READING DERMATOLOGY
MEDICAL, COSMETIC & SKIN CANCER CENTER

PATIENT INFORMATION

Today's Date: ____ /____/____

_Mr. _Mrs. _Miss. _Ms. Marital Status: _Single _Married _Divorced _ Separated _ Widowed

Name:_____ Date of Birth: ____/____/_____ Age:___ Sex:__

First Last M.I

Address_____

Street City State Zip

Cell Phone:_____-____-_____ Home: _____-_____-_____ Email_____

Where did you hear about us? __Advertising __Word of Mouth __Web Search __Other

Primary Care Physician: _____Location:_____Phone: ____-____-____

Preferred Pharmacy:_____Location:_____Phone: ____-____-____

Do you have a living will or surrogate decision maker? Meaning, you have someone to make any medical decision for you if for any reason you are unable to.

Patient IS their own POA (Power of Attorney) __Yes __No

If no, Name of POA: _____ Phone:____-____-____

INSURANCE INFORMATION

Primary Insurance_____Subscriber ID#_____Spec Co Pay$____

Primary Card Holder __Self __Spouse __Parent _Other:_____

Primary Holder Name:_____DOB:____/____/____SSN:_____

Secondary Insurance:_____ Subscriber ID#_____

Primary Card Holder: __Self __Spouse __Parent __Other

Primary Holder Name:_____DOB:____/____/____SSN:_____

EMERGENCY CONTACT

Name:_____ Relationship to patient:_____Phone:____-____-___

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Reading Dermatology Associates or my insurance company to release information required to process my claims. All Services are provided by this medical practice either by one of our duly licensed medical professionals or by a trained assistant under the supervision and at the direction of one of our duly licensed medical professionals. No services provided by this medical practice are provided by an individual holding less than a registered nurse license unless such individual is being directed and overseen by another individual holding no less than a registered nurse license.

Signature of Patient or Authorized Guardian: _____Date: ____/____/_____

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Health Insurance Portability and Accountability Act (HIPAA)

Name:_____ DOB:____/____/_____

	Yes	No
May we leave medical information for you on your cell/home phone and/or answering machine?	____	____
Appointment reminders via text message?	____	____
Emails on appointment reminders/specials/promotions?	____	____
May we send medical information through mail?	____	____

With whom may we share privacy information regarding your care? Please list name(s) and contact information:

Name:_____Relationship:_____Phone:_____-_____-_____

Name:_____Relationship:_____Phone:_____-_____-_____

Name:_____Relationship:_____Phone:_____-_____-_____

Patient/Guardian Signature:_____Date:____/____/_____

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Notice of Privacy Practices

Patient Acknowledgement

Patient Name:_____DOB:_____/_____/_____

I have received and/or reviewed this practice's **Notice of Privacy Practices**. This Notice provides details about the uses and disclosure of my protected health information that may be needed by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with the respect to my information.

I understand that this practice reserves the right to change the terms of its **Notice of Privacy Practices** and to make any changes regarding all protected health information residing or controlled by this practice. I understand that I may obtain this practice's current **Notice of Privacy Practices** upon request.

Signature:_____Date:_____/_____/_____

Relationship to patient (if signed by a personal representative of the patient):

_____

Name _____ Gender _____ Age _____ Date of Appointment _____

Past Medical/Surgical History

Have you ever had any of the following?

- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anxiety Disorder
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ AIDS/HIV
- ☐ Bleeding Disorder
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Bone Marrow Transplant
- ☐ BPH (Benign Prostatic Hyperplasia)
- ☐ Bowel Disorder
- ☐ Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery
- ☐ Diabetes
- ☐ Depression
- ☐ Eating Disorder
- ☐ End Stage Renal Disease
- ☐ Epilepsy
- ☐ GERD (Acid Reflux)
- ☐ Hay Fever
- ☐ Hearing Loss
- ☐ Heart Disease
- ☐ Heart Problems
- ☐ Hepatitis –A, B, or C
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Joint Disorder
- ☐ Kidney Disorder
- ☐ Liver Disorder
- ☐ Lung Disease
- ☐ Lupus
- ☐ Measles
- ☐ Migraines
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Rheumatic Fever
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Skin Disorder
- ☐ Stroke
- ☐ Stomach Ulcer
- ☐ Substance Abuse
- ☐ Tuberculosis
- ☐ Valve Replacement
- ☐ Venereal Disease
- ☐ Other:

Surgical History:

- ☐ Basal Cell Cancer Surgery
- ☐ Joint Replacement: Hip [R, L, Bilateral]
- ☐ Mastectomy [R, L, Bilateral]
- ☐ Mechanical Valve Replacement
- ☐ Melanoma Surgery
- ☐ Skin Biopsy
- ☐ Squamous Cell Carcinoma Surgery
- ☐ Other:

Skin

Do you have any of the following?

- ☐ Abnormal Moles
- ☐ Acne
- ☐ Boils
- ☐ Bleed Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Cold Sores
- ☐ Dry/Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching and Flaking
- ☐ Psoriasis
- ☐ Rash
- ☐ Rosacea
- ☐ Scars
- ☐ Sores that won't heal

Have you ever had a biopsy for a suspicious growth?
☐ Yes ☐ No

When you are exposed to the sun do you:
☐ Tan Only ☐ Tan and Burn ☐ Burn Only

Have you visited tanning salons or do you sunbathe?
☐ Yes ☐ No

Do you regularly apply sunblock to exposed areas?
☐ Yes ☐ No If yes, which SPF? _____

Have you ever had skin cancer?
☐ Yes ☐ No If yes, what type? _____

When? _____ Where? _____

Do you have a family history of Melanoma?
☐ Yes ☐ No If yes, who? _____

Current Medications

Are you currently taking any blood thinners?
☐ Yes ☐ No

What medications are you currently taking?

_____
_____
_____
_____
_____

Allergies

Are you allergic to any of the following?

- ☐ Adhesive Tape
- ☐ Antibiotics
- ☐ Latex
- ☐ Barbiturates (Sleeping Pills)
- ☐ Aspirin
- ☐ Iodine
- ☐ Codeine
- ☐ Sulfa
- ☐ Local Anesthetics

Do you have any other allergies?

_____
_____
_____

Social History

Cigarette Smoking:

☐ Never ☐ Quit: Former smoker ☐ Smokes daily ☐ Smokes less than daily

Alcohol Use:
☐ Yes ☐ No

Occupation: _____

Language:
☐ English ☐ Spanish ☐ Other: _____

Race:
☐ White ☐ Black/African American ☐ Asian ☐ American Indian/Native American ☐ Native Hawaiian/Pacific Islander

Ethnicity:
☐ Hispanic/Latino ☐ Non-Hispanic/Latino

Vaccine:
☐ FLU: When? _____ ☐ PNEUMONIA When? _____

Family History

Please indicate which conditions exist or have existed by marking the boxes below:

	Mother	Father	Brother	Sister	Daughter	Son
Arthritis	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Heart Disease/Pacemaker	☐	☐	☐	☐	☐	☐
Hepatitis	☐	☐	☐	☐	☐	☐
Hypertension [High Blood Pressure]	☐	☐	☐	☐	☐	☐
Psoriasis	☐	☐	☐	☐	☐	☐
Skin Cancer	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

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FINANCIAL POLICIES AND PROCEDURES

Thank you for choosing us as your skin care provider. We are committed to providing you with quality and affordable health care. We understand you may have some questions regarding patient and insurance responsibility for services rendered and hope we can provide more understanding on this topic.

INSURANCE. We participate in most plans, including Medicare. If you are not insured by a plan we are contracted with, payment in full is expected at each visit. If you are insured by a plan we are contracted with, but do not have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage.

It is your responsibility to keep us updated with your correct insurance information. Upon arrival we ask that you come prepared to present your current insurance card and photo identification at every visit to verify that our office has the most updated card on file.

Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. Please call the telephone number on your insurance card before your appointment and they will assist you in finding out whether the service to be provided at the appointment is covered, what your copay is and what your deductible is. If your insurance does not cover the cost of your visit or procedure, you will be responsible for the charges for all services rendered.

CO-PAYMENTS AND DEDUCTIBLES. According to your insurance plan, you are responsible for any and all co-pays, deductibles, and coinsurances. All co-payments and deductibles must be paid for at the time of service.

We accept checks, cash, Care credit and all major credit cards.

An additional $30.00 fee will be charged for any checks returned for insufficient funds or any other reason the check would be declined. Checks will no longer be permitted as a method of payment if there is a history of returned checks.

NON-COVERED SERVICES. Please be aware that some, and perhaps all, of the services you receive may be non-covered or not considered medically necessary by your insurance company. You must pay for these services and any cosmetic procedures in full at the time of visit.

ELECTIVE PROCEDURES/NON_COVERED PROCEDURES Patients are required to pay the estimated self-pay portion of elective/non covered procedures prior to services being rendered.

UNINSURED/SELF-PAY patients are expected to pay for services in full at the time of each visit.

PROOF OF INSURANCE. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

CLAIMS SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. The balance becomes your responsibility if no payment is received from the insurance company.

REFERRALS: If your insurance carrier requires a referral or authorization for your visit, it is your responsibility to make sure that out office receives current valid authorization. If you do not have a valid referral or authorization at the time of service, we will be unable to treat you until a valid authorization/referral is obtained, and you may be sent back to your primary care physician to obtain authorization prior to being treated or full payment will be expected at the time of service. Please remember to notify a staff member if your insurance prefers a specific lab. We appreciate your understanding of the ever-changing requirements of managed care plans and our position to adhere to their policies or requirements.

COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

APPOINTMENTS: All children under the age of 18 must be accompanied by an adult that has authority to make health care decisions and authority to sign necessary forms. If parent/guardian cannot be present an **Authorization to Treat Minor Patient in Absence of Parent/Guardian form** must be provided. You may print the form from our website by going to readingderm.com and selecting *Patient Forms* or you may send a note stating that Reading Dermatology may treat the patient as deems necessary and appropriate otherwise the visit will have to be rescheduled.

MISSED APPOINTMENTS We understand that you may not be able to keep all of your scheduled appointments or might occasionally be late. Please understand that missed appointments have a detrimental impact on our practice and other patients. They also affect our ability to serve other patients in need of medical care. We understand there may be inclement weather or other circumstances that may require you to cancel your appointment. If you must cancel or reschedule your appointment, please do so at least 24 hours in advance. Failure to cancel or reschedule an appointment at least 24 hours in advance will be considered a no-show. We reserve the right to charge you $50.00 for any no-show If permitted by law and your insurance contract. Payment of the missed appointment will be required prior to scheduling another appointment. Reading Dermatology Associates, reserves the right to terminate any patient with more than two no-show appointments upon 30 days written notice to the patient to seek medical help from another practice.

If you are running late on the day of your appointment due to unforeseen circumstances, please contact our office immediately so that we can determine whether we can see you that day or if we will need to reschedule your appointment. If you are more than 15 minutes late. For an appointment, Reading Dermatology, may reschedule your appointment and refuse to see you at the originally scheduled time.
Cosmetic procedure deposits are **nonrefundable** unless a (5) day notice is given prior to your appointment. Any cancellation thereafter forfeits your deposit.
FORMS. We may bill $20 for forms or letters that a provider completes on your behalf. FMLA, Disability, and Supplemental insurance forms.

Copies of records for personal use will be charged the allowed fee by the Commonwealth of Pennsylvania.

ASSIGNMENT OF BENEFITS
I request that payment of authorized Medicare, Medicaid and commercial insurance benefits be made on my behalf to the name of provider service and (or) supplier for any services furnished to me by that provider of service and (or) supplier. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents, or any other insurer and its agents, any information needed to determine these benefits payable for related service.

I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health/medical plan, to issue payment check(s) directly to Reading Dermatology Associates, for medical services rendered to myself and/or my dependents regardless of my insurance benefits, if any. I understand that I am responsible for any amount not covered by insurance or this assignment.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize Reading Dermatology Associates: (1)release any information necessary to insurance carriers regarding my illness and treatments; (2) process insurance claims generated in the course of examination or treatment; and (3) allow a photocopy of my signature to be used to process insurance claims for all services provided to me by Reading Dermatology Associates. This order will remain in effect until revoked by me in writing.

I have read and understand the office policy and agree to abide by its guidelines:

Name of patient or responsible party (PRINT):

_____

Signature of patient or responsible party:

_____ Date: _____