CHOICEDERMATOLOGY

Marc Meulener MD, PhD

Patient Information

Name _____ Address _____

(First) (MI) (Last) City/State/Zip_____

Social Security Number _____ Date of Birth _____

Primary Phone_____ (home/cell/work) Secondary Phone _____ (home/cell/work)

E-mail: _____ (Our use only) Contact Method: phone / e-mail / text

Emergency Contact/relationship _____ Phone Number _____

Primary Physician _____Address_____

Phone_____ City/State/Zip_____

Gender ___ Male ___ Female ____ Other

Race(s) ___ White ___ Black or African American ___ Hispanic ___ Asian ___ Decline to Specify

Insurance Information

Primary Insurance Company _____

Address _____ Phone _____

ID Number _____ Group Number _____

Primary Insured (If Different From Above)

*Responsible Party Name _____ Sex: Male/Female

*Date of Birth_____ Address (if different) _____

Home Phone _____ *Cell Phone_____

*Relationship to Patient _____

Responsible Party's Employer Company _____ City _____

* required for billing

Do you have additional insurance? If yes, complete the following

Secondary Insurance Company _____ Phone _____

ID Number _____ Group Number _____

Subscriber's Name _____DOB _____ Relationship to patient _____

Do you have an Advance Care Plan _____ YES _____ NO

Who is your Health Care Proxy_____

(Name) (Phone Number)

Medical History (please check all that apply)

___Anxiety
___Arthritis
___Asthma
___Atrial Fibrillation (Irregular Heartbeat)
___BPH (Benign Prostatic Hyperplasia)
___Bone Marrow Transplantation
___Breast Cancer
___Colon Cancer
___COPD
___Coronary Artery Disease
___Depression
___Diabetes
___End Stage Renal Disease
___GERD
___Hearing Loss
___Hepatitis
___Hypertension
___HIV/AIDS
___Hypercholesterolemia
___Hyperthyroidism
____Hypothyroidism
___Leukemia
___Lung Cancer
___Lymphoma
___Prostate Cancer
___Radiation Treatment
___Seizures
___Stroke
Other _____

Other Medical (Please check all that apply)

___Problems with bleeding
___Problems with healing
___Problems with scarring (keloid)
___Immunosuppression
___Rapid heartbeat with epinephrine
___Premedication prior to procedure
___Artificial heart valve
___Pacemaker
___Defibrillator
___Pregnancy or planning pregnancy

Do you have any other medical history that you would like Dr. Meulener to be aware of?

_____

_____

Surgical History (please check all that apply)

___Appendix Removed
___Bladder Removed
___Breast: Mastectomy (Right, Left, Bilateral)
___Breast: Lumpectomy (Right, Left, Bilateral)
___Breast Biopsy (Right, Left, Bilateral)
___Breast Reduction
___Breast Implants
___Colectomy: Colon Cancer Resection
___Colectomy: Diverticulitis
___Colectomy: Inflammatory Bowel Disease
___Gallbladder Removed
___Heart: Coronary Artery Bypass
___Heart: PTCA (Percutaneous Transluminal Coronary Angioplasty)
___Heart: Mechanical/Biological Valve Replacement
___Heart Transplant
___Joint Replacement, Knee (Right, Left, Bilateral)
___Joint Replacement, Hip (Right, Left, Bilateral)
___Joint Replacement Within last 2 Years
___Kidney Biopsy
___Kidney Removed (Right, Left)
___Kidney Stone Removal
___Liver: Hepatectomy
___Liver: Transplant
___Liver: Shunt
___Ovaries Removed: Endometriosis
___Ovaries Removed: Cyst
___Ovaries Removed: Ovarian Cancer
___Prostate Removed: Prostate Cancer
___Prostate Biopsy
___Prostate: TURP (Transurethral Resection of Prostate)
___Skin: Skin Biopsy
___Skin: Basal Cell Carcinoma
___Skin: Squamous Cell Carcinoma
___Skin: Melanoma
___Spleen Removed
___Uterus/Hysterectomy: Fibroids
___Uterus/Hysterectomy: Uterine Cancer
___Uterus/Cervical Cancer

Other_____

Patient Name _____ DOB_____ Visit Date_____

Do you have any of the following skin conditions (please check all that apply)

___Acne ___Dry Skin ___Hay Fever/Allergies ___Precancerous Moles
___Actinic Keratosis ___Eczema ___Melanoma ___Psoriasis
___Basal Cell Skin Cancer ___Flaking/ itchy scalp ___Poison Ivy ___Squamous cell skin cancer
___Blistering Sunburns Other _____

Do you wear sunscreen? Yes/No If yes, what SPF _____ Do you tan in a tanning salon? Yes/No

Do you have a family history of melanoma? Yes/No If yes, which relative? _____

Medications: all current Prescriptions /Vitamins/Supplements/Herbal Remedies/ OTCs i.e., aspirin, ibuprofen

Medication	Dose	Frequency	Form: *pill, patch*	Medication	Dose	Frequency	Form: *pill, patch*

Vaccinations: Please list the dates (or "do not know") of your most recent vaccinations for:

Influenza:_____Pneumonia:_____ Tetanus:_____COVID 19:_____

Allergies to Foods and Medications including Lidocaine and Latex (please specify reactions)

_____

***Pharmacy and Location*_____**

(Please check one)

Alcohol Use: ___No alcohol use
___Less than 1 drink per day
___1-2 drinks per day
___3+ drinks per day

(Please check all that apply)

Tobacco Use: ___Has never smoked
___Currently smokes: Daily? Y / N
___Has smoked in the past
Total number of years smoking _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES, ELECTRONIC ACCESS, AND OFFICE PROCEDURES

A scanned copy of this authorization shall be considered as valid as the original.
This authorization may be revoked by me in writing.

1. PRIVACY PRACTICES AND RELEASE OF MY PROTECTED HEALTH INFORMATION

I may refuse to sign this acknowledgement.

I have received a copy of Choice Dermatology LLC's Notice of Privacy Practices.

I hereby authorize the Physician to release any information acquired in the course of my examination or treatment to my referring physician and/or to my insurance carrier, information needed to determine benefits

2. AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby assign payment directly to the Physician for the Surgical and/or Medical benefits, if any, otherwise payable to me for services as described but not to exceed my indebtedness to Physician for those services. I understand that I am financially responsible for charges not covered by insurance.

3. CANCELLATION POLICY

I understand that if I cancel or change my appointment with less than 24 hours notice, I may be charged $25.00. The charge for cancellation of a cosmetic appointment, surgery or patch testing less than 24 hours from your appointment is $100 – this includes Botox, Filler, Laser, TruSculpt, Microneedling, and any other cosmetic procedures. Deposits of $50 are required to hold a spot for Facials, Peels and any treatment completed by the Aesthetician and the deposit is non-refundable if cancellation occurs within 24hrs of appointment time.

4. INSURANCE VERIFICATION:

It is your responsibility to provide up to date medical insurance information and to notify us of any changes in your insurance coverage. You are personally responsible for all charges incurred. Failure to provide accurate insurance information that results in non-payment for services, or denial of claims from insurance, will result in charges to your account, plus an additional fee of $25 for inactive or terminated insurance. This charge is added to account for processing costs to the practice.

5. COLLECTIONS:

If you fail to make any payment when due to Choice Dermatology, we have the right to refer your account to a third party for collection (a collection agency). You will be responsible for all costs associated with collections including an Administration Fee of $35.

6. ELECTRONIC MEDICAL RECORD ACCESS

I am aware that I will be assigned a portal for electronic access to my medical record. The practice will provide me a username and password via paper or email.

7. REFERRALS

Many Insurance carriers require a referral from your Primary Care Physician. It is your responsibility to obtain a referral prior to your visit.

_____

Signature of Patient or Parent if Patient is a Minor Date

AUTHORIZATION FOR THE RELEASE OF MY MEDICAL INFORMATION TO THIRD PARTY

The following person(s) may receive medical information on my behalf:

_____ _____

Please Print Name(s)/Relationship **Patient's signature**

For Office Use Only:
We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
_____ Individual Refused to Sign
_____ Communications barriers prohibited obtaining the acknowledgement

CREDIT CARD on FILE AGREEMENT

Choice Dermatology has implemented a credit card policy. We require keeping your credit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable.

Co-pays are still due at the time of service.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card.

A COURTESY CALL WILL BE RECEIVED THE DAY OF, BEFORE THE CARD WILL BE CHARGED.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize **CHOICE DERMATOLOGY** to keep my signature and my credit card information securely on file in my account. I authorize **CHOICE DERMATOLOGY** to charge my credit card for any balances due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give **CHOICE DERMATOLOGY** a new, valid credit card. I agree that the new card may be used with the same authorization as the original card I presented.

Print Patient Name(s):

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

_____ DOB: _____

Name on Card: _____

_____ Exp. Date: _____

Credit Card Number: _____ Billing Zip Code: _____

CVV or Security Code:

Credit Card Holder`s Signature:

_____

DATE SIGNED