

THE CLINICAL SKIN CENTER OF NORTHERN VIRGINIA, PLLC MEDICAL HISTORY

Patient Name: _____ Date: ____/____/____

What skin issue are you here for: _____

Are you ALLERGIC to LATEX? YES / NO If Yes, explain reaction: _____

Are you ALLERGIC to any medicines? YES / NO If Yes, please list:

<u>MEDICATION ALLERGY</u>	<u>REACTION</u>
_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS and SUPPLEMENTS/HERBALS you are currently taking : NONE

- | | |
|---------|---------|
| 1 _____ | 5 _____ |
| 2 _____ | 6 _____ |
| 3 _____ | 7 _____ |
| 4 _____ | 8 _____ |

Do you have any MEDICAL PROBLEMS ? (Not Skin) YES / NO If Yes, please list them:

History of SKIN PROBLEMS?: NONE List: _____

Have you ever had a SKIN CANCER? YES / NO If YES, Circle Type:

MELANOMA / BASAL CELL CARCINOMA / SQUAMOUS CELL CARCINOMA

Is there a FAMILY HISTORY of MELANOMA: YES / NO Who? _____

Is there a FAMILY HISTORY of Other SKIN CANCER : YES / NO

Do you CURRENTLY have any Fevers, Chills or Sweats? YES / NO

CURRENT OCCUPATION: _____

Please present insurance cards and photo ID to the receptionist so copies can be made.

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PATIENT FINANCIAL POLICY AND SIGNATURES ON FILE

Patient Name: _____ Date ____/____/____

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.

PAYMENT POLICIES:

MEDICARE: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible, paying for the co-payment and charges for non-covered /cosmetic services. If we participate with your secondary/supplemental carriers we will file a claim for you. However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. I authorize any holder of medical or other information about me to be released to the Social Security Administration, Center for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PPO, HMO, TRICARE, OR OTHER MANAGED CARE PATIENTS: If we participate (are contracted) with an **insurance plan** under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible for paying your annual deductible, co-payment and charges for any non-covered, cosmetic service. In the event that we are not aware that a particular service is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

NON-MEDICARE PATIENTS WHO HAVE INSURANCE COVERAGE WITH A CARRIER THAT WE DO NOT HAVE A CONTRACT (PARTICIPATE) WITH: Patients covered by private, commercial plans in which our physicians are not members will be responsible for payment in full at the time of service, regardless of the benefits and payment policies of your carrier. We will *NOT* file claims directly with your insurance company. Patients may elect to independently seek reimbursement from their carrier, if so we can provide you documentation of the services performed.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient or Responsible Party Signature _____ Date ____/____/____

If you have a **SUPPLEMENTAL POLICY** to which your **MEDICARE** carrier automatically “crosses over”: I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related service.

Signature as it appears on Supplemental card _____ Date ____/____/____

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HIPAA CONSENT AGREEMENT

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) does not require that health care providers obtain a consent agreement in order to the use and disclose individually identifiable health information (IIHI), as long as it is only shared with others who are treating you or supporting us in providing you quality health care.

However, it is Important to have your consent to allow us to use and/or disclose your IIHI to health care plans to ensure accurate and timely payments for the services we render. The law requires that we inform you of our policy regarding the protection of your IIHI through our Privacy Notice. Please refer to our Privacy Notice (this document is available from the front desk) for a full explanation of how this office will protect your individually identifiable health information (IIHI).

Thank you for your continued confidence in our practice and for supporting our new requirements.

The following is a statement that allows us the necessary latitude to work within the new requirements:

I have been offered an opportunity to review a Privacy Notice and I understand my rights regarding individually identifiable health information (IIHI). I consent to the use and/or disclosure of my IIHI for purposes of treatment, payment or other health care operations (TPO). Other uses of my IIHI will require an authorization from me for the specific intention of disclosure.

Signature: _____ Date: _____

Please present insurance cards and photo ID to the receptionist so copies can be made.

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