloids	YES	NO
(Females) Pregnant or Planning Pregnancy	YES	NO
(Females) Nursing Mother	YES	NO