

WELCOME TO ARIZONA DESERT DERMATOLOGY

PATIENT INFORMATION (Please Print)

Latest Revision 10/16

Name: Last		First		M.I.		A.K.A. (Nickname)	
DATE OF BIRTH	SSN:	GENDER M / F	RACE: <input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic Latino		<input type="checkbox"/> Black/African American <input type="checkbox"/> Multiracial <input type="checkbox"/> Hawaiian/Pacific Islander		<input type="checkbox"/> White <input type="checkbox"/> Decline to answer
MAILING ADDRESS:				ETHNICITY: <input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Latino <input type="checkbox"/> Unknown			
CITY				STATE		ZIP	
HOME PHONE:				CELL:		WORK:	
						Marital Status:	
CIRCLE ONE: WINTER / SUMMER ADDRESS (if different):				CITY		STATE	
						ZIP	
EMERGENCY CONTACT:			RELATION:		PHONE:		
EMERGENCY CONTACT: (OTHER THAN SPOUSE)			RELATION:		PHONE:		

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME:		POLICY #		SECONDARY INSURANCE COMPANY NAME		POLICY #	
NAME OF INSURED: (if other than patient)		GROUP #		NAME OF INSURED: (if other than patient)		GROUP #	
BIRTHDATE OF INSURED:		RELATION TO PATIENT:		BIRTHDATE OF INSURED:		RELATION TO PATIENT:	
IS INSURANCE PROVIDED BY EMPLOYER: YES / NO		NAME OF EMPLOYER:		IS INSURANCE PROVIDED BY EMPLOYER YES / NO		NAME OF EMPLOYER:	

Do you have Power Attorney: Y/N

If yes, please give name: _____ Phone: _____

I authorize you to discuss my medical records with the following individual(s)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

Patient Signature Authorizing Release: _____

ALL PATIENTS

- I acknowledge full financial responsibility for medical services rendered and I agree to pay in full at the time of service, or to make prior arrangements for payment. If my account is placed for collections, I acknowledge responsibility for associated collection expenses. A fee, determined by our collection agency, will be added to any balance turned over to collections. There will be a charge for canceled or broken appointments without 24 hours notice as follows: \$20.00 established, \$40 new, \$50 cosmetic, and \$100 for all surgery and Mohs appointments. There will be a \$35 charge for all returned checks.
- We will bill your insurance as a courtesy to you. We will wait 60 days to remit payment. If it is not paid within this time, the total bill becomes due and payable in full by the person responsible for payment of this account. We suggest you work closely with your insurance to expedite payment. It is your responsibility to provide them with information requested. Please forward any information they may request.
- A written copy of the Privacy Practices for Arizona Desert Dermatology has been made available to me.
- I authorize you to take photographs of my medical condition to be used for educational purposes.
- I authorize Arizona Desert Dermatology to release my medical records to the doctor who referred me and to a doctor I am referred to. I further authorize the release of any information to my insurance company necessary for processing my claims.
- I request that the payment of benefits be made on my behalf to Arizona Desert Dermatology for and services furnished me by their providers.

Print Name _____ Signature _____ Date _____

*****GET TO KNOW YOUR INSURANCE*****

INSURANCE CONTRACTS:

Aetna
 Blue Cross Blue Shield
 GEHA (AFMC)
 Humana (Medicare Replacement)
 Medicare & Medicare Railroad
 Phoenix Health Plan (Medicare Replacement)
 Sierra Health & Life
 Tricare
 United Healthcare (NOT all policies)

NETWORK CONTRACTS:

Accountable Health
 Aetna
 AZ Foundation for Medical Care
 Beech Street
 Blue Cross Blue Shield
 First Health
 Health Smart
 HMA/HMN
 Intragroup

Managed Care Consultants
 MultiPlan
 PHCS

Contracted Insurances: co-pay's are usually applied to the office visit charge. Some insurances apply procedures done at the same visit to the in network deductible, co-insurance or another co-pay.

Non-Contracted Networks: charges are usually applied to your out of network deductible and co-insurance; however, you receive a network discount.

Insurance companies have their own rules and guidelines independently. If you are unsure how your insurance will process your claims, please contact your representative for clarification. **Our office does not guarantee nor take responsibility for how your insurance company processes your claims.**

Print Name _____ Signature _____ Date _____

MEDICARE PATIENTS ONLY

Provider's name: Arizona Desert Dermatology

I request that payment under the medical insurance program be made either to me or to the provider named above on any bills for service furnished to me during the effective period of this authorization and I authorize the above named provider to release to the Social Security Administration or it's intermediaries or carries any information needed for this claim or any related Medicare Claim. I further permit a copy of this authorization to be used in place.

Print Name _____ Signature _____ Date _____

Patient Name: _____ DOB: _____ Date: _____

History and Intake Form

Past Medical History: (please circle all that apply)

- | | |
|-------------------------|----------------------|
| Anxiety | Hepatitis A, B, C |
| Arthritis | Hypertension |
| Artificial joints | HIV/AIDS |
| Asthma | Hypercholesterolemia |
| Atrial fibrillation | Hyperthyroidism |
| BPH | Hypothyroidism |
| Bone Marrow Transplant | Leukemia |
| Breast Cancer | Lung Cancer |
| Colon Cancer | Lymphoma |
| COPD | Prostate Cancer |
| Coronary Artery Disease | Radiation Treatment |
| Depression | Seizures |
| Diabetes | Stroke |
| End Stage Renal Disease | Valve Replacement |
| GERD | None |
| Hearing Loss | |
| Other _____ | |

Past Surgical History:

None

List Surgeries:

Skin Disease History: (please circle all that apply)

- | | |
|------------------------|---------------------------|
| Asthma | Actinic Keratoses |
| Dry Skin | Basal Cell Skin Cancer |
| Eczema | Melanoma |
| Flaking or Itchy Scalp | Precancerous Moles |
| Psoriasis | Squamous Cell Skin Cancer |
| | None |

Other _____

Do you wear Sunscreen? Yes No

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)? _____

Medications:

(attach list if there is not enough space below)

Dosage & Frequency:

Drug Allergies: (Please enter all medication allergies)

Do you have a pacemaker? Yes No
Do you have a defibrillator? Yes No

Are you pregnant? Yes No
Are you breastfeeding? Yes No

Social History: (Please circle all that apply)

Tobacco Use:

- Never used tobacco
- Quit: former tobacco user
- Uses tobacco less than daily
- Uses tobacco daily

Illicit Drug Use:

- Drug Use
- IV Drug Use
- No Drug Use

Alcohol Use:

- Alcohol: none
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

Your Preferred Local Pharmacy: _____

Reason for Today's Visit:

Review of Systems Yes No

rash	<input type="checkbox"/>	<input type="checkbox"/>
problems with bleeding	<input type="checkbox"/>	<input type="checkbox"/>
problems with healing	<input type="checkbox"/>	<input type="checkbox"/>
problems with scarring (hypertrophic or keloid)	<input type="checkbox"/>	<input type="checkbox"/>
immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>
thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
chest pain	<input type="checkbox"/>	<input type="checkbox"/>
anxiety	<input type="checkbox"/>	<input type="checkbox"/>
fever or chills	<input type="checkbox"/>	<input type="checkbox"/>
night sweats	<input type="checkbox"/>	<input type="checkbox"/>
unintentional weight loss	<input type="checkbox"/>	<input type="checkbox"/>
sore throat	<input type="checkbox"/>	<input type="checkbox"/>
blurry vision	<input type="checkbox"/>	<input type="checkbox"/>
abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>
bloody stool	<input type="checkbox"/>	<input type="checkbox"/>
bloody urine	<input type="checkbox"/>	<input type="checkbox"/>
joint aches	<input type="checkbox"/>	<input type="checkbox"/>
muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>
<hr/>		
neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>
headaches	<input type="checkbox"/>	<input type="checkbox"/>
seizures	<input type="checkbox"/>	<input type="checkbox"/>
cough	<input type="checkbox"/>	<input type="checkbox"/>
shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
wheezing	<input type="checkbox"/>	<input type="checkbox"/>
depression	<input type="checkbox"/>	<input type="checkbox"/>
hay fever	<input type="checkbox"/>	<input type="checkbox"/>



ARIZONA DESERT DERMATOLOGY MEDICAL RECORDS RELEASE

I, _____ herein request and authorize
Patient Name Date of Birth

Arizona Desert Dermatology & Surgery, P.C. to forward a copy or summary of the following medical records:

- Complete medical records
- Biopsy report(s)
- Lab report(s)
- Consultation reports
- Medication allergies
- Surgical procedure(s)

TO:

Doctor or Facility (Primary Care Physician)

Address City State Zip Code

Phone Fax

Patient Signature Date

Witness Date

Form is valid for one year from date signed

ARIZONA DESERT DERMATOLOGY- PAYMENT POLICY

A payment policy lets our patients know what we expect of them and what they can expect of us. We believe a well-crafted policy will prevent patients from being surprised about their financial obligation when they receive services. It will also give our practice some legal protection should a patient fail to pay what we are entitled to collect.

- Payment is due on the day of service, unless other arrangements have been made in advance.
- Self-pay patients are responsible for the entire amount billed for that day of service.
- Patients who have medical insurance are responsible for any amounts not covered by their insurance.
- If the patient's insurance company pays directly to the patient, the entire balance is due on the date of service. (i.e. BCBS Fed - we bill insurance on request only)
- Deductibles and copays are collected at each visit.
- Forms of payment accepted: personal checks, debit cards, credit cards, cash, and care credit
- We enlist a collection agency's help after three months of non-payment.

MEDICAL INSURANCE

Two common mistakes regarding medical insurance:

- 1) Thinking that your insurance company is responsible for paying your medical bills.
- 2) Thinking that your medical providers are required to bill your insurance company.

The truth is consumers are responsible for their own medical debts. Meaning the consumers must ensure that their insurance company is billed in a timely manner and that it is being billed correctly.

As a convenience for you, most medical providers will offer to bill your insurance company. Accepting their offer doesn't relieve you of the responsibility of ensuring that the bill gets paid. The bottom line is that the consumer is still responsible for paying any medical debt. In some cases your insurance company will reject a bill or refuse to pay the bill, if this happens the provider will expect you to pay the bill. Unless you have disputed the debt, you are legally expected to pay the bill in a timely manner. You may have to argue with your insurance company or go through dispute resolution, but the provider is entitled to a timely payment. You may have to pay the provider yourself, and then work with your insurance company to get reimbursed.

Patient Signature _____ Date _____

****ATTENTION PATIENTS****

By supplying my phone number and email address, I authorize my health care provider to use a third-party automated messaging system to use my information, the name of my provider, the time and place of my scheduled appointment(s), and other limited information for the purpose of notifying me. This includes notification of a pending appointment, a missed appointment, balances due, or any other healthcare related function. I authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare visits. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voice mail, answering system, or with another individual, if I am unavailable at the number provided by me.

How would you like to be contacted?

Emails go out **FIVE** days prior to appointment, phone calls go out **THREE** days prior to appointment, and text messages go out **TWO** days prior to appointment.

Email: YES/ NO If yes please provide an email address:

Phone Call: YES/ NO If YES please provide a phone Number:

Home Mobile

Text: YES/ NO If YES please provide a mobile phone Number:

Would you like all three? YES/ NO

Patient Name: _____

Date of Birth: _____

Patient Signature: _____