Intake and History Form

Name: _____Date of Birth: _____ Date: _____

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ None
- ☐ Anxiety disorder
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bipolar disorder
- ☐ Blood coagulation disorder
- ☐ Cerebrovascular accident
- ☐ Chronic obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depressive disorder
- ☐ Diabetes mellitus
- ☐ Disease caused by 2019-nCoV
- ☐ Elevated blood pressure
- ☐ End-stage renal disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Guillain-Barre syndrome
- ☐ H/O: Deep vein thrombosis
- ☐ H/O: asthma
- ☐ H/O: hay fever
- ☐ H/O: hypertension
- ☐ H/O: migraine
- ☐ H/O: thyroid disorder
- ☐ H/O: tuberculosis
- ☐ Hepatitis B virus
- ☐ Hepatitis C visus
- ☐ Human immunodeficiency virus infection
- ☐ Hypercholesterolemia
- ☐ Inflammatory bowel disease
- ☐ Inflammatory disease of liver
- ☐ Leukemia
- ☐ Malignant lymphoma
- ☐ Malignant tumor of breast
- ☐ Malignant tumor of lung
- ☐ Malignant tumor of prostate
- ☐ Multiple sclerosis
- ☐ Parkinson's disease
- ☐ Radiation therapy treatment management
- ☐ Other:

_____
_____
_____

Past Surgical History

Have you had any surgeries?

- ☐ None
- ☐ H/O: tubal ligation
- ☐ History of colectomy
- ☐ Hysterectomy
- ☐ Mechanical heart valve replacement
- ☐ Oophorectomy
- ☐ Splenectomy
- ☐ Total replacement of left hip joint
- ☐ Total replacement of left knee joint
- ☐ Total replacement of right hip joint
- ☐ Total replacement of right knee joint
- ☐ Transplantation of heart
- ☐ Transplantation of liver
- ☐ Other_____

_____

Intake and History Form

Skin Disease History

Have you had any of the following?

Skin Conditions

- ☐ None
- ☐ Acne
- ☐ Actinic keratosis
- ☐ Basal cell carcinoma of skin
- ☐ Dysplastic nevus of skin
- ☐ Eczema
- ☐ Malignant melanoma
- ☐ Psoriasis
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ Other

_____

_____

Skin Protection

Do you wear Sunscreen?

Yes No

If yes, what SPF? _____

Do you tan in a tanning salon?

Yes No

Family History of Melanoma

Do you have a family history of Melanoma?

Yes No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Uncle
- ☐ Aunt
- ☐ Nephew
- ☐ Niece
- ☐ Grandmother
- ☐ Grandfather
- ☐ Grandson
- ☐ Granddaughter
- ☐ Other

_____

_____

Medications

List all current medications:

_____

_____

_____

_____

Allergies

List all allergies and reactions if known:

_____

_____

_____

_____

Intake and History Form

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy _____

Quit Smoking:

- mm/dd/yyyy _____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (please choose one):

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

What is your caffeine use?

- ☐ Unspecified
- ☐ Several times a day
- ☐ Once a day
- ☐ A few times a week
- ☐ A few times a month
- ☐ Never
- ☐ Other

_____

Occupation and Workplace:

_____

_____

Place of Residence:

_____

_____

Family History

Please include only first-degree relatives:

_____

_____

_____

Alerts

Add any alerts such as planning pregnancy

_____

_____

_____

QUALDERM PARTNERS™
A SKIN & AESTHETICS WELLNESS FAMILY

Treatment of Minors

Patient Name: _____

Thank you for entrusting the dermatology care of your child to our practice. From time to time there are situations in which a parent/guardian cannot attend the appointment with their child. **Please choose the most suitable option(s) below that meets your wishes for the care of your minor patient, in the event you are not present:**

☐ As the parent/guardian of the above stated patient, **I allow the minor (16+) to attend appointments without my physical presence**. I understand this authorization is valid unless otherwise revoked. I acknowledge that all surgical appointments would require the physical presence of a parent/guardian. The minor may consent to participation in the routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.). I understand there may be instances in which the provider chooses to schedule the necessary treatment at a future date if my physical presence is deemed to be necessary.

☐ As the parent/guardian of the above stated patient, my child may attend appointments without me (legal guardian), however they may not attend alone. **My child may attend the appointment with the below individuals and the adult may consent to treatment on my behalf**. This treatment includes routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.) and may also consent to surgical procedures within the office.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

☐ As the parent/guardian of the above stated patient, I **DO NOT give consent for the patient to attend appointments without a parent/guardian** present at the appointment.

☐ The minor may attend an appointment without a parent/guardian/other adult, but I request to provide **verbal authorization before the appointment**. The patient may consent to participation in the routine office exam, receipt of prescriptions, and minor procedures (such as wart removal, simple excisions, etc.) once my verbal consent is given. I understand there may be instances in which the provider chooses to schedule the necessary treatment at a future date if my physical presence is deemed to be necessary.

Please note that both parents are considered legal guardians and may seek treatment/authorize treatment for the minor. If you have a court order indicating that a parent may not make these decisions for the patient, it is important that we receive a copy of this documentation for the patient's record.

The above treatment plan will remain in effect unless otherwise revoked and/or until the child turns 18. I understand that the Guarantor is financially responsible for any treatment provided.

Signature_____ Relationship: _____

Today's Date: _____

Office Use Only:

Verbal Authorization obtained for DOS _____ Parent/Guardian Authorizing: _____

Employee Witness 1: _____ Employee Witness 2: _____

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Financial Policy, Consent, and HIPAA Acknowledgement

Patient Name: _____

Today's Date: _____

- **Insurance Billing**: I consent for the practice to bill my insurance company according to the most recent insurance information and insurance card(s) including, Medicare and Medicaid Advantage Plan cards, that I have provided. I understand that all payment of all balances is my responsibility, including co-pays, co-insurance amounts, deductible amounts and services that are not covered by my insurance plan (such as cosmetic services). I understand that if claims are denied due to lack of current insurance information, I will be responsible for the balance.
- **Insurance Network:** I understand that it is my responsibility to ensure that this practice and the provider of services are in my insurance network and to obtain any referrals or authorizations required by insurance plan. If my claim is denied because I am out of network or failed to obtain a referral or authorization, I understand that I will be responsible for the balance.
- **Co-payment:** I understand all co-payments must be paid at the time of service. I understand co-payment and co-insurance are determined by my insurance. The practice accepts cash, check, Visa, MasterCard, American Express, Discover and Care Credit.
- **Deductible:** An annual deductible is the dollar amount I must pay out of pocket during the year for medical expenses before my insurance begins to pay.
- **Credit Card on File:** For any prearranged payment plans, the practice will keep credit cards on file (CCOF). We do not keep any credit card information on file in the office or on any of our computers. We use a secure, encrypted gateway that is completely compliant as required by law.
- **Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is available for subsequent visits. All co-pays or monies due are expected to be paid at the time of each service.
- **Determining Guarantor:** The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if they are over the age of 18. The guarantor for a minor child is the parent that presents the child for care at the time of the initial visit.
- **Self-Pay**: I understand and agree that if I do not have insurance or opt out of insurance coverage if permitted and elect to be seen as a self-pay patient, I have full financial responsibility for my visits and will pay for all services at the time of service, unless other arrangements have been made. I understand I will be subject to and will abide by the practice's self-pay policy. This agreement will remain in effect unless proof of insurance is provided at a subsequent date.
- **Good Faith Estimates:** If I am uninsured, or if I request that covered services not be billed to insurance, I understand that I may request a Good Faith Estimate of the total fees that I may be charged and that fees for all services must be paid on the date that services are rendered.
- **Past Due Balances:** I understand that if my account is over 90 days past due, this practice will send a statement and I will have 20 days in which to pay the balance in full. Partial payments will not be accepted unless previously negotiated. I understand that if the balance remains unpaid this practice may refer my account to a collection agency and/or I may be dismissed from this practice.
- **Late Arrivals or Missed Appointments:** I am aware that if I am late to my appointment I may be rescheduled. I also understand that multiple missed appointments without adequate notice and/or late arrivals may result in my dismissal from the practice. If I am unable to keep my appointment, I will notify this office at least 24 hours in advance. I understand failure to provide 24-hour notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. The no-show fee is $50 for a Monday-Friday non-surgical medical visit and $100 for a Saturday non-surgical medical appointments. The no-show fee for cosmetics is $100 for a cosmetic consultation and $250 for a cosmetic procedure. The no-show charge for surgery related appointments, including a Mohs surgery, is $250. No-show charges are not billable to my insurance.

- **Prescription History:** I authorize this practice to request prescription history information electronically from my local pharmacy(ies) for the purpose of providing direct health care services unless otherwise revoked.
- **HIPAA Disclosure and Notice of Privacy Practices:** I consent for this practice to release information to my insurance company, primary care/referring physician, and any other covered entities in accordance with the HIPAA Privacy Act. I understand that medical information disclosed may be used and forwarded to provide continuing treatment or care, for filing claims, and for all other healthcare operations. I have received this practice's Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have had the right to review such notice prior to signing this consent form.
- **Use of my Contact Information.** I understand the practice may use my information to contact me regarding my treatment and payment, including through voicemail messages, text messages, and email, and for appointment reminders, billing matters, and test results (for benign test results, a message may be left stating such). I understand I can revoke this authorization at any time in writing to the practice.
- **Disclosure of Information to Others:** I authorize for the practice to contact the following person as my emergency contact: Name: _____ Telephone: _____
  Additionally, I voluntarily and at my discretion authorize the practice to verbally discuss my scheduling/appointment information, billing and payment information, prescriptions and refills, laboratory and test results (except HIV or genetic testing), and medical information (but not mental or behavioral health information), including my symptoms, diagnosis, medications and treatment plans with the below persons. I understand I have the right to revoke this consent, in writing, except where the practice has already made disclosures in reliance on my prior consent. I understand that I am responsible for notifying the practice if there are changes to those that may participate in my care. This form does not authorize releasing copies of my medical records to the persons below.

Name	Telephone Number	Relationship to Patient
_____	_____	_____
_____	_____	_____
_____	_____	_____

My signature indicates that I have been given the opportunity to review this information, ask questions and have had my questions answered. I understand that I am financially responsible for all services as described in this consent form.

_____
Patient Signature

_____
Patient Date of Birth

QUALDERM PARTNERS™
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Treatment of Minors

Patient Name: _____

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Signature_____ Relationship: _____

Today's Date: _____

Office Use Only:

Verbal Authorization obtained for DOS _____ Parent/Guardian Authorizing: _____

Employee Witness 1: _____ Employee Witness 2: _____