MOHS SURGERY & DERMATOLOGY

PATIENT CONSENTS, POLICIES AND RESPONSIBILITIES

**Consent for Treatment:** In presenting myself for treatment at Mohs Surgery & Dermatology Center, I give my consent to Dr. Suleman J Bangash, Dr. John W Cox, Dr. Matthew J. Fanelli, Jacob Klaustermeier, PA-C, Chelsy Kimes, PA-C, and all agents under their direction, for treatment, medical and surgical, as recommended and directed by the above-listed providers.

**Consent to Treat a Minor Patient:** All minors (under age 18) must be accompanied by a parent or legal guardian at their first visit. At that time parent or legal guardian may sign a release allowing patient to present him/herself for treatment unaccompanied by parent or legal guardian.

**Privacy Policy:** Mohs Surgery & Dermatology Center maintains complete compliance with all HIPAA regulations regarding privacy and protection of patient medical and financial information. In accordance with HIPAA guidelines, presentation of your insurance card as payment for your services, allows Mohs Surgery & Dermatology Center permission and authorization to file claims electronically and to release private medical information concerning your claims to your insurance company. You will be presented with a copy of our HIPAA privacy policy at your first visit to our office.

**Release of Medical Records:** Medical records are released to other medical providers in accordance with HIPAA guidelines concerning continuity of care. There is a $15 charge for processing and copying records, at the patient’s request, for any reason other than continuing care as directed by a provider in this office.

**24 – Hour Notice:** We require a 24-hour notice of appointment cancellation. A $35 fee will be charged for late cancellation or failure to keep your scheduled appointment.

**Assignment of Benefits:** My signature below gives full assignment of my insurance benefits for my treatment to Mohs Surgery & Dermatology Center

**Financial Policy:** My signature below attests that I have read, understand and accept responsibility for compliance with the Financial Policy of Mohs Surgery & Dermatology Center:

1. Full payment is expected at the time of service unless we are contracted with your insurance company. We accept cash, checks, debit cards, and all major credit cards.

2. Insurance copays are due at the time of service.

3. Balances after insurance processing of your claim are due within 30 days. This balance may include, and not limited to, deductibles and co-insurance. Any patient balances over 30 days are considered past due.

4. Past due balances requiring collection activity will be subject to a charge equal to 30% of the full balance.

5. $25.00 will be charged to your account for any check returned to us by your bank.

___________________________  ______________________________  ______________
Patient Name                  Signature of Patient/Parent/Guardian                   Date
Mohs Surgery and Dermatology Center

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION AND DESIGNATION OF PERSONAL REPRESENTATIVE

With your consent, MOHS SURGERY AND DERMATOLOGY CENTER may use and disclose protected health information (PHI) about you to carry out treatment, payment and health care operations (TPO). Please refer to our Notice of Privacy Practices for a more complete description of such uses and disclosures. You have the right to review our Notice of Privacy Practices prior to signing this consent. We reserve the right to revise our Notice of Privacy Practices at any time.

With your consent, MOHS SURGERY AND DERMATOLOGY CENTER may call your home or office and leave a message in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items and any call pertaining to your clinical care.

With your consent MOHS SURGERY AND DERMATOLOGY CENTER may mail to your home or office any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements.

You have the right to request that we restrict how we use or disclose your PHI to carry out treatment, payment and health care operations. However, we are not required to agree to your requested restrictions, but if we do, we are bound by our agreement.

By signing this form, you are consenting to our use and disclosure of your PHI to carry out treatment, payment and health care operations. This consent may be revoked in writing except to the extent that we may have already made disclosures in reliance upon your prior consent. **If you decline to sign this consent, we may decline to provide treatment for you.**

Signed (Patient or representative)  Patient’s date of birth

Printed name  Date

As required by the Health Insurance Portability and Accountability Act of 1996 you have a right to nominate one or more persons to act on your behalf with respect to the protection of health information that pertains to you. By completing this form you are informing us of your wish to designate the named person as your personal representative. You may revoke this designation at any time by signing and dating the revocation of your copy of this form and returning it to this office.

DESIGNATION SECTION

I, ____________________________ (print name), hereby nominate the following person to act as my personal representative with respect to decisions involving the use and/or disclosure of health information that pertains to me. This person may receive information regarding my health care treatment.

Print name of personal representative  Signed (Patient)

REVISED 01.01.0909
CONFIDENTIAL PATIENT INFORMATION

Name_________________________________________ Today’s Date ______________

Last                                                                                          First                                                MI

Birthdate_______________________ M___F___     Patient’s SS# __________________________

Address ____________________________________________________________

Home Phone (___)_________________ Work Phone (___)_________________ Cell Phone (___)__________

Race___________________ Ethnicity _______________ Primary Language __________________________

Email Address __________________________________________ Preferred Method of Contact □ phone □ email □ text

Alternate Contact: __________________________________________ Relationship: _______________ Phone __________________

(Different than Patient’s Home #)

Employer (Parent’s if minor) ______________________________________________________________

Employer Address ______________________________________________________________

Responsible Party (if patient is under 18) __________________________________________

Address ______________________________________________________________

Home Phone (Include Area Code) Work Phone (Include Area Code) SS#________________

Personal Physician________________________________________ Phone __________________

Were you referred by a physician? _______yes ______ no

If yes, physicians name __________________________________________

Or (choose all that apply):

☐ Yellow Pages ☐ Article/Newspaper ☐ Word of Mouth ☐ Walk-In ☐ Website

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Mohs Surgery and Dermatology Center

The physicians in this office are Participating Providers with Medicare and several other health plans. Our staff is familiar with many insurance plans, but we are not responsible to know and understand each patient’s plan and benefits. If you have questions about your insurance benefits, please contact your insurance company prior to your appointment. Co-Pays are expected at the time of service. We do not accept Medicaid/IPA/KidCare. PAYMENT IS EXPECTED AT THE TIME OF SERVICE if we are not contracted with your insurance plan, unless other arrangements have been made in advance.

We require a 24 hour notice of appointment cancellation. A fee of $35.00 will be billed for late cancellation or failure to keep your scheduled appointment.

We accept payment by cash, check or credit card. Any account not paid after 90 days will be considered delinquent and may be submitted to an independent collection agency and reported to the Credit Bureau. In the event your account is referred out for collection, you will be responsible for all collection costs up to thirty percent (30%) of the past due balance. A minimum charge of $25.00 will be added to your account for any check returned to us by your bank.

Your signature below signifies your understanding and willingness to comply with these policies.

Patient’s Signature (or responsible party)________________________________________ Date ______________

Revised 12/2014
MEDICAL HISTORY

Patient Name_______________________________________ _______________________________Date_______________

Reason for today’s visit

Please check any of the following concerns/interest that you have:

Y__N__ Acne Prone Skin
Y__N__ Aging Skin
Y__N__ Sun Damaged Skin
Y__N__ Irregular Pigment
Y__N__ Irregular Vessels
Y__N__ Irregular Moles and Lesions

Y__N__ Pore Congestions
Y__N__ Loss of Skin Tone
Y__N__ Loss of Skin Radiance
Y__N__ Daily Skin Care
Y__N__ Prevention of Skin Aging
Y__N__ Prevention of Sun Damage

Please check any of the following conditions that you now have (or have ever had):

Y__N__ Asthma
Y__N__ Hay Fever
Y__N__ Allergy Problems
Y__N__ Hives
Y__N__ Allergic reaction to local anesthetics
Y__N__ Skin cancer
Y__N__ Family history of skin cancer
Y__N__ Sun poisoning
Y__N__ Cold sores/fever blisters
Y__N__ Pacemaker
Y__N__ Mitral valve prolapse
Y__N__ Artificial heart valve
Y__N__ Artificial joints

Y__N__ Abnormal chest x-ray
Y__N__ High blood pressure
Y__N__ Chest pain
Y__N__ Heart attack
Y__N__ Irregular heartbeat
Y__N__ Heart murmur
Y__N__ Irregular heartbeat
Y__N__ Heart attack
Y__N__ Joint pains/arthritis
Y__N__ Stomach problems
Y__N__ Bowel disorder
Y__N__ Stomach problems
Y__N__ Bowel disorder
Y__N__ Liver disease
Y__N__ Liver disease
Y__N__ Hepatitis
Y__N__ Exposure to AIDS

Y__N__ Blood clot in lung
Y__N__ Seizures
Y__N__ Nervous disorders
Y__N__ Shingles
Y__N__ Stroke
Y__N__ Faint easily
Y__N__ Glaucoma
Y__N__ Cataracts
Y__N__ Diabetes
Y__N__ Positive skin test for tuberculosis
Y__N__ Anemia
Y__N__ Irregular periods
Y__N__ Yeast infection

Y__N__ I take aspirin
Y__N__ I take a blood thinner
Y__N__ I take antibiotics before I see my dentist

I take the following medications/vitamins/herbal supplements:________________________________________________________________________

My occupation is:________________________________________________________________________

I drink_______alcoholic beverages per week I smoke______cigarettes per day

I AM / AM NOT now pregnant I AM / AM Not now nursing

Family history of other skin diseases:________________________________________________________________________

I have the following other skin diseases(s):________________________________________________________________________

I am allergic to the following medications:________________________________________________________________________

I have had the following surgeries:________________________________________________________________________

I have the following medical conditions not mentioned above:________________________________________________________________________

My personal physician’s name and address are:________________________________________________________________________

Form completed by: _____Patient _____Nurse

Reviewed/Date:_______Reviewed/Date:_______Reviewed/Date:_______Reviewed/Date:_______

05.01.08
Mohs Surgery and Dermatology Center