Boulevard Dermatology

Patient Demographics

New Patient____ Name Change____ Address Change____ Insurance Policy/Holder Change____

Name: _____ SS#_____-_____-_____ Sex: M_____F_____
First Last
Address: _____ Marital Status: S___M___D___W___
Street City/State Zip
Birth Date: _____/_____/_____ Age:_____ Email: _____ Occupation:_____

Work Phone#: _____ Home #: _____ Cell#: _____
Preferred Method of Contact:_____

Ethnicity: Hispanic/ Latino _____ Not Hispanic/Not Latino _____ Unknown _____ Declined to Specify _____
Race: American Indian or Alaskan Native _____ Asian _____ Black or African American _____
Native Hawaiian or Pacific Islander _____ White _____ Other Race _____ Declined to Specify _____

Primary Insurance: _____ Policy Number: _____
Policy Holder Name (if not the patient): _____ Birth Date: _____/_____/_____
Address: _____ SS#: _____-_____-_____
Street City/State Zip
Secondary Insurance: _____ Policy Number: _____
Policy Holder Name (if not the patient): _____ Birth Date: _____/_____/_____
Address: _____ SS#: _____-_____-_____

Primary MD/DO: _____ Phone #: _____

Address: _____
Street City/State Zip

Pharmacy: _____ Phone #: _____
Street, City/State, Zip

Please list anyone, other than yourself, you would allow us to disclose any medical information **if needed:**
Name: _____ Relation: _____ Phone #: _____
Name: _____ Relation: _____ Phone #: _____

Please list your emergency contact person/s
Name: _____ Relation: _____ Phone#: _____

Patient Signature: _____ Date: _____/_____/_____

Printed Name: _____

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Financial Policy

We appreciate the opportunity to serve you, and want to thank you for choosing our clinic for your Dermatology services. We are committed to your treatment success and strive for providing you excellence in service. Prior to receiving any services, we do require you to read and sign the following statement regarding our Financial Policy:

Forms of Payment We accept Cash, Check, Visa, MasterCard, Discover, AMEX and CareCredit.

Patient Responsible Balances Due at the Time of Service Co-pays that are required by your insurance policy are due at the time of service. If you have no insurance and are self-pay, or if having an elective non-covered service, your balance in full is required at time of service. If you or any of your family members have an outstanding balance, we may ask for payment of this balance at this time.

Insurance Billing As a courtesy to our patients, we bill most major insurance carriers directly. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. You are responsible for understanding how your insurance works. If your insurance denies a claim due to inaccurate or incomplete information you have provided to either us or them, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. We will ordinarily help you as best as possible to get proper and timely payment from your insurance. If you have a deductible, and your insurance applies any visit you have with us to that deductible, it is your responsibility to pay the full amount your insurance has deemed your financially responsible for. If you have a deductible that has not been met and require surgery, payment is due in full at time of your appointment unless you have made other arrangements with us.

Minor Patients A parent or legal guardian must accompany minors at EVERY visit, this person becomes the responsible party. Unaccompanied minors will have to reschedule to a date a parent can attend. If parents are separated or divorced, accurate parent and insurance information is required at the time of service, and only with written consent can any parent become the responsible party. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances.

Missed Appointment Fees If you miss, cancel or reschedule an appointment within less than 24 hours of the appointment time, there may be a $35 fee assessed to your account, depending on the circumstances and previous appointment history. Missed surgery appointment: We need 48-hour notice to change a surgery appointment or a fee of $100 will be assessed.

Cosmetic Cancelation Fees We require 24 hours' notice for the cancelation of any cosmetic procedure, failure to comply will result in the charge of a $100 fee.

Returned Check Fees If your check is returned by the bank due to insufficient funds in your account, there will be a $36 fee assessed to your account and you will no longer be able to pay via check.

Account Balances Please pay your bill promptly or call us at your earliest convenience if you have any questions about your balances due. Our general policy is that balances due be paid within 30 days. Outstanding balances not paid within 90 days may be turned over to a collection agency, resulting in further finance charges and reporting to national credit bureaus, such as TransUnion, Experian and Equifax. Please contact us immediately if special financial circumstances arise, as we may be able to arrange a payment plan.

Telephone Consumer Protection Act (TCPA)
You agree, in order for us to service your account or to collect monies you may owe, **BOULEVARD DERMATOLOGY**, and/or our agents may contact you by telephone or any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre recorded/artificial voice messages and/or use of automatic dialing device, as applicable.

Medicare Health Insurance Form I request that payment of authorized Medicare benefits be made either to me or my behalf to Boulevard Dermatology for any services furnished to me by Boulevard Dermatology. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Thank you for taking the time to read and understanding our Financial Policy. Please let us know if you have any questions or concerns.

I/we have read this disclosure and agree that **BOULEVARD DERMATOLOGY**, its employees and/or agents may contact me/us as described above.

My signature below indicates that I have read, understand and agree to the terms of this Financial Policy:

_____ _____

Signature of Patient or Responsible Party **Date**

_____

Printed Name

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Informed Consent

Consent for Treatment: By signing this form, I authorize Boulevard Dermatology's practitioners and staff to evaluate and treat me to include but not limited to: biopsies; excisions to include Mohs surgery, shave excisions and removals; Electrodessication and Curettage (ED&C); liquid nitrogen cryosurgery; intralesional injections; intramuscular injections; Superficial Radiotherapy (SRT); and Photodynamic Therapy (PDT). All procedures will be fully explained to me prior to treatment and as with any treatment plan, I understand it is my responsibility to follow the recommended treatment plan and that there are potential risks involved. The most common risks are, but are not limited to: scarring (any procedure can produce a permanent scar); infection; bleeding; reaction to anesthesia; pain; nerve injury resulting in no sensation or movement in the surrounding area; blood vessel injury which could cause localized death of skin and tissue; allergic reactions; and/or potentially life threatening reactions to surgical procedures

How we may use and disclose Protected Health Information (PHI): With my consent, Boulevard Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Boulevard Dermatology Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Boulevard Dermatology. With my consent, Boulevard Dermatology may call my home or other designated locations and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any calls pertaining to my clinical care including laboratory among others. With my consent, Boulevard Dermatology may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent, Boulevard Dermatology may e-mail my home or other designated locations any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statement. I have the right to request that Boulevard Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Boulevard Dermatology use and disclosure in reliance upon my prior consent. If I do not sign this consent, Boulevard Dermatology may decline to provide treatment to me.

- **Treatment**: We may use and disclose PHI for your treatment and to provide you with treatment related health care services. We may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care
- **Payment**: We may use and disclose PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received.
- **Health Care Operations**: We may use or disclose your PHI in order to support the business activities of your physician's practice. The activities include, but are not limited to: quality assessment activities; employee review activities; training of medical students, licensing, and conducting or arranging for other business activities
- **Appointment Reminders, Treatment Alternatives and Health Related Benefits and Services**: We may use and disclose PHI such as your name, email address, physical address or phone number to contact you to remind you that you have an appointment with us. We may mail out reminders of upcoming appointments. I understand that these reminders will be in a postcard format which will allow anyone who sees that postcard to know that I have a dermatology appointment with no further detail. We also may use and disclose PHI (name, email, address, phone number) to tell you about treatment alternatives or health related benefits and services that may be of interest to you
- **Individuals Involved in Your Care or Payment for Your Care**: When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a legal representative and/or guardian.
- **Research**: Under certain circumstances, we may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another for the same condition.
-**Taking of Photographs**: I consent to the taking of a series of photographs along with pertinent information pertaining to these pictures for my practitioner's use for: documenting your medical records; educational lecturing; or submittal to appropriate sources for research purposes.
-Consent to Contact via Email: I acknowledge Boulevard Dermatology will contact me via unencrypted email with the email address I listed for the following reasons: appointments; for access to the Patient Portal to view my Medical Records; for insurance/financial matters; to give information about products and services (which you can opt-out of anytime).

With your signature, you verify that you have read, understand, and agree to comply with the above consents and policies. If you do not sign agreeing to these consents and policies, Boulevard Dermatology may decline providing you medical treatment.

Signature:(Patient) _____Date:_____
Signature:(Parent/Guardian/Caretaker)_____

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HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy.

Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services.

HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care.

Additional information is available from the U.S. Department of Health and Human Services.www.hhs.gov

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate or your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions on the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

Patient or Legal Guardian Signature: _____ Date: _____

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Consent to Obtain Patient Medication History

Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also, over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

Patient/Legal Guardian Name: _____

Signature of Patient or Legal Guardian: _____

Date: _____

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Name _____ **Height** _____ **Weight** _____

Visit Reason:

_____

_____

Past Medical History:

__ Anxiety	__Colon Cancer	__Hearing Loss	__Leukemia
__ Arthritis	__COPD	__Hepatitis	__Lung Cancer
__Asthma	__Coronary Artery Disease	__Hypertension	__Lymphoma
__Atrial Fibrillation	__Depression	__HIV/AIDS	__Prostate Cancer
__Bone Marrow Transplant	__Diabetes	__Hypercholesterolemia	__Radiation Treatment
__Benign Prostatic Hyperplasia	__End Stage Renal Disease	__Hyperthroidism	__Seizures
__Breast Cancer	__GERD	__Hypothyroidism	__Stroke

Other:_____

_____

Past Surgical History:

_____

_____

Have you had your Flu Vaccine this year? _____ **Have you had your pneumonia booster?** _____

Skin Disease History:

__Acne
__ Actinic Keratosis
__Asthma
__Blisterin Sunburns
__Cold Sores
__Dry Skin
__Eczema
__Flaking or Itching scalp
__Hay Fever/Allergies
__ Precancerous Moles
__ Psoriasis
__ Poison Ivy
__ Scars
__ Basal Cell Skin Cancer
Location & year_____
__ Squamous cell skin cancer
Location & year_____
__ Melanoma
Location & year_____

Family Skin Disease History:

_____

Medications & OTC you take(name and dose):

_____

_____

_____

Medication Allergies and Reaction:

_____

Have you ever had an allergic reaction to: __Adhesive Tape __Latex __Local Anesthetics

Social History:

Smoke: __Everyday __Occasional __Former Smoker __ Never Smoker
Drink: __Everyday __Socially __ Never

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