WEST VIRGINIA DERMATOLOGY & SKIN SURGERY CENTER

PATIENT INFORMATION:

DATE:_____

Patient Name: _____ Gender:_____ DOB: _____

Address: _____ Preferred Phone _____ Other Phone _____

SSN: _____ Occupation: _____

Employer: _____ Address: _____ Phone#: _____

REFERRAL INFORMATION:

Who referred you to our practice? _____

Who is your Primary Care Physician?_____

Primary Care Physician Address: _____ Phone: _____

INSURANCE INFORMATION:

Primary Insurance: _____ **Secondary Insurance**: _____

Name of Insured: _____ Name of Insured: _____

Insured DOB: _____ Relationship: _____ Insured DOB: _____ Relationship:_____

Subscriber Social Security Number:_____ Subscriber Social Security Number: _____

ID#_____Group#_____ ID#_____Group#_____

EMERGENCY CONTACT:

Name: _____ Relationship:_____

Phone: (H)_____ (Cell)_____ (W)_____

PHARMACY INFORMATION:

Pharmacy Name:_____ Phone:_____

Address:_____

WEST VIRGINIA DERMATOLOGY & SKIN SURGERY CENTER

NAME:_____

DOB:_____

Please read the following statement carefully and sign below:

All of the information that I have provided on the patient information forms is true and complete. The signature below will also be used as a "signature on file" for insurance purposes including any medical information necessary to process relevant claims.

I hereby authorize all physicians and staff at West Virginia Dermatology & Skin Surgery Center, PLLC to administer any treatment or to administer such anesthetics and to perform such procedures as may be deemed necessary or advisable for my diagnosis and treatment.

I hereby assign my insurance benefits to be paid directly to West Virginia Dermatology & Skin Surgery Center, PLLC. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims.

I certify that the insurance information I have provided above is accurate and that the coverage I have listed above is currently active and not expired. I have read the West Virginia Dermatology & Skin Surgery Center, PLLC's Financial Policy Statement and agree that I am ultimately responsible for all non-covered services.

Printed Name: (First, Middle, Last):_____

Signature: _____Date:_____

WEST VIRGINIA DERMATOLOGY & SKIN SURGERY CENTER

NAME:_____

DOB:_____

FINANCIAL DISCLOSURE POLICY

Thank you for choosing our office for your care. In order to reduce any confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have questions regarding this policy, please discuss them with our office manager at 304-925-SKIN (7546). We are dedicated to providing the best possible care and service to you and regard your complete understanding of this policy as an essential element of your care and treatment.

- Your insurance policy is a contract between you and your insurance company only. If you fail to notify us of an insurance change, you are fully responsible for any amount not paid by your insurance company.
- It is your responsibility to be aware of your deductibles, co-payments, and co-insurance, and it will be your obligation to remit all appropriate payments as outlined in your insurance policy.
- If you have out-of-network benefits we will be happy to assist you with filing the claim. Therefore, our charges for your care and treatment are due at the time of service. In the event your health plan determines a service is "not covered," "not medically necessary" or a "cosmetic procedure" you will be responsible for the complete charges.
- For service rendered to minor patients, the accompanying parent or guardian is responsible for payment.
- Although benefits may be verified at the time of service, please note this is NOT a guarantee of payment.
- Patient balances are due within 30 days of receipt of statements. At that point, additional charges may be applied. We will work with you to make payment arrangements. If these efforts do not result in resolution of the account, the account may be referred to a collection agency; you will be responsible for any and all fees charged by the collection agency. These fees will be added to your account.
- If your insurance plan denies payment for any reason, you will be responsible for payment. It is your responsibility as the patient to pay the denied amounts in full.
- If you need laboratory services (pathology, wound culture), you will receive a separate bill from the pathology laboratory for said tests.

24 HOUR CANCELLATION POLICY:

We kindly ask that you give us 24-hour notice if cancellation is necessary. ***If you do not show for your appointment or cancel with less than 24 hours notice, you will be charged a no-show fee of $25 for missed office visits or $150 for missed surgery or procedure appointments.*** This fee is not covered by your insurance company.
****If you have 2 No Show appointments the physician-patient relationship will be terminated. We will forward your medical records to another physician once written request is received from you.**

PAYMENT POLICY:

It is my responsibility to confirm that the physician is a covered provider under my insurance plan. I hereby authorize the assignment of benefits (payments) directly to West Virginia Dermatology & Skin Surgery Center for all my insurance claims related to services received. I understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract and non-covered services. I have read, understood, and agree to the financial and cancellation policies above.

Printed Name: (First, Middle, Last):_____

Signature: _____Date:_____

WEST VIRGINIA DERMATOLOGY & SKIN SURGERY CENTER

NAME:_____

DOB:_____

RECORDS RELEASE:

I authorize the release of any medical information necessary to my primary care or referring physician and to consultants as necessary. I authorize the release of any necessary medical information in order to process insurance claims, insurance applications, and prescriptions. I also authorize payment of medical benefits to West Virginia Dermatology & Skin Surgery Center. I permit a copy of this authorization to be used in place of the original.

TELEPHONE INFORMATION & COMMUNICATION RELEASE:

- May we leave personal medical information on your answering machine or cell phone? ☐YES ☐NO

  If yes, please check all that we may leave information on: ☐HOME ☐ CELL ☐WORK

- May we e-mail personal medical information to you? ☐ YES ☐NO

  E-mail address:_____

- May we use email and/or text messaging for appointment reminders? ☐YES ☐NO

  Preferred e-mail and/or text number:_____

- Do you give our office permission to discuss your medical information with family members? YES NO
  If yes, please provide their information below.

I authorize West Virginia Dermatology & Skin Surgery Center to disclose and/or release my medical information pertaining to my diagnosis and/or treatment, laboratory results, medical history, or any such related information these listed below (physician, family member):

Name	Phone #	Relationship to patient
Name	Phone #	Relationship to patient
Name	Phone #	Relationship to patient

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

Printed Name: (First, Middle, Last):_____

Signature: _____**Date:**_____

WEST VIRGINIA DERMATOLOGY & SKIN SURGERY CENTER

NAME:_____

DOB:_____

PAST MEDICAL HISTORY (please circle all that apply)

Anxiety	Hepatitis
Arthritis	High Blood Pressure
Artificial Joints	HIV/AIDS
Asthma	High Cholesterol
Atrial Fibrillation	Hyperthyroidism
Enlarged Prostate	Hypothyroidism
Bone Marrow Transplantation	Leukemia
Breast Cancer	Lung Cancer
Colon Cancer	Lymphoma
COPD	Pacemaker
Coronary Artery Disease	Prostate Cancer
Depression	Radiation Treatment
Diabetes	Seizures
End Stage Renal Disease	Stroke
GERD	Valve Replacement
Hearing Loss	NONE

Other:_____

PAST SURGICAL HISTORY (please circle all that apply)

Appendix Removed	Kidney Biopsy
Bladder Removed	Kidney Removed (Right, Left)
Mastectomy(Right, Left, Bilateral)	Kidney Stone Removal
Lumpectomy(Right, Left, Bilateral)	Kidney Transplant
Breast Biopsy(Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Reduction	Ovaries Removed: Cyst
Breast Implants	Ovaries Removed: Ovarian Cancer
Colectomy: Colon Cancer Resection	Prostate Removed: Prostate Cancer
Colectomy: Diverticulitis	Prostate Biopsy
Colectomy: IBD	TURP
Gallbladder Removed	Skin Biopsy

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PAST SURGICAL HISTORY (please circle all that apply)

Coronary Artery Bypass	Basal Cell Cancer Surgery
Stents	Squamous Cell Carcinoma Surgery
Mechanical Valve Replacement	Melanoma Surgery
Biological Valve Replacement	Spleen Removed
Heart Transplant	Testicles Removed (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Uterine Cancer
Joint Replacement within last 2 years	NONE

Other:_____

SKIN DISEASE HISTORY (please circle all that apply)

Acne	Hay Fever/Allergies
Actinic Keratoses	Melanoma
Asthma	Poison Ivy
Basal Cell Skin Cancer	Precancerous Moles
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	NONE
Flaking or Itchy Scalp	

Other:_____

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF?_____

Do you tan in a tanning salon? ☐ Yes ☐ No

FAMILY HISTORY (Please circle all that apply to Mother/Father, Brother/Sister)

Melanoma	Hypertension	High Cholesterol	Cancer: _____
Diabetes	Hyperthyroidism	Hypothyroidism	Stroke
Heart Disease	Kidney Disease	Autoimmune Disorders	

WEST VIRGINIA DERMATOLOGY & SKIN SURGERY CENTER

NAME:_____

DOB:_____

Height: _____Weight:_____ Blood Pressure (most recent):_____ /_____

MEDICATIONS: (please enter all current medications including <u>dosage</u> and <u>frequency</u>)

_____
_____
_____
_____
_____
_____
_____
_____

Have you received a flu shot within the last 12 months? ☐ Yes ☐ No

Have you received the pneumonia vaccine? ☐ Yes ☐ No

DRUG ALLERGIES: (please enter all allergies)

_____
_____
_____

SOCIAL HISTORY: (please circle all that apply)

Cigarette Smoking:
- Never Smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily

Alcohol Use:
- Alcohol: None
- Alcohol: less than 1 drink a day
- Alcohol: 1-2 drinks a day
- Alcohol: 3 or more drinks a day

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NAME:_____

DOB:_____

REVIEW OF SYSTEMS: Are you currently experiencing any of the following? (please check yes or no for the following)

Symptom	Yes	No
Problems with bleeding		
Problems with healing		
Problems with scarring		
Rash		
Immunosuppression		
Hay fever		
Chest pain		
Fever or chills		
Night sweats		
Unintentional weight loss		
Thyroid problems		
Sore throat		
Blurry vision		
Abdominal pain		
Bloody stool		
Bloody urine		
Joint aches		
Muscle weakness		
Neck stiffness		
Headaches		
Seizures		
Cough		

Shortness of breath/Wheezing		
Anxiety/Depression		

Other Symptoms:_____

ALERTS: Are you currently experiencing any of the following? (please check yes or no for the following)

Alert	Yes	No
Allergy to adhesive		
Allergy to lidocaine		
Allergy to topical antibiotic ointments		
Artificial heart valve		
Artificial joints within past 2 years		
Blood thinners		
Defibrillator		
MRSA		
Pacemaker		
Premedication prior to procedure		
Rapid heartbeat with epinephrine		
Personal history of melanoma		
Pregnancy or planning a pregnancy		
Perforated ear drum		

Other Symptoms: _____

_____