# Anders Dermatology Inc.

**Today's Date**_____

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

**Email address**_____ **Height** _____ **Weight** _____**lbs**

**Past Medical History**: *(please circle all that apply)*

| | | |
|---|---|---|
| Anxiety | Diabetes | Lung Cancer |
| Arthritis | End Stage Renal Disease | Lymphoma |
| Asthma | GERD | Mitral Valve |
| Atrial fibrillation | Hearing Loss | Prostate Cancer |
| Bone Marrow Transplantation | Heart Failure | Radiation Treatment |
| BPH | Hepatitis | Seizures |
| Breast Cancer | High Blood pressure | Stroke |
| Colon Cancer | HIV/AIDS | Tuberculosis |
| COPD | High Cholesterol | Irritable Bowel |
| Coronary Artery Disease | Thyroid Problems (Hyper or Hypo) | |
| Depression | Leukemia | |

Other _____

**Past Surgical History**: *(please list all)*

_____

_____

_____

Do you have a Pacemaker Y N , Defibrillator Y N , Artificial Joint Y N , Year _____, Where_____

**Skin Disease History**: *(please circle all that apply)*

| | | |
|---|---|---|
| Acne | Dry Skin | Poison Ivy |
| Actinic Keratoses | Hay Fever/Allergies | Rosacea |
| Basal Cell Skin Cancer | Melanoma | Squamous Cell Skin Cancer |
| Blistering Sunburns | Chicken Pox | Warts |
| Eczema | Psoriasis | NONE |
| Flaking or Itchy Scalp | Precancerous Moles | |

Other _____

Are you pregnant? Y N Are you breastfeeding ? Y N
Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

**Family History** (List relationship)- Melanoma_____ Skin Cancer_____

Rosacea _____Psoriasis _____ Eczema _____ Diabetes _____

Allergies _____ Heart DZ _____ High B/P _____ Stroke _____ TB_____

**Medications**: Name Dosage Frequency
*(Please enter all current medications, the dosage and frequency or provide a list of all medications)*

_____

_____

_____

_____

**Allergies**: *(Please enter all allergies and the side effect from them)* Are you allergic to Latex? Y N

_____

_____

_____

**Social History**: *(Please circle all that apply)*

**Cigarette Smoking/Tobacco Use:**
Never
Quit: Former Smoker/User
Smokes/Uses Tobacco Less Than Daily
Smokes/Uses Tobacco Daily

**Alcohol:**
None
Less than 1 drink a day
1-2 drinks per day
3 or more drinks per day

How often do you exercise? _____

What is your caffeine use? _____

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65? (please circle)

0 1 2 3 4 5

Have you received the Covid vaccination? Y N

Have you received a pneumonia vaccination? Y N

Have you received a flu vaccination? Y N

Do you have a living will? Y N Proxy /Designee's name _____ Phone number_____

**Pharmacy Name:**_____ **Mail Order Pharmacy Name** _____

Street:_____ Zip code:_____

**Primary Care Provider:** _____

**Referring Physician Address:** _____

(Please Print)

# ANDERS DERMATOLOGY, INC.

(Please Print)

PATIENT NAME: _____
(LAST) (FIRST) (M.I)

ADDRESS: _____
(STREET) (APARTMENT #) (CITY) (STATE) ( ZIP CODE)

STATUS: ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED PHONE: ( ____ ) _____

BIRTHDATE: _____ AGE: _____ SEX: _____ *OK to Leave a Message?* ☐ *YES* ☐ *NO*

SOCIAL SECURITY #: _____ CELL PHONE: ( ____ ) _____

E-MAIL: _____ RACE: _____ ETHNICITY: _____

EMPLOYER: _____ OCCUPATION: _____

PHONE: ( ____ ) _____ ADDRESS: _____

## PARENT / GUARDIAN / RESPONSIBLE PARTY

NAME: _____
(LAST) (FIRST) (M.I) (RELATIONSHIP TO PATIENT)

ADDRESS: _____
(STREET) (CITY) (STATE) (ZIP CODE)

SOCIAL SECURITY #: _____ HOME PHONE: _____

WORK PHONE: _____ EMPLOYER: _____

EMPLOYER'S ADDRESS: _____

## INSURANCE

**(IN ORDER FOR US TO FILE YOUR INSURANCE, PLEASE BE SURE TO COMPLETE THE FOLLOWING AND PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST.)**

PRIMARY INSURANCE TO FILE: _____

NAME OF INSURANCE POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER ADDRESS: _____ PHONE: _____

POLICY # _____ GROUP # _____ S. S. # _____

DATE OF BIRTH: _____ EMPLOYER: _____ PHONE: _____

SECONDARY INSURANCE TO FILE: _____

NAME OF INSURANCE POLICY HOLDER: _____ RELATIONSHIP TO PATIENT: _____

POLICY HOLDER ADDRESS: _____ PHONE: _____

POLICY # _____ GROUP # _____ S. S. # _____

DATE OF BIRTH: _____ EMPLOYER: _____ PHONE: _____

ASSIGNMENT OF BENEFITS/AUTHORIZATION FOR TREATMENT: I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf, or to myself.
**I understand that I am financially responsible for all charges not covered by my insurance.**

SIGNATURE: _____ **DATE:** _____

**(OVER)**

**ANDERS DERMATOLOGY, INC.**

**PATIENT CONSENT FORM**

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 reserves 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

**This Consent was signed by**:_____

Printed Name-Patient or Representative/ Relationship

_____ ___/___/___

Signature Date

Anders Dermatology, Incorporated
4126 N. Holland Sylvania Rd., Suite 200
Toledo OH 43623

# AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name_____ Date of Birth _____

I hereby authorize the use and disclosure of individually identifiable health information relating to me as described below from Anders Dermatology, Incorporated:

Results from any laboratory testing (skin and/or blood), medications prescribed, diagnosis of my skin disease and/or treatment thereof, insurance response/payment, account balance due, appointment scheduled with us or with another Medical Provider.

Person(s) receiving my authorized information include:

Name _____ Their relationship to me_____

Name _____ Their relationship to me _____

I understand that I have the right to cancel this authorization at any time by notifying Anders Dermatology, Incorporated in writing. If I choose to do so, my cancellation will not affect any actions taken by Anders Dermatology Incorporated before receiving my cancellation notification. I understand that the cancellation will not apply to my insurance company when the law gives my insurer the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I do not need to sign this form to obtain treatment unless the sole purpose for the treatment is the disclosure of information for which this authorization is necessary. I understand that I may inspect or copy the information to be used or disclosed, as provided by the federal government's rules, which are in the United States Code of Federal Regulations at section 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**This authorization will expire one year from date signed.**

**Patient Signature** _____
**Or Legal Representative / Relationship to Patient**

**Address:** _____

**Phone:** _____

**Date Signed:** _____

# ANDERS DERMATOLOGY INC. FINANCIAL POLICY

The following Financial Policy will become effective for our patients, immediately:

## PLEASE BRING ALL OF YOUR INSURANCE CARDS WITH YOU; IF YOU DO NOT HAVE THEM YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED IN THE OFFICE.

1. We accept assignment and participate in most insurance plans. If your insurance is not a plan we participate in, payment in full is expected at each visit. Knowing your insurance benefits is **your responsibility.** Please contact your insurance carrier with any questions you may have regarding your coverage to receive the maximum benefit.

2. All copayment amounts are due and payable at the time of service, in accordance with the legal requirements for collecting patient responsibility amounts. If you do not have your copay you may incur an additional fee of $10.00 for billing cost.

3. All patients must complete our patient information form, which will be entered into our computer to maintain accurate information for proper billing. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. **IF YOU FAIL TO PROVIDE US WITH THE CORRECT INSURANCE INFORMATION, OR YOUR INSURANCE CHANGES AND YOU FAIL TO NOTIFY US IN A TIMELY MANNER, YOU MAY BE RESPONSIBLE FOR THE BALANCE OF A CLAIM. MOST INSURANCE COMPANIES HAVE TIME FILING RESTSRICTIONS; IF A CLAIM IS NOT RECEIVED WITHIN THE TIME FILING LIMIT BECAUSE OF WRONG INSURANCE GIVEN, IT CAN BE RENDERED INELIGIBLE FOR PAYMENT AND YOU WILL BE RESPONSIBLE FOR THE BALANCE THAT REMAINS.**

4. It is the patient's ultimate responsibility to obtain a current referral if required by the Insurance Company prior to the appointment. We suggest you do this at least two weeks prior to your appointment. If you do not have a current referral, we will reschedule your appointment so you may obtain one. If it is necessary for the patient to obtain lab work (i.e., blood, or urine) then it is the patient's responsibility to patronize the correct contracting Lab with whom their insurance participates.

5. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request.

   For those patients who are eligible for Medicare, we are "Participation Physicians". We will accept assignment on all services covered by Medicare. This means we will accept the approved amount as our payment in full, writing off Medicare's non-approved portion of our charges to you. Medicare will send a check to our office for 80% of the approved amount minus any deductible and or copays for which you are responsible. If you have supplemental insurance coverage that will cover the portion of the approved amount Medicare does not pay, please make certain we have a copy of your insurance card (front and back).

   Although we will accept assignment for Medicare patients, the patient by law, is responsible for any portion of the approved amount not covered by Medicare or a secondary insurance carrier.

6. The responsibility for payment for services rendered to any dependent children whose parents are divorced rest with the parent who seeks treatment. Any court ordered responsibility judgement must be determined between the individuals involved without the inclusion of our office.

7. Patients with no insurance coverage are asked to pay as services are rendered unless financial arrangements are made in advance.

8. **Twenty- four (24) Hours advance notice is required for a Cancelled Appointment. Failure to give adequate notice or to appear for your appointment may result in a fee of $40.00 for an established patient and $70.00 for a New Patient. Failure to comply with this policy can result in the dismissal of the patient from this practice.**

We have been and will always be sensitive to our patients' needs. It is our hope that the above financial policy will allow us to provide quality care to our valued patients. If you have any questions, need clarification of any of the above policies, or if a problem regarding your account should arise, please do not hesitate to contact our office.

**I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.**

_____ _____

**Patient Signature (or responsible party, if minor)** **Date**

_____ _____

**Please print name of patient** **D.O.B.**