VAN DAM DERMATOLOGY & LASER CENTER | VERSA MEDI·SPA

CONFIDENTIAL PATIENT DATA (*Please write legibly)*

Patient Name_____ **Birth Date**_____
(first) (MI) (last) Female□ Male□

Address _____ Occupation_____

City,State,Zip _____ SS#_____

Preferred Pharmacy: Street, City, Zip Code_____

Please check the preferred method of contact

Home (____)_____ ☐
Work (____)_____ ☐
Mobile (____)_____ ☐
Providing phone numbers & email address indicates the practice may contact and leave messages.

E-mail _____ ☐

Would you like to receive emails on our promotions and events? ☐Yes ☐No

Emergency Contact
Name _____
Relationship _____
Phone _____
Other _____

Responsible Party (if patient is a under 18)
Name _____
Address_____
City,State,Zip_____
Phone (___)_____
Relationship to patient_____

Spouse _____ Children_____

Primary Care Physician _____

I heard about Dr. Van Dam in/from (choose all that apply):
☐ Word of mouth ☐ Insurance Company ☐ Doctor referral ☐ Internet (google,yahoo) ☐_____

Referral
I was referred by (name and relation):_____

Are any members of your family patients of this practice? (names)_____

Financial Policy

Please read carefully. I understand and accept that Van Dam Dermatology & Laser Center, Ltd. Accepts most PPO plans from BCBS, United Healthcare, Humana, Aetna and Medicare. For patients with any other insurance carrier, payment in full is expected at the time of service. Co-pays for BCBS, United Healthcare, Humana, Aetna and Medicare will be collected at the time of service.

Van Dam Dermatology accepts payment by cash, check or credit card. In the event that an account is referred for collection, the patient/responsible party will be responsible for all fees and costs incurred to achieve collection. Billing statements are sent once per month and only after we have received any applicable insurance benefits. There will be a fee of $15.00 for the second and third monthly statements. This fee can be avoided by payment upon receipt of your first billing statement. Any balance unpaid with 15 days after the third statement will be considered delinquent.

A charge of $25.00 will be added to the patient/responsible party account for any check returned by the bank. All "no-show" appointments will be charged a missed-appointment fee of $50.00. (A "no-show" is an appointment which a patient does not cancel at least 24 hours prior to their scheduled appointment time.) Missed appointment fees are expected to be paid and will not be adjusted off your account.

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Health History:

I take these prescription medications:_____

_____

I take/use the following contraceptives or hormone replacement therapy:_____

_____

I take aspirin: Yes No Dose/Frequency:_____

I take the following vitamins/herbal supplements:_____

_____

Are you allergic to any medications:_____

_____

I have had the following surgeries:_____

_____

I am presently under a doctor's care for the following conditions:_____

_____

Lifestyle & Personal History:

____Abnormal Chest X-Ray	____Diabetes	____Kidney Disease
____Asthma	____Extreme Weight Loss/Gain	____Mitral Valve Problems
____Allergy to Local Anesthetics	____Faints Easily	____Pacemaker
____Autoimmune Disorders	____Glaucoma	____Pregnant
____Allergy Problems	____Heart Attack	____Seizures
____Anemia	____Heart Murmur	____Shingles
____Artificial Heart Valve	____Hepatitis	____Skin Cancer
____Artificial Joints	____High Blood Pressure	____Skin Cancer, family history
____Blood Clot in Leg/Lung	____Hives	____Sun Poisoning
____Bruise Easily	____Irregular Heartbeat	____Swelling Foot/Ankle
____Bowel Disorder	____Irregular Periods	____Thyroid Problems
____Cataracts	____Joint Pains/Arthritis	____Tuberculosis, positive test
____Cold Sores/Fever Blisters	____Keloids/Excessive Scarring	____Yeast Infections

I have the following medical conditions not mentioned above:_____

_____

I presently smoke or use nicotine: Yes No Amount:_____

I consume alcoholic beverages: Yes No Frequency:_____

I AM HERE TODAY BECAUSE:

____Acne Skin	____Growth	____Rash
____Body Exam	____Hair Loss	____Irregular Pigment
____Excessive Perspiration	____Irregular Vessels/Veins	____Cosmetic

I currently use the following skin care products:_____

_____

I have had the following skin treatments:_____

_____

My signature below affirms my understanding and willingness to comply with the above stated policies.
I attest that the following history is completed to the best of my knowledge. I also accept that my failure to fully disclose all health information may adversely affect my safety or the outcome of any treatment prescribed by David P. Van Dam, MD, or any member of his staff, including Van Dam Dermatology & Laser Center and Versa Medi-Spa. **MINOR PATIENTS MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN. A "CONSENT TO TREAT UNACCOMPANIED MINOR" FORM IS AVAILABLE.**

Patient or Guardian Signature_____**Date** _____

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS

I acknowledge that Van Dam Dermatology & Laser Center has the "**Notice of Privacy**" and the "**Red Flag Rule**" policies in the office waiting room for me to review.

Compliance with the "Red Flag Rule" is required by the federal government and is intended to help safeguard against identity theft. The "Red Flag Rule" requires that we obtain a photo ID that confirms you are the person you say you are.

I consent to the use or disclosure of my Protected Health Information (PHI) by Van Dam Dermatology & Laser Center for purposes of Treatment, Payment and Health Care Operations as described in the "Notice of Privacy".

I understand that this consent remains in effect until I revoke it. I have the right to rescind this consent in writing at any time, but such revocation will not apply to any uses or disclosures that occurred before the effective date of the revocation.

I understand that Van Dam Dermatology & Laser Center will attempt to communicate with me regarding my PHI and that I have the right, at any time, to request restrictions and changes in how my PHI is used or disclosed and how I am contacted by Van Dam Dermatology & Laser Center.

I understand that I have a right to a copy of this consent form.

The **Notice of Privacy Practices** for Van Dam Dermatology & Laser Center is subject to change and revision. If we make any revisions, paper copies of that revision will be available in our office as of the effective date and will also be posted in our waiting room.

I hereby acknowledge all of the above:

☐ Patient Refused to Sign

_____
Print Patient Name Date

X_____ _____
Signature of Patient or Personal Representative Relationship of Personal Representative to Patient

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, authorize Van Dam Dermatology to disclose
(Print your name)

☐ **YES**, Release all of my entire Protected Health Information.

To: _____
(Print **NAME** and **RELATIONSHIP** of person we may speak to regarding your Protected Health Information)

☐ **ONLY**, My Protected Health Information consisting of: _____
(Describe the Protected Health Information to be disclosed)

To: _____
(Print **NAME** and **RELATIONSHIP** of person we may speak to regarding your Protected Health Information)

☐ **NO**, I want my Protected Health Information to be discussed with me only.

I understand the purpose for disclosing this Protected Health Information to the person noted above. I understand that these changes/ restrictions will remain in effect until I rescind them in writing.

Signature: X_____ Date: _____

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Information on the Privacy Form

CONSENT FOR PURPOSES OF TREATMENT, PAYMENT & HEALTH CARE OPERATIONS
states that we are HIPAA compliant.
We follow all privacy rules to keep your information private.

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION
lets us know whom we can legally speak with besides the patient.

This would include family members, friends, assistants, etc.
Add the name(s) & relationship in the YES or ONLY line.

If you are the only person that we would discuss your care with check the NO box.

Some examples of the second part of the form that you would check YES or ONLY:

- **A spouse calling with questions on a prescription or appointment**
- **A patient over the age of 18 whose parents are still involved in their medical care**
- **The adult child of an elderly parent that is involved in their medical care**
- **Minor patients (under 18) who have a caregiver besides the parents (i.e. grandparent, nanny)**

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PRIMARY INSURANCE COVERAGE

Name of Insurance Company

_____

Subscriber/Card Holder Information:

_____

First Name MI Last Name Birth date

Patient Information:

_____

First Name MI Last Name Birth date

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

SECONDARY INSURANCE COVERAGE

Name of Insurance Company _____

Subscriber/Card Holder Information:

_____

First Name MI Last Name Birth date

Patient Information:

_____

First Name MI Last Name Birth date

Patients Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN

I hereby authorize Van Dam Dermatology & Laser Center to furnish information to insurance carriers listed above concerning my illness and treatments. I hereby assign to the physician all payments for medical services rendered to me or my dependents. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY MY INSURANCE. This includes but is not limited to missed appointment fees, and re-billing fees.

Signed _____ Date_____

Insured person/Parent/Guardian

For front office only ☐ Entered ☐ Verified