Cleveland Dermatology Group LLC

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PATIENT INFORMATION: ☐ New Patient ☐ Update Requested ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: Today's Date _____ / _____ / _____

Last Name_____ First Name_____ M.I_____

Date of Birth _____ / _____ / _____ Age: ___ SS# _____ / _____ / _____ ☐ Male ☐ Female

ADDRESS_____ CITY_____ ST _____ ZIP_____

Home Ph (_____) _____ Work Ph (_____) _____ Ext ____ Cell Ph (_____) _____

Would you like to receive text message reminders to your cell phone? ☐ Yes ☐ No
****If yes, we will make your cell phone your preferred contact phone number. ****

Email _____ Employer _____

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed ☐ Separated

PLEASE RESPOND TO ETHNICITY AND RACE CHECK BOXES BELOW:

1) ETHNICITY: Hispanic or Latino? ☐Yes ☐No ☐ Declines to Answer

2) Race: ☐ American Indian or Alaska Native ☐ Asian ☐ White ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ Other Race _____ ☐ Declines to Answer

PARENT/GUARDIAN, OR RESPONSIBLE PARTY INFORMATION (Statement Recipient and Patient Portal User):

Last Name_____ First Name_____ M.I_____

Relationship of patient to responsible party: ☐ Child ☐ Other _____ Employer _____

Date of Birth _____ / _____ / _____ Age: ___ SS# _____ / _____ / _____ ☐ Male ☐ Female

ADDRESS_____ CITY_____ ST _____ ZIP_____

Home Ph (_____) _____ Work Ph (_____) _____ Ext ____ Cell Ph (_____) _____

Email _____

PRIMARY INSURANCE COVERAGE:

Insurance Name:_____ Policy Holder (Insured) _____

Insured Date of Birth ____/____/____ SS# _____ / _____ / _____ Employer _____

Relationship of patient to insured: ☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Other _____

Policy # _____ Group # _____ Copay $ _____

SECONDARY INSURANCE COVERAGE:

Insurance Name:_____ Policy Holder (Insured) _____

Insured Date of Birth ____/____/____ SS# _____ / _____ / _____ Employer _____

Relationship of patient to insured: ☐ Self ☐ Spouse ☐ Partner ☐ Child ☐ Other _____

Policy # _____ Group # _____ Copay $ _____

→ → → → → → **Please fill out other side** → → → → **Please fill out other side** → → → → → →

Referral Information, patient financial policy & signature on file

Referred by _____ Primary Care Physician _____
(Please specify if you were referred by a physician)

Other family members who are patients _____

Emergency Contact _____ Phone (_____) _____

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physicians, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _____ Today's Date ___/___/___

FINANCIAL POLICY:

You will be responsible for paying your annual deductible, copayment, coinsurance and charges for any non-covered services or cosmetic services. As always, copays and cosmetic services are due at the time of service. Regarding credit balances: Refunds will be issued upon request for credits over $10.00. Credits $10.00 and less will remain on the account for the patient to use upon return to the office. We will transfer credit balances to household/family members' accounts that are carrying a balance.

Patient or Responsible Party Signature _____ Today's Date ___/___/___

MEDICARE PATIENTS ONLY (Original Medicare / Red, White & Blue Card):

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

Medicare: **We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting thei deductible and paying for the 20% coinsurance. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you, and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card _____ Today's Date ___/___/___

AND - If you have a supplemental policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Supplemental Card _____ Today's Date ___/___/___

Dermatology Medical History

Patient Name _____ Date _____

Date of Birth _____ Preferred Local Pharmacy _____
Pharmacy Location (ie: Westlake) _____
Mail Pharmacy _____

List all medication you are currently taking (including prescription, over-the-counter meds, vitamins, herbals)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

List all allergies to medications: _____

Review of Systems:

Skin (Please ✔)

Have you ever had skin cancer? _____ Type? _____
Do you have a family history of skin cancer? _____ Type? _____
Do you bleed easily? _____
Do develop keloids? (Raised, thick scars)? _____
Do you have problems healing? _____

List any skin conditions/diseases _____

_____

Other Systems:

Do you have (Please ✔)

Diabetes ___ Heart disease ___ Defibrillator ___
Thyroid disease ___ Artificial joint ___ Artificial heart valve ___
Kidney disease ___ Pacemaker ___ HIV/AIDS ___

List any other medical conditions/diseases _____

List any surgical procedures during the last 6 months _____

Women:

Are you pregnant? (Y / N) ___ Are you nursing? (Y / N) ___

Social History (Please ✔)

Do you drink alcohol? Currently ___ Former ___ Never ___
Do you smoke? Currently ___ Former ___ Never ___

Completed by: Patient ___ Guardian ___ Medical Assistant ___

		Updated	Initials
_____	_____	_____	_____
Patient / Guardian Signature	Date	_____	_____
		_____	_____
_____	_____	_____	_____
Reviewed by	Date		

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HIPAA COMPLIANT AUTHORIZATION FOR THE RELEASE AND TREATMENT OF PATIENT INFORMATION:
New patient consent to the use and disclosure of health information for treatment, payment or health care operations

PATIENT NAME _____ DOB ___ /___ / ___ TODAY'S DATE ___ / ___ / ___

Patient OR Parent/Guardian if patient is of Minor Child

I, _____ understand that as part of my health care, CDG originates and maintains paper & electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatments and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among any health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals

I understand and have been provided with a *Notice of Information Practices* that provides a more complete description of information and uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

I understand that CDG is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon. I also understand that by refusing to sign this consent or by revoking this consent, CDG may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that CDG reserves their right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the Code of Regulations. Should CDG change their notice, they will send a copy of any revised notice to the address I have provided either by US mail or email.

I wish to have the following restrictions to the use or disclosure of my health information:

_____

_____

I understand that as part of CDG's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax. I fully understand and accept / decline the terms of this consent.

_____
Signature of patient OR parent/guardian of minor child (consent) TODAY'S DATE __ / __ / __

(Optional) - I GIVE CDG MY CONSENT TO LEAVE ANY BIOPSY OR TEST RESULTS ON MY VOICEMAIL, ANSWERING MACHINE, OR WITH A FAMILY MEMBER:

_____
Signature of patient OR parent/guardian of minor child (consent)

(PATIENT PORTAL) - IF you share a family email account, please understand that members of your family will have access to your patient portal. Sign below that you understand and are agreeable to this:

_____
Signature of patient OR parent/guardian of minor child (consent)

2001 Crocker Road, Suite 500 || Westlake, Ohio 44145 || Phone: 440.617.1522 || Fax: 440.617.1523
29001 Cedar Road, Suite 305 || Lyndhurst, Ohio 44124 || Phone: 440.565.7773 || Fax: 440.459.2022