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: ☐ American Indian or Alaska Native ☐ Asian ☐ Hispanic Latino ☐ Black/African American ☐ Multiracial ☐ Hawaiian/Pacific Islander ☐ White ☐ Decline to answer

MAILING ADDRESS:	ETHNICITY: ☐ Hispanic/Latino ☐ Non-Hispanic/Latino ☐ Unknown Preferred Language:
CITY STATE ZIP	PRIMARY CARE PHYSICIAN:

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

SECONDARY INSURANCE COMPANY NAME	POLICY #
NAME OF INSURED: (if other than patient)	GROUP #
BIRTHDATE OF INSURED:	RELATION TO PATIENT:
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 responsibly 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 responsibly 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:	**NETWORK CONTRACTS:**	
Aetna	Accountable Health	Managed Care Consultants
Blue Cross Blue Shield	Aetna	MultiPlan
GEHA (AFMC)	AZ Foundation for Medical Care	PHCS
Humana (Medicare Replacement)	Beech Street	Cigna
Medicare & Medicare Railroad	Blue Cross Blue Shield	VA- Triwest
Phoenix Health Plan (Medicare Replacement)	First Health	Golden Rule
Sierra Health & Life	Health Smart	AFMC
Tricare	HMA/HMN	
United Healthcare (NOT all policies)	Intragroup	

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

Past Surgical History:

None
List Surgeries:

_____
_____
_____
_____
_____
_____
_____

Skin Disease History: (please circle all that apply)

Asthma
Dry Skin
Eczema
Flaking or Itchy Scalp
Psoriasis
Actinic Keratoses
Basal Cell Skin Cancer
Melanoma
Precancerous Moles
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	Are you pregnant?	Yes	No
Do you have a defibrillator?	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	○	○
problems with bleeding	○	○
problems with healing	○	○
problems with scarring (hypertrophic or keloid)	○	○
immunosuppression	○	○
thyroid problems	○	○
chest pain	○	○
anxiety	○	○
fever or chills	○	○
night sweats	○	○
unintentional weight loss	○	○
sore throat	○	○
blurry vision	○	○
abdominal pain	○	○
bloody stool	○	○
bloody urine	○	○
joint aches	○	○
muscle weakness	○	○
neck stiffness	○	○
headaches	○	○
seizures	○	○
cough	○	○
shortness of breath	○	○
wheezing	○	○
depression	○	○
hay fever	○	○

Arizona
Desert Dermatology

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:_____