LAM DERMATOLOGY + ASSOCIATES

(Office Use Only) Patient Account Number _____

NAME: _____ **DATE OF BIRTH:** _____
LAST *FIRST* *M.I.*

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP CODE:** _____

HOME #: _____ **CELL #:** _____ **WORK #:** _____

LEAVE A DETAILED VOICEMAIL: □Yes □No **RECEIVE BILLING E-STATEMENT:** □Yes □No

EMAIL: _____ **SSN #:** _____

SEX: □ Female □ Male **MARITAL STATUS:** _____ **HEIGHT:** _____ **WEIGHT:** _____

RACE: □ Caucasian □ American Indian or Alaska Native □ Asian □ African American
□ Native Hawaiian or other Pacific Islander □ Other

ETHNICITY: □ Hispanic or Latino □ Not Hispanic or Latino

EMPLOYER: _____ **OCCUPATION:** _____

EMERGENCY CONTACT:
NAME: _____RELATIONSHIP: _____PHONE #:_____

PERSON RESPONSIBLE FOR PAYMENT (IF DIFFERENT FROM ABOVE)
NAME: _____RELATIONSHIP: _____PHONE #:_____
ADDRESS:_____CITY:_____STATE:_____ZIP CODE:_____

*****PLEASE PRESENT ID AND INSURANCE CARDS AT EVERY VISIT*****

PRIMARY INSURANCE:
INSURANCE CO._____POLICY #_____GRP #_____
NAME OF INSURED_____DOB_____SSN_____
RELATIONSHIP TO PATIENT_____

SECONDARY INSURANCE:
INSURANCE CO._____POLICY #_____GRP #_____
NAME OF INSURED_____DOB_____SSN_____
RELATIONSHIP TO PATIENT_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby authorize that I have received a copy of Lam Dermatology's Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I so choose.

_____ _____
Signature of Patient or Legal Representative (if applicable) *Date*

BENEFITS TO PROVIDER

I hereby authorize payments directly to Lam Dermatology PLLC of the surgical and/or medical benefits. I understand that I am responsible for any portion of my bill not covered by my insurance company within the terms of its contract.

_____ _____
Signature of Patient or Legal Representative (if applicable) *Date*

RELEASE OF INFORMATION

I hereby authorize release of information necessary for filing my insurance claim or filing a payment review.

_____ _____
Signature of Patient or Legal Representative (if applicable) *Date*

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AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby authorize Lam Dermatology to use and/or disclose my protected health information as described below to:

Name and relationship to recipient(s): _____

I understand that:

1) **THIS AUTHORIZATION IS VOLUNTARY AND I MAY REFUSE TO SIGN THIS AUTHORIZATION WITHOUT AFFECTING MY HEALTH CARE OR THE PAYMENT FOR MY HEALTH CARE**
2) I have the right to request a copy of this form after I sign it as well as inspect or copy any information to be used and/or disclosed under this authorization (if allowed by state and federal law. See 45 CFR § 164.524).
3) I may revoke this authorization at any time by notifying Lam Dermatology in writing as set forth in the Notice of Privacy Practices. However, it will not affect any actions taken before the revocation was received or actions taken in reliance thereon, or if the authorization was obtained as a condition of obtaining insurance coverage and other applicable law provides the insurer with the right to contest a claim under the policy.
4) Lam Dermatology agrees to maintain the confidentiality of my protected health information; however, if the person or organization authorized to receive the information is not a health plan, health care clearinghouse or health care provider, federal law (HIPAA) requires me to be advised that information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA rules.

Type of information to be disclosed:

□ Entire Medical Record □ Office Chart Notes □ Billing Statements □ Laboratory Reports □ Pathology Reports
□ Other _____

_____ _____

Signature of Patient or Legal Representative (if applicable) *Date*

_____ _____

Printed Name of Patient or Legal Representative (if applicable) *Relationship to Patient (if applicable)*

OFFICE POLICIES

OFFICE HOURS

Our office is open Monday through Friday from 8:00 AM until 4:30 PM, excluding holidays. We typically close for lunch between 12:00 PM and 1:00 PM. In the event of a medical emergency, please go to the nearest emergency room. Prescription refills are not considered an emergency.

APPOINTMENTS AND NO-SHOW POLICY

We make every attempt to schedule patients at the earliest possible availability. Should you need to cancel or reschedule, it is very important you give us at least 24-hour advance notice so that we can offer the appointment to another patient. In an event you are running late, please contact our office. If you are more than 15 minutes late to your scheduled appointment, you may be asked to reschedule. Many of our patients have complex diagnostic problems – although our staff tries to stay on schedule, a patient's condition may require additional time which may create delays in our schedule. We do ask for your patience and understanding in these instances.

We have a "no-show" policy in which a patient is allowed up to three (3) no-show appointments. Patients with multiple cancellations or missed appointments may be discharged from our practice.

For surgical and patch test application appointments only, any patient that fails to show or cancel/reschedule with 24-hour advance notice will be charged a $100.00 fee. The no-show fee is billed directly to the patient and the credit card on file will be charged. This charge is not reimbursable by your insurance and must be paid prior to rescheduling the surgical or patch testing appointment at the discretion of the provider.

PRESCRIPTION REFILLS

We require the patient to request prescription refills during an office visit. For any other instances, please call at least 48 hours in advance of the need for medication. We ask that you contact your pharmacy with your request and allow the pharmacist to contact our office. Please check with the pharmacy directly to see if your refill has been approved – and remember to allow 2 business days. **No refill requests will be processed after office hours or on weekends.**

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DIAGNOSTIC TESTS/LAB RESULTS

If tests are ordered by any providers within this practice, you will be contacted by telephone with the results within 5 business days by our office. If the test was ordered or performed by another practice or physician, you should contact that office directly for your results.

You may receive a separate bill for laboratory or pathology services from an off-site lab for any tests your physician may order. Please discuss any billing errors or discrepancies with that laboratory.

FINANCIAL POLICY

All patients are required to keep a credit card on file and signed authorization to charge the card for patient balances. **Patients are responsible for payment at the time of service**. We do accept Cash, Checks, MasterCard, Visa, Discover and AMEX. There will be a $30.00 charge for all returned checks.

Lam Dermatology is a contracted provider with many insurance plans and may accept assignment of benefits. As a courtesy, we will file all claims, including secondary insurance, to the plans with which we participate. Please inform us of any special requirements in your plan.

You are responsible to pay for any co-payments, any applicable dermatology procedures, and cosmetic treatments at the time of each visit. Most dermatology procedures go toward your deductible. Should your insurance pay these procedures in full, we will refund your payment upon receipt of your insurance payment. You are required to pay the deductible or co-insurance amounts designated by your insurance company. If your insurance company denies your bill, you will be billed directly for those services and are held financially responsible.

In the event your health plan determines a service to be "not covered," or you do not have an authorization, you may be responsible for the complete charge. We encourage our patients to understand their policy and to contact their insurance company for clarification of benefits prior to services being rendered. You must inform the office of all insurance changes, authorization and/or referral requirements, e-mail changes, and address changes. In the event the office is not informed before care is rendered, you will be responsible for any denied charges.

Patients with balances over $100.00 must make payment arrangements prior to future appointments being made. Patients who have questions about their bills or would like to discuss a payment plan option may contact our billing office at (954) 852-3604.

In cases of divorce or separation, the parent authorizing treatment for a child will be the parent responsible for those charges. If the divorce decree requires the other parent to pay all or part of the costs, it is the authorizing parent's responsibility to collect from the other parent.

NON-VISIT RELATED FORMS

We charge **$15 per non-visit related form** to be completed, and **without exception** the **money must be prepaid** at the time the form is left with our office. FMLA forms are charged at **$40 per form**, and again, we require this to be prepaid at the time the form is left with our office. We require 5 business days to complete the forms. Patients may come by to retrieve their form, or they may provide our office with a stamped, self-addressed envelope and it will be forwarded as indicated.

_____ **(Initials)** I have signed the patient Authorization for Use and Disclosure of Protected Health Information from Lam Dermatology.

_____ **(Initials)** I have received Lam Dermatology's office and financial policies.

_____ **(Initials)** I have received the Appointments and No-Show Policy and agree to its terms.

_____ **(Initials)** I understand that co-payments and any other applicable dermatology procedures and cosmetic treatments are due at time of service as specified by these terms.

_____ **(Initials)** With my consent, Lam Dermatology PLLC may e-mail to my home or another designated location any items that assist the practice in carrying out treatment, payment and healthcare operations, such as appointment reminder cards, correspondence and billing statements.

By signing below, I acknowledge, with my initials above, I have received, read, and understand the office and financial policies, and I agree to be bound by its terms. I understand and agree such terms may be amended in the future by the practice.

_____ _____

Signature of Patient or Legal Representative (if applicable) *Date*

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Credit Card on File Agreement

Lam Dermatology and Associates has a credit card on file requirement. Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. The credit card on file policy is a convenient method to pay for the portion of services that are deemed patient's responsibility, such as copay, deductible and co-insurance.

Co-pays are due at time of visit. At check-in, the credit card information will be obtained and kept confidential and secure until the insurance(s) have paid their portion and notifies Lam Dermatology of the balance due, if any. That amount will automatically be charged to your card after two (2) net-30-day statements have been sent to you via mail and/or e-mail. In the event that your card has reached its limit maximum, the bill will be subject to additional collection activity.

If you have any questions about the policy, please email your inquiries to info@lam-dermatology.com.

I authorize Lam Dermatology and Associates to keep my debit/credit card on file and to charge my debit/credit card for any outstanding balances that my health plan has identified as my financial responsibility.

If the provided debit/credit card has changed, expired or denied for any reason, I agree to immediately give Lam Dermatology and Associates a new, valid debit/credit card which I will allow to be charged over the phone. I agree that the new card will be used with the same authorization as the original card I presented.

☐ **Visa**	☐ **MasterCard**	☐ **Discover**	☐ **American Express**
Patient's Name (print):			
Date of Birth (mm/dd/yyyy):			
Cardholder Name (print):			
Last Four Digits of Debit/Credit Card Number:		Exp. Date:	
Billing Address:			
☐ Please check this box if you prefer not to receive a statement and would like us to bill your debit/credit card immediately for any balances due after the processing of your insurance.			

Debit/Credit Card Holder's Signature: _____ Date: _____

OFFICE USE

Authorization Received by: _____ (Initials) Date: _____

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PRIMARY CARE PHYSICIAN:_____ **PHONE #**:_____
Do you have a health care proxy? □Yes □No If yes, please list designee's name and phone #:_____
PHARMACY: _____ **PHONE:** _____ **ADDRESS:** _____

CHIEF COMPLAINT (REASON FOR VISIT): _____

PAST MEDICAL CONDITION(S)
□ Anxiety
□ Arthritis
□ Asthma
□ Atrial Fibrillation
□ BPH (benign enlargement of the prostate)
□ Bleeding Tendency
□ Cancer, Type _____
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ Hepatitis, Type _____
□ Hypertension (high blood pressure)
□ HIV/AIDS
□ Hypercholesterolemia
□ Hyperthyroidism
□ Hypothyroidism
□ Leukemia
□ Seizures
□ Stroke
□ **None Apply to Me**
□ Other _____ _____

PAST SURGICAL HISTORY	
□ Breast Mastectomy: □ Left □ Right □ Both	
□ Breast Lumpectomy: □ Left □ Right □ Both	
□ Heart: Mechanical Valve	
□ Heart: Biological Valve	
□ Heart: Transplant	
□ Hip Replacement - Year: _____ □ Left □ Right □ Both	
□ Knee Replacement – Year: _____ □ Left □ Right □ Both	
□ Ovaries (Oophorectomy)	
□ Skin: Skin Biopsy	
□ Skin: Skin Cancer, Type _____	
□ Uterus (Hysterectomy)	
□ **None Apply to Me**	
□ Other _____	
<u>WOMEN ONLY</u> – PREGNANCY AND CHILDBEARING INFORMATION	
Are you pregnant?	**Y N**
Are you breastfeeding?	**Y N**
Planning pregnancy?	**Y N**
Are you on birth control? If yes, what form? _____	**Y N**

PERSONAL HISTORY
□ Basal Cell Carcinoma
□ Squamous Cell Carcinoma
□ Melanoma
□ Actinic Keratoses
□ Atypical Moles
□ Blistering Sunburns
□ Precancerous Moles
FAMILY HISTORY OF SKIN CANCER
□ Basal Cell Carcinoma
□ Squamous Cell Carcinoma
□ Melanoma
□ No Family History of Skin Cancer

PERSONAL HISTORY OF SUN EXPOSURE	
Wear Sunscreen Daily?	**Y N**
Tan in Tanning Salon?	**Y N**
ALERTS	
Artificial Heart Valve	**Y N**
Artificial Joints within 2 years	**Y N**
Blood Thinners	**Y N**
Defibrillator	**Y N**
Pacemaker	**Y N**
MRSA/Staph	**Y N**
Premedication prior to procedures	**Y N**
Rapid heartbeat to epinephrine	**Y N**

ALCOHOL USE
□ Never drink alcohol
□ Less than 1 drink per day
□ 1-2 drinks per day
□ 3+ drinks per day
SMOKING STATUS
□ Never smoked
□ Former smoker
□ Smokes less than daily
□ Smokes daily

ALLERGIES	
Adhesive	**Y N**
Lidocaine	**Y N**
Topical Antibiotic Ointments	**Y N**

Other Medication Allergies:
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

CURRENT MEDICATION(S)
Import Rx history from primary care physician: □Yes □No

REVIEW OF SYSTEMS: PLEASE CIRCLE YES OR NO FOR ALL SYMPTOMS YOU ARE <u>CURRENTLY</u> EXPERIENCING

Hematologic/Lymphatic		**Respiratory**	
Problems with bleeding	**Y N**	Cough	**Y N**
Integumentary - Skin		**Gastrointestinal**	
Rash	**Y N**	Nausea or vomiting	**Y N**
Allergic/Immunologic		Persistent diarrhea	**Y N**
Immunosuppression	**Y N**	Tightness or abdominal pain	**Y N**
Constitutional		**Genitourinary**	
Fever, chills or shakes	**Y N**	Rash/ulcers in genital area	**Y N**
Eyes		**Musculoskeletal**	
Pain or vision change	**Y N**	Joint pain	**Y N**
Ears/Nose/Mouth/Throat		**Neurological/Psychiatric**	
Sores in mouth	**Y N**	Headaches	**Y N**
Cardiovascular		Dizziness	**Y N**
Sudden onset of chest pain	**Y N**		