Patient Name

First Last

Date

Address:

Phone:

Mobile: \_

Email: \_

D.O.B Gender: **[ ] Male [ ] Female** Marital Status: **[ ] S [ ] M [ ] D [ ] W**

**RACE:** [ ] White [ ] Hispanic [ ] Asian [ ] Black/African American **LANGUAGE:** [ ] English [ ] Spanish

[ ] American Indian or Alaska Native [ ] Hawaiian or Pacific Islanders [ ] other: [ ] other

What is/are the main reason(s) you came in for this consultation?

Please check any areas you would like to discuss or receive more information about:

* Botox/Dysport/Xeomin
* Fillers (Restylane/Juvederm)
* Sculptra
* Chemical Peel
* Microneedling/Vampire
* Facial
* Excessive Hair Growth
* Wrinkles
* Volume Loss/Sagging skin
* Facial red vessels
* Leg Spider Veins
* Red complexion
* Brown spots/Age Spots
* Sun Damage
* Dry Skin
* Skin Care Regimen/Products
* Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

What cosmetic treatments and procedures, if any, have you had in the past?

Which of the following best describes your skin type and natural hair color?

Hair Color

* Black
* Brown/Light/Dark
* Blonde/Light/Dark
* Red
* White/Grey
1. Always burns, never tans 4. Always burns, sometimes tans
2. Sometimes burns, always tans 5. Rarely burns, always tans
3. Brown moderately pigmented 6. Black Skin

Do you have permanent make-up or tattoos anywhere? [ ] Yes [ ] No Do you sunbathe, or go to tanning salons? [ ] Yes [ ] No

Do you use chemical sunless tanning? [ ] Yes [ ]

Do you use sunscreen daily? [ ] Yes [ ] No

Other illnesses or medical conditions?

Medical history, please check ‘yes’ if you have ever been diagnosed with the following:

* Hepatitis A-B-C
* HIV/AIDS
* Cold Sores/ Shingles
* Anaphylaxis/Severe allergic reactions
* Sun sensitivity disorders
* Actinic Keratosis/Skin cancer
* Keloid scars
* Melasma

Autoimmune and neurologic diseases: (please check any that apply)

* Myasthenia Gravis
* Eaton-Lambert disease
* Multiple sclerosis
* Lupus
* Scleroderma
* Other:

Are you allergic to any products/medications? If yes, please describe your reaction

Are you taking any blood thinners? [ ] Yes [ ] No If yes please list: Are you pregnant, nursing, or trying to become pregnant? [ ] Yes [ ] No Do you smoke? [ ]Yes [ ] No

Would you like to receive information about Prism special events, cosmetic or product discounts? [ ] Yes [ ] No

Patient/Guardian Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |
| --- | --- |
| (PLEASE PRINT)  |  **PATIENT INFORMATION**  |

LAST NAME \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FIRST \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MIDDLE \_\_\_\_\_\_\_\_\_\_\_

CELL PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALT/HOME PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ EMAIL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ APT # \_\_\_\_\_\_\_\_\_\_\_\_\_\_

CITY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ STATE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ZIP CODE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMPLOYER/SCHOOL \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEX \_\_\_\_\_\_\_ MARITAL STATUS\_\_\_\_\_\_\_\_\_\_SSN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

RACE \_\_\_\_\_\_\_\_\_ ETHNICITY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LANGUAGE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW WERE YOU REFERRED? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EMERGENCY CONTACT & NUMBER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PHYSICIAN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **RESPONSIBLE PARTY INFORMATION**

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ RELATIONSHIP \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE OF BIRTH\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOME PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ WORK PHONE \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ADDRESS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

IF MINOR: MOTHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ FATHER \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ LEGAL GUARDIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**INSURANCE INFORMATION**

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (if diff than patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Group number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relation to patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Address (if diff than patient) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **METHODS OF COMMUNICATION**

 ***May we leave personal information on your answering machine?* Yes No *Text to your cell phone?* Yes No  *Send to your email address?*  Yes No**

**I acknowledge that Prism Dermatology, PLLC may communicate with me via US mail, home or cell phone. \_\_\_\_\_\_\_\_\_\_(Initial)**

**I request for an alternative method of communication such as alternative address or work phone number. \_\_\_\_\_\_\_\_\_\_(Initial)**

**Alternative Method:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**□ I request to be web enabled thru *Modernizing Medicine* for secure access to information related to my care. I will be emailed the instructions and password for web access: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have an *Advanced Directive (Living Will)*? Yes No If YES, does anyone make medical decisions on your behalf? Yes No**

 **Medical Decision Maker Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE INITIAL EACH SECTION BELOW TO INDICATE YOU HAVE READ AND UNDERSTAND THE INFORMATION:**

\_\_\_\_\_\_\_ **ASSIGNMENT OF INSURANCE AND FINANCIAL RESPONSIBILITY**

I do, hereby authorize payment of my insurance benefits, including authorized Medicare benefits, basic and major medical for the services I receive, to be made directly to **Prism Dermatology, PLLC.**

\_\_\_\_\_\_\_ **CONSENT FOR MEDICAL SERVICES**

I authorize **Prism Dermatology, PLLC** to render treatment to me or my dependents for dermatological care or medical procedures as deemed medically necessary for treatment as indicated.

\_\_\_\_\_\_\_ **REFERRALS/AUTHORIZATIONS**

I understand that if my insurance requires a referral or an authorization, I am responsible for obtaining the referral prior to my visit. If I do not have a referral or authorization at the time of my visit, I may be rescheduled or sign a waiver of financial responsibility. In such case I understand that full payment will be required at the time of service.

\_\_\_\_\_\_\_ **FINANCIAL RESPONSIBILITY**

I understand that although **Prism Dermatology, PLLC** will file a claim to my insurance plan(s), I am expected to pay my copayment, coinsurance, deductible and non-covered services amounts at the time services are rendered. I acknowledge that **Prism Dermatology, PLLC** does not guarantee payment of my claim by my insurance plan and that it is my responsibility to know the provisions of my insurance. Not all procedures are deemed “Medical Necessity” by insurance carriers and can be considered cosmetic. For example-Skin tag

removal, correction of dark spots, yearly skin cancer screenings without specific areas of concern, would not be a covered service. I understand that I would be responsible for payment of such services. I am ultimately responsible for any unpaid balance or non-covered service. I agree to pay all costs of collecting, securing or attempting to collect or secure payment, including reasonable attorney fees or collection agency fees.

 I also understand that any prior unpaid balances on my account must be paid in full before being seen by a provider. If my prior balance cannot be paid in full, I will speak with a financial counselor at **Prism Dermatology, PLLC** to make a payment arrangement before services can be rendered.

I also understand that if **Prism Dermatology, PLLC** does not participate with my insurance plan that I will be expected to pay in full for my services. And it is my responsibility to know if **Prism Dermatology, PLLC** is in network with my insurance plan.

I understand that payments to **Prism Dermatology, PLLC** can be made by cash, checks and all major credit cards. I also acknowledge that returned checks will be subject to a non-sufficient fund fee of $25.00.

\_\_\_\_\_\_\_ **COSMETIC SERVICES**

Cosmetic services are not a covered benefit under insurance plans. I understand that to make an appointment for cosmetic services, I will be expected to pay half of the service as a down payment and be expected to pay the remaining balance when services are rendered.

\_\_\_\_\_\_\_ **PATIENT RESPONSIBILITY**

I understand that due to Federal (red flag) rules that **Prism Dermatology, PLLC** is prevented from filing to my insurance without proof of identification. I will be expected to present a photo ID and insurance card(s) at every office visit. I will also update any changes to my addresses, telephone numbers and insurance if they have changed since my last visit and I understand that I will be asked to update my demographics and signatures annually.

\_\_\_\_\_\_\_ **MISSED APPOINTMENTS**

It is my responsibility to notify **Prism Dermatology, PLLC** at least *48 hours* prior to my appointment if I am unable to keep the appointment. I acknowledge that if I miss two appointments without sufficient notification that I will be charged a **$50** fee. If I miss three appointments without sufficient notification, I will be dismissed from the practice for non-compliance.

\_\_\_\_\_\_\_ **PRIVACY POLICY NOTICES**

I have been offered a copy of **Prism Dermatology, PLLC’s** ***Notice of Privacy Policies*** that details how my personal health information may be used, disclosed and my rights as permitted by federal law. As well I understand that this notice is posted for my benefit in the reception areas and on the website of **Prism Dermatology, PLLC**.

\_\_\_\_\_\_\_ **ePRESCRIBING CONSENT**

I acknowledge that **Prism Dermatology, PLLC** utilizes electronic health records and will transmit my prescriptions electronically as permitted to the pharmacy that I designate as my pharmacy provider. To enable electronic prescriptions to my pharmacy, I grant **Prism Dermatology, PLLC** my permission to access my medication history to view current and past prescription information.

\_\_\_\_\_\_\_ **LAB SERVICES**

I am aware that my laboratory/pathology services may not be billed from **Prism Dermatology, PLLC**. I will receive a separate statement from the lab or pathologist. In addition it is my responsibility to contact my insurance plan to determine what laboratory is in network for my plan.

**PATIENT/GUARDIAN SIGNATURE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **DATE:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **WITNESS:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_