

CONFIDENTIAL PATIENT DATA (Please write legibly)

Patient Name _____ **Birth Date** _____
(first) (MI) (last) Female Male
Address _____ **Occupation** _____
City,State,Zip _____

Preferred Pharmacy: Name, Street, City, Zip Code _____

Please check the preferred method of contact

Home (____) _____ **E-mail** _____
 Work (____) _____
 Mobile (____) _____

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

Providing phone numbers & email address indicates the practice may contact and leave messages.

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 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.

CONTINUED ON OTHER SIDE

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:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Chest X-Ray | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Extreme Weight Loss/Gain | <input type="checkbox"/> Mitral Valve Problems |
| <input type="checkbox"/> Allergy to <u>Local</u> Anesthetics | <input type="checkbox"/> Faints Easily | <input type="checkbox"/> Pacemaker |
| <input type="checkbox"/> Autoimmune Disorders | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Pregnant |
| <input type="checkbox"/> Allergy Problems | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Shingles |
| <input type="checkbox"/> Artificial Heart Valve | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Skin Cancer |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Cancer, family history |
| <input type="checkbox"/> Blood Clot in Leg/Lung | <input type="checkbox"/> Hives | <input type="checkbox"/> Sun Poisoning |
| <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Swelling Foot/Ankle |
| <input type="checkbox"/> Bowel Disorder | <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Thyroid Problems |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Joint Pains/Arthritis | <input type="checkbox"/> Tuberculosis, positive test |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Keloids/Excessive Scarring | <input type="checkbox"/> 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 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** _____

Patient or Guardian Signature _____ **Date** _____

Patient or Guardian Signature _____ **Date** _____

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
Initial

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:** _____

Relationship of Personal Representative to Patient

PRIMARY INSURANCE COVERAGE

Name of Insurance Company _____

Subscriber/Card Holder Information:

 First Name MI Last Name Birth date
 Social Security Number _____

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