Mobile Dermatology

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Patient Name _____ Date of Birth:_____

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

Phone:_____email:_____

Primary Insurance:_____ Policy ID #:_____

Primary Policy Holder:_____Policy Holder Date of Birth:_____

Secondary Insurance:_____ Policy ID #:_____

Secondary Policy Holder:_____Policy Holder Date of Birth:_____

1. CONSENT TO TREAT: I hereby authorize the providers of Mobile Dermatology, P.C. to examine me/the patient named below and to furnish such diagnostic, therapeutic, and surgical services as deemed necessary and appropriate by my provider. If I am authorizing on behalf of someone other than myself, such examination, procedures and services may be provided in my absence.
2. ASSIGNMENT AND RELEASE: I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including cosmetic services and those amounts not paid by my insurance company. Also, if necessary, I authorize the release of my medical records to my insurance carrier to determine payment for medical services. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that I will be charged for, and hereby agree to pay, all costs and expenses incurred in collecting any past due fees, and interest as allowed by law.

3. OFFICE POLICIES:

-Cancellation policy: We require 24 hour notice when cancelling or rescheduling appointments. Failure to do so may result in a $50 fee for standard appointments and a $100 fee for procedure appointments. Any patient who is late for their appointment may be asked to reschedule.
-Referral Policy: It is the patient's responsibility to ensure that any required referrals are current BEFORE the scheduled appointment time.
-Co-Payments and Deductibles: Co-pays and Deductibles must be paid at the time of check-in.
-Insurance Re-billing Charge: If incorrect or outdated insurance information provided by the patient results in multiple insurance claim filings, there may be an additional $25.00 charge applied to the patient's account. If the correct insurance information is not obtained before the insurance company's filing deadline, then the patient will be responsible for the entire cost of the visit.
-Refill Policy: A follow-up visit may be required for prescriptions that are over a year old.
-Returned Check Policy: There is a $30.00 processing fee for returned checks.
-Late Payment Fee: A $35.00 late fee will be added to all accounts that are more than 90 days delinquent.
-Patient Dismissal: Mobile Dermatology, PC reserves that right to terminate patients from the practice. Reasons for termination may include, but are not limited to, disruptive and abusive behavior, non-payment, failure to follow clinical advice or treatment, and failure to keep follow up appointments.

The undersigned, who is the patient or the patient's spouse, parent or guardian, agrees to all of the terms set forth herein. This agreement shall remain valid for all subsequent visits and all services after this date unless expressly revoked. I have read this document or it has been read to me. I understand and voluntarily accept its terms. If I am signing for someone else, I certify that I have the authority to do so.

Patient Name:_____ Date of Birth: _____

Signature: _____ Date: _____

Patient Representative Name: _____

Representative Signature: _____ Date: _____

Patient Name _____ Date of Birth:_____

HIPAA - Health Information Privacy Policy

This document acknowledges that you were offered a copy of our Notice of Privacy Practices and Notice of Nondiscrimination and Accessibility. A paper copy is available from the receptionist for your review during regular office hours. You may also request a copy by calling 251-635-1315.

Name:_____ Date of Birth: _____

Signature: _____ Date:_____

Individual was unable to sign because of the following reason:

☐ Patient left without being seen by a provider

☐ Patient unresponsive

☐ Patient refused to sign

Signature of Mobile Dermatology representative:

_____ **Date:**_____

Personal Health Information / Patient Portal Release

I hereby give Mobile Dermatology permission to share my Personal Health Information with the following individual(s):

Name: _____ Relationship:_____

Phone:_____

Name: _____ Relationship:_____

Phone:_____

Name: _____ Relationship:_____

Phone:_____

☐ I do **Not** wish to share My Personal Health Information

☐ I do **Not** wish to communicate through my Patient Portal

☐ I want be notified that new results have been posted my patient portal using this email address:_____

☐ Please use the email address below for my patient portal notifications

_____

Signature: _____ Date: _____

PATIENT NAME _____ DATE OF BIRTH:_____

CREDIT CARD ON FILE POLICY

By signing below:

- I understand and agree to all of the terms of Mobile Dermatology's Credit Card on File Policy.
- I authorize Mobile Dermatology to keep my signature and valid credit card number securely on file.
- I agree to allow Mobile Dermatology to automatically charge my credit card for any outstanding balance, including but not limited to insurance denials for any reason, deductibles, co-insurances, partially paid claims, and any other charge my insurance carrier (or the insurance carrier that covers any individual whose payment of services I have accepted responsibility for, including as applicable my spouse, children, or other related party) has not or I have not already paid.
- I agree to allow Mobile Dermatology to charge my credit card if my insurance company delays or denies payment of any services Mobile Dermatology provides.
- I agree to promptly give Mobile Dermatology information for a new, valid credit if the credit card I have on file is expired, cancelled, or otherwise cannot be charged.
- I agree to give Mobile Dermatology correct contact information and to promptly update my contact information if any changes.
- I agree to allow Mobile Dermatology to contact me through any of the following means: by mail, by email, by telephone call.
- I understand and agree that Mobile Dermatology will use the contact information I provide and that is it my responsibility to control who has access to my mail, email, and telephone.
- I understand and agree that this authorization, including all the terms above, will continue to remain valid unless and until I cancel this authorization by providing Mobile Dermatology written notice that I am cancelling this authorization.

☐ I Do Not Wish to Leave my Credit Card Information on File

_____ _____

Signature of Patient/Guardian & Credit Card Holder | Date

_____ _____

Print Name of Person Signing Above | Relationship to Patient (if not Patient)

MOBILE DERMATOLOGY MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____ Date filled out: _____

Preferred phone number for test results: _____

Email address (to activate your patient portal): _____

Preferred Pharmacy: _____

» **MEDICATIONS:** ☐ No medications

• *If you have a medication list, please give it to the receptionist to be copied instead of writing them down.*

» **ALLERGIES TO MEDICATIONS:** ☐ No allergies

Do you now have, or have you ever been diagnosed with any of the following conditions: (CHECK IF YES)

❑ Anxiety	❑ Diabetes	❑ Leukemia
❑ Arthritis	❑ End stage kidney disease	❑ Lung cancer
❑ Artificial Joint	❑ Heartburn/Acid reflux	❑ Lymphoma
❑ Asthma	❑ Hearing loss	❑ Pacemaker
❑ Atrial fibrillation	❑ Hepatitis B /C (circle one)	❑ Defibrillator
❑ Breast cancer	❑ High blood pressure	❑ Prostate cancer (males)
❑ Colon cancer	❑ HIV / AIDS	❑ Seizures
❑ COPD	❑ High cholesterol	❑ Stroke
❑ Coronary artery disease	❑ Hyperthyroid (high)	❑ Valve replacement (heart)
❑ Depression	❑ Hypothyroid (low)	❑ ***None of these***

»***Other Medical Problems/Surgeries***: _____

»***Gynecology: (Females only):*** Pregnant or planning pregnancy ❑YES ❑NO ***Due Date:*** _____

»Do you have any problems with your ***immune system***? ❑YES ❑NO

»Do you have a history of developing ***thick scars/keloids***? ❑YES ❑NO

»Have you ever had skin cancer? ☐ YES ☐ NO ☐ Not Sure

If yes, check what type(s): ☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ Not sure

»***Family History:*** Do any of your ***first degree relatives*** *(Parents, siblings or children)* have a history of:
Melanoma? ❑YES Relationship: ❑Mother ❑Father ❑Brother ❑Sister ❑Son ❑Daughter

»***Social History:*** Do you use or have you used tanning beds? ❑YES ❑NO

Do you drink alcohol? ❑YES ❑NO----------*If yes*, _____drinks per day
Do you smoke? ❑YES ❑Quit ❑NO --------*If yes*, _____packs per day