

*Cassis Dermatology & Aesthetics Center*

**PATIENT INFORMATION**

**PLEASE PRINT**

GENDER (please circle) Male Female

PATIENT \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_  
STREET PO BOXES MUST INCLUDE STREET ADDRESS CITY STATE ZIP COUNTY

HOME PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ WORK PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ EXT \_\_\_\_

CELL PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ MARITAL STATUS S M D W O  
(Please circle one)

EMPLOYER OR SCHOOL \_\_\_\_\_  
NAME & ADDRESS

PHONE NUMBER

JOB TITLE/DEPARTMENT

FULL-TIME OR PART-TIME STUDENT

**GUARANTOR INFORMATION**

If same as the patient, please write "same" and move to next section.

GUARANTOR \_\_\_\_\_  
LAST FIRST MIDDLE

ADDRESS \_\_\_\_\_  
STREET CITY STATE ZIP COUNTY

HOME PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ WORK PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ EXT \_\_\_\_

CELL PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ SS# \_\_\_\_-\_\_\_\_-\_\_\_\_ MARITAL STATUS S M D W O  
(Please circle one)

RELATIONSHIP TO PATIENT \_\_\_\_\_

EMPLOYER \_\_\_\_\_  
NAME & ADDRESS

PHONE NUMBER

JOB TITLE/DEPARTMENT

FULL-TIME OR PART-TIME

**INSURANCE INFORMATION**

**PLEASE PROVIDE COPY OF INSURANCE CARD**

**PRIMARY INSURANCE COMPANY** \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

POLICYHOLDER'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ POLICYHOLDER'S SS# \_\_\_\_\_

**SECONDARY INSURANCE COMPANY** \_\_\_\_\_

EFFECTIVE DATE \_\_\_\_\_ EMPLOYER \_\_\_\_\_

POLICYHOLDER'S NAME \_\_\_\_\_ POLICYHOLDER'S DATE OF BIRTH \_\_\_\_\_

RELATIONSHIP TO PATIENT \_\_\_\_\_ POLICYHOLDER'S SS# \_\_\_\_\_

**EMERGENCY CONTACT INFORMATION**

1) NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

HOME PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ WORK PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ EXT \_\_\_\_

CELL PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

2) NAME \_\_\_\_\_ RELATIONSHIP TO PATIENT \_\_\_\_\_

HOME PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ WORK PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ EXT \_\_\_\_

CELL PHONE \_\_\_\_/\_\_\_\_-\_\_\_\_ BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

## *Cassis Dermatology & Aesthetics Center*

### **INSURANCE AND BILLING AUTHORIZATION**

I understand I am personally responsible to Cassis Dermatology & Aesthetics Center (The Practice) for any charges incurred for services performed regardless of insurance coverage. I accept full FINANCIAL RESPONSIBILITY for the patient's account in accordance with the regular rates and terms of The Practice's policy.

I understand most health insurance carriers require The Practice to file a claim for my services, but that I am responsible for any and all amounts not covered and not paid by my insurance carrier. These amounts may include co-payments, deductibles, and fees not covered by my health insurance. IF MY INSURANCE CARRIER REQUIRES A REFERRAL FOR MY OFFICE VISIT, I UNDERSTAND IT IS MY RESPONSIBILITY TO OBTAIN THIS AND PRESENT THIS REFERRAL AT THE TIME OF MY VISIT (IF NOT BEFORE). Failure to obtain a referral, if required, does not release me from my responsibility to The Practice. SERVICES PROVIDED WITHOUT A REFERRAL, IF A REFERRAL IS REQUIRED, REMAIN MY RESPONSIBILITY.

I understand that if I am not covered under a current insurance policy or if I do not present a current insurance card at the time of service, that I will be responsible for payment in full at the time services are rendered.

Most aesthetic services are not covered by health insurance. Biopsy and removal of skin lesions may not be covered by my health insurance. I am responsible for payment of any aesthetic services or treatments or any medical conditions not covered by my insurance.

I hereby authorize The Practice to submit a claim to my Insurance Carrier or it's intermediaries related to services rendered by any physician or medical provider employed by Cassis Dermatology & Aesthetics Center, and direct my insurance carrier or it's intermediaries to issue payment directly to The Practice and/or provider who accepts assignment.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **NO SHOW FOR APPOINTMENTS AND COLLECTION FEES**

I understand when The Practice provides an appointment time; I remain responsible for payment for services. If I fail to notify The Practice with 24-hour notice, I remain responsible for payment for my appointment. Failure to notify The Practice may result in a \$25 no show fee. I understand my health insurance will not cover this fee, and I will remain personally responsible for payment of this fee. Repeated failure to show for appointments may result in my dismissal from The Practice.

If Cassis Dermatology & Aesthetics Center refers my account to a collection agency, I agree to pay all fees, collection fees and legal fees, associated with my delinquent account. I understand I will be responsible for any collection fees, including any legal expenses incurred in settling my delinquent account. I understand a delinquent account may be reason for termination from The Practice.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

### **CONSENT FOR CARE AND TREATMENT OF DEPENDENT**

PERMISSION FOR TREATMENT is hereby grant to any physician or medical provider employed by The Practice to render such medical and surgical treatment as deemed necessary for

\_\_\_\_\_  
Dependent's Name

\_\_\_\_\_  
Signature of Parent or Guardian

\_\_\_\_\_  
Relationship to Patient

### **NOTICE OF PRIVACY PRACTICES**

I acknowledge Cassis Dermatology & Aesthetics Center (the Practice) has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient or Personal Representative  
(If different than patient only)

\_\_\_\_\_  
Relationship to Patient

*Cassis Dermatology & Aesthetics Center*

**CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION**

I hereby consent to Cassis Dermatology & Aesthetics Center using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (if different than patient only)

\_\_\_\_\_  
Relationship to Patient

**SPECIFIC INFORMATION RELEASE (if applicable)**

I specifically authorize release of the following information for the purposes of treatment, payment, and health care operations:  
**(Initial any you agree to release)**

\_\_\_\_\_ Chemical Dependency/Substance Abuse

\_\_\_\_\_ Sexually Transmitted Diseases

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name (if different than patient only)

\_\_\_\_\_  
Relationship to Patient

# Dermatology Medical History

Referred by: \_\_\_\_\_

Patient: \_\_\_\_\_ Age: \_\_\_\_\_

Today's Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Are you allergic to any medications?  YES  NO If yes, list below:

1. \_\_\_\_\_ 2. \_\_\_\_\_

Have you ever had dental anesthesia (Novocaine)?  YES  NO Any bad reaction?  YES  NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_  
2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

<b>Lungs:</b>	<b>YES</b>	<b>NO</b>	<b>Other Systemic:</b>	<b>YES</b>	<b>NO</b>
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
			Gastrointestinal		
			Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
			Nausea, vomiting, diarrhea		
			when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Yeast infection when		
			taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
			Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
			Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
			Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
			<b>Artificial joint</b>	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: \_\_\_\_\_

List surgical procedures you have had in the last 6 months: \_\_\_\_\_

**Skin:** Have you ever had skin cancer?  YES  NO  
Has anyone in your family had skin cancer?  YES  NO If yes, TYPE: \_\_\_\_\_  
Do you have a history of any specific skin diseases?  YES  NO If yes, \_\_\_\_\_  
Do you have problems with healing  YES  NO  
Do you develop keloids (scars) after surgery  YES  NO  
Do you bleed easily?  YES  NO  
Do you develop skin rashes in reaction to  Medications  Food  Environment  Bandages  Topical Neosporin  
 Other \_\_\_\_\_

**Social History:**  
Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day  
Do you use IV drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_  
Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_  
Have you had or have you been exposed to HIV (AIDS)?  YES  NO HEPATITIS? If YES, TYPE: A B C

Please answer the following questions:  
**(Women) Are you pregnant?**  YES  NO Due Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
What is your occupation? \_\_\_\_\_ Hobbies? \_\_\_\_\_

Completed by:  Patient \_\_\_\_\_ / /  
 Medical Assistant \_\_\_\_\_ Signed by Patient \_\_\_\_\_ Date  
Initials \_\_\_\_\_ / /  
Reviewed by \_\_\_\_\_ Date



## FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality treatment of each and every patient. Please understand that payment for your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

**All patients must complete our Patient Registration process prior to seeing the physician.**

WE ACCEPT CASH, CHECKS, VISA & MASTERCARD & AMERICAN EXPRESS.

In the event of a returned check, for any the following reasons: non-sufficient funds, stop payment or closed account, a fee of \$30.00 will be charged to your account.

### INSURANCE CARD

We will not bill your insurance company unless you provide a current insurance card.

### PARTICIPATING PROVIDER (CONTRACTED)

We accept assignment of insurance benefits on many insurance plans. During the Patient Registration process you will be told whether or not we accept assignment of your insurance benefits. We will file all charges to your insurance company. Because we are a participating provider with your insurance carrier, you be responsible to pay any **co-pay** amounts **each visit**. You will also be responsible for any deductible/coinsurance amounts, as stated in your policy, and you will receive a statement in the mail, from our office, for these amounts. If you participate in a High Deductible Insurance Plan, you will be asked to pay at the time of service. We will file the claim on your behalf with your carrier. Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be **due in full at the time of service**.

### NON-PARTICIPATING PROVIDER (NON-CONTRACTED)

Because we are not contracted with your insurance carrier, you will be responsible to pay your total charges. We will file all charges to your insurance company. You will be responsible for any charges not covered by your insurance carrier, as stated in your policy. We will allow 45 days to receive payment from the insurance carrier; if not received, the entire balance will be billed to you. You will receive a statement in the mail from our office for these amounts. Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be **due in full at the time of service**. We will **not** follow-up with your insurance carrier on any unpaid claim. It is your responsibility to work directly with your insurance carrier on any disputed or unpaid claims.

### RATES

Our practice is committed to providing the best treatment for our patients at a rate considered usual and customary for our area.

### MINOR PATIENTS

Minor patients must be accompanied by a parent or legal guardian each visit. The parent/legal guardian accompanying the minor to the first visit will be considered guarantor on the account; therefore, accepting full financial responsibility for all services rendered on the minor's behalf and charged to their account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

**I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.**

X \_\_\_\_\_  
Patient Name (Please Print)

X \_\_\_\_\_  
Signature of Patient or Responsible Party

Date \_\_\_\_\_

X \_\_\_\_\_  
Signature of Co-Responsible Party

Date \_\_\_\_\_