Premier DERMATOLOGY

Bentonville, Bella Vista, Fayetteville
p: 866.973.3376 f: 479.273.3468
info@premierderm.net premierderm.net

MEDICAL PATIENT UPDATE FORM

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS

Date _____

Name: _____ _____ _____ _____
Last *First* *M.I.* *Date of Birth*

Mailing Address: _____ _____ _____ _____
Street/PO *City* *State* *Zip*

Physical Address: _____ _____ _____ _____
Street *City* *State* *Zip*

Home Phone: _____ Mobile Phone: _____

Work Phone: _____ E-mail: _____

Emergency Contact: _____ Relationship: _____ Emergency Phone #: _____

Employer Name: _____ Phone: _____

Employer Address: _____ _____ _____ _____
Street/PO *City* *State* *Zip*

RESPONSIBLE PARTY / SUBSCRIBER INFORMATION

Relationship to Patient: _____

Responsible Party Name: _____ Date of Birth: _____
Last *First* *M.I.*

___ *Check here if address is same as patient*

Mailing Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Employer Name: _____ Phone: _____

Employer Address: _____ _____ _____ _____
Street/PO *City* *State* *Zip*

Please present your insurance card(s) to the receptionist.

MEDICAL HISTORY

Past Medical History: Check Yes or No

Anxiety	__ Yes __ No	Depression	__ Yes __ No	Leukemia	__ Yes __ No
Arthritis	__ Yes __ No	Diabetes	__ Yes __ No	Lung cancer	__ Yes __ No
Artificial joints	__ Yes __ No	End stage renal disease	__ Yes __ No	Lymphoma	__ Yes __ No
Asthma	__ Yes __ No	GERD	__ Yes __ No	Pacemaker	__ Yes __ No
Atrial fibrillation	__ Yes __ No	Hearing loss	__ Yes __ No	Prostate cancer	__ Yes __ No
Bone marrow transplant	__ Yes __ No	Hepatitis	__ Yes __ No	Prostate issues	__ Yes __ No
Breast cancer	__ Yes __ No	HIV/AIDS	__ Yes __ No	Radiation treatment	__ Yes __ No
Colon cancer	__ Yes __ No	High Blood Pressure	__ Yes __ No	Seizures	__ Yes __ No
COPD	__ Yes __ No	Hypercholesterolemia	__ Yes __ No	Stroke	__ Yes __ No
Coronary artery disease	__ Yes __ No	Hypothyroidism	__ Yes __ No	Valve replacement	__ Yes __ No
Dementia/Alzheimer's	__ Yes __ No			Other: _____	

PATIENT COMMUNICATION PREFERENCES

A. Family and Friends

It is the office policy of Premier Dermatology and The Skin Renewal Center not to release confidential medical information regarding your treatment to family members or friends, except for

i. parent/legal guardian
ii. other persons authorized by the patient
iii. as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment)
iv. in emergency situations
v. as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later, please confirm this in writing, or call our staff.)

		Yes	No
Spouse	_____	_____	_____
Parent	_____	_____	_____
Other	_____	_____	_____
	_____	_____	_____

B. Alternative Communications

You are also entitled to specify an alternative, reasonable means of communication if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only: _____

PREMIER DERMATOLOGY CANCELLATION POLICY

A primary goal at Premier is to provide skillful and timely service for all patients. To do so, we require individual appointments to be cancelled at a minimum of 24 hours in advance or it will be considered a No-Show appointment. Thank you in advance for your cooperation.

PREMIER DERMATOLOGY CONSENT FORM

I. **Consent to Treatment:** I voluntarily consent to receive medical and health care services that may include examinations, diagnostic procedures and treatments. If patient is under the age of 18, I give permission for the patient to receive follow-up care from the physicians and staff at Premier Dermatology PLLC in my absence.

II. **Assignment of Benefits:** I authorize my insurance company to make direct payment to the provider of services for the profession of medical expense benefits allowable under my current insurance policy. That is, my insurance company will make direct payment to Premier Dermatology for services rendered rather than to myself.

III. **Financial Responsibility:** I agree to pay all charges for medical or other services not covered by my insurance company. I further understand that I am responsible for all collection, small claims court and/or attorney fees necessary to collect this debt, as per the Financial Policy.

IV. **Outside Laboratory Charges:** In the event that I have a skin biopsy, I consent to have my biopsy sent to the pathologist my doctor determines most appropriate for arriving at an accurate diagnosis of my condition. I understand that this may incur a second bill from the pathologist who interprets my pathology. This may also be the case for certain other routine lab tests that my doctor may order to make an accurate medical diagnosis.

V. **HIPAA Consent:** The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law that governs the use and disclosure of a person's health information. The following statements cover the basics of your rights as a patient under HIPAA.

- Protected health information may be disclosed for treatment, payment, or health care operations.
- Premier Dermatology has a Notice of Privacy Practices and the patient has an opportunity to review this notice. To obtain a copy of the notice ask the office staff. Premier Dermatology reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of his or her protected health information, but Premier Dermatology does not have to agree with those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- Premier Dermatology may offer or refuse treatment based upon the execution of this consent.

PREMIER DERMATOLOGY FINANCIAL POLICY (Effective February 2021)

1. All patients are required to complete the Premier Dermatology Patient Registration form and Medical History, sign the Consents page as well as provide insurance card (if applicable), and a photo ID before clinic services are rendered.
2. Patients are responsible for payment:
    a. For cosmetic & self-pay medical patients, **FULL PAYMENT** is due at the time of service.
    b. For aesthetician and massage services, appointments must be secured with an active credit card or existing Open House credit at the time of booking. If the booked service is considered a no-show, the estimated value of the service will be charged to the account provided.
    c. For medical patients with insurance, a co-payment and/or co-insurance is due at the time of service, including unmet deductible.
    d. For payments made with a credit card, any overpayments will be refunded to that card.
    e. All charges not paid by insurance are due by the patient.
    f. Money on account for cosmetic services may also be used for payment of medical bills.
3. A **non-refundable deposit** may be collected at the time of booking for select appointments. If the patient comes to the appointment, the deposit will be applied to the service and any overage will be refunded.
    a. Cosmetic surgery visit - $500
    b. Cosmetic office visit - $150 (collected if patient has at least 2 no-shows or same-day cancellations)
    c. Mohs surgery visit - $1,000 (collected if patient has at least 2 no-shows or same-day cancellations)
    d. Medical office visit - $150 (collected if patient has at least 2 no-shows or same-day cancellations)
4. Payment plans for medical appointments are available on request for large balances and **must be signed by patient and secured with a credit card to be charged monthly**.
5. Patient balances that extend beyond 180 days may be assessed a finance charge of 1% per month.
6. Collection efforts on past due balances will include fees assessed to the patient. Fees will be 35% of the outstanding balance if sent to a collection agency who will also report to the credit bureaus. If sent to Small Claims court, fees will be $118 plus garnishment fee.

CREDIT CARD AUTHORIZATION

The credit cards we accept are processed through Elavon and are Payment Card Industry Data Security Standard (PCI-DSS) compliant whose purpose is protecting card data. As such, our system does not store your complete card information, and our employees do not have access to anything other than the last four digits of the card. Premier Dermatology, PLLC and The Skin Renewal Center at Premier Dermatology, PLLC have Certificates of Compliance available for your review as our commitment to the process of PCI-DSS.

By my signature, I certify that I have read the five sections above, agree to the above statements, and have been given a copy of Premier Dermatology's Financial Policy and Privacy Policy/HIPAA (or I have read the policies online).

Printed Name of Patient or Responsible Party: _____

Signature: _____ Date: _____