HARTSOUGH DERMATOLOGY

PLEASE PRINT ☐ **New Patient** ☐**Name Change** ☐**Address Change** ☐**Insurance Change**

Patient:		M F	Age:
Address:		Birth date: / /	
City: State: Zip:		Telephone: ( ) -	
SSN: - -	Marital Status: S[ ] M[ ] W[ ] D[ ]	Cell: ( ) -	

E-Mail:

Main reason for your visit:

Patient's Employer/School [ ] Full Time [ ] Part Time [ ] Retired	Other:
Occupation:	
Name:	Telephone: ( ) -
Address:	City: State: Zip:

Insurance Information **Is Medicare your Primary Insurance Carrier? Yes [ ] No [ ]**

Primary Insurance Co.:	Telephone: ( ) -	
Is there a Referral Required?	Employer:	
Group/Policy #:	ID #:	
Policy Holder:	Relationship:	Birth date: / /

Secondary Insurance Co.:	Telephone: ( ) -	
Is there a Referral Required?	Employer:	
Group/Policy #:	ID #:	
Policy Holder:	Relationship:	Birth date: / /

Person Financially Responsible (If different from patient)	**Relationship:**
Name:	DOB: Telephone: ( )
Address:	City: State: Zip:
Employer:	SS#: **(REQUIRED)**

Referred by Physician [ ]

Other:	**Family Physician**
Name:	Name:
Telephone: ( ) -	Telephone: ( ) -

_____ _____ _____

Signature of Patient, Parent, or Guardian **Relationship** **Today's Date**

HARTSOUGH DERMATOLOGY

BOARD CERTIFIED DERMATOLOGIST

Phone (815) 226-9642	Nicole A. Hartsough, M.D.	Fax (815) 226-9672

AGREEMENTS & AUTHORIZATIONS

CONSENT FOR TREATMENT

I hereby authorize and consent to treatment provided by ***Hartsough Dermatology***, employees or designees and authorize medical services, diagnostic procedures and medication as deemed necessary or advisable by the caregiver(s) providing treatment. I understand that no guarantee has been made as to the results of the care, treatment, and/or medications, which may be given to me.

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize ***Hartsough Dermatology*** to release information required in the processing of application for financial coverage for services rendered. This authorization provides that my physician or my physician's staff may release objective clinical information related to my diagnoses and treatment, which may be requested by my insurance company or its designated agent. This authorization also includes any medical records containing information related to HIV (AIDS) testing and/or psychiatric care rendered to me if such records are released to an insurance company writing Life, Accident or Health Insurance or a Non Profit Health Care Service Plan Corporation to evaluate my claims or its liability under such policies or contracts or coordination of benefits pursuant to such policy or contract provisions. The information obtained will be treated as privileged and confidential and will not be released to any person without my expressed or written consent. Correspondence and test results will only be released to physicians involved in my care.

ASSIGNMENT OF INSURANCE BENEFITS/REFERRALS/PAYMENTS GUARANTEE/COLLECTION FEE/NSF FEE

I hereby authorize payment to be made directly to ***Hartsough Dermatology*** for insurance benefits payable to me. I understand that I am financially responsible to ***Hartsough Dermatology*** for any covered or non-covered services, as defined by my insurer, which are not paid by my primary or secondary insurer. I understand I am financially responsible for payment in full if no required referral is received by this office. I understand that I am financially responsible for any collection fee and any reasonable attorney's fees and other costs incurred for collection including but not limited to 1 ½ % interest per month on any outstanding amounts unpaid 90 days after insurance resolution. I understand that I am financially responsible for a returned check for any reason and a $25.00 NSF fee.

I understand that I can be terminated from the practice for monetary reasons ***or*** non-compliance with medical advice.

PAYMENT POLICY

The Adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

MISSED APPOINTMENTS

In order to best serve our patients, we ask for at least 24 hours notice if you are not able to meet an appointment. This allows us to try to fill the appointment time with another patient. If we do not receive this notice, we will charge $87 for a missed office appointment or $174 for a missed surgical appointment. Further Terms & Conditions Provided Upon Request _____

Initial

IF MY INSURANCE CHANGES OR I HAVE NO CURRENT INSURANCE CARD(S) AT TIME OF SERVICE: If I do not have my **current** insurance card(s) for any date of service, I will be billed as a Self Pay. ***Hartsough Dermatology*** might not be able to back date from the time of service to when I do present my **current** insurance card(s) to ***Hartsough Dermatology***. I may be asked to seek reimbursement from my insurance carrier(s).

MEDICARE

Patient's Certification, Authorization to Release Information, and Payment Request. I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf directly to ***Hartsough Dermatology***.

NOTICE OF PRIVACY PRACTICES - NPP

I hereby acknowledge receipt of the physician's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that ***Hartsough Dermatology*** has reserved the right to change their privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available.

PATIENT ACKNOWLEDGEMENT

I have read the Agreement and Authorization form and I understand its contents and that I have had an opportunity to discuss its contents to my satisfaction. I understand that my signature represents agreement with the contents of the form and that any statement may not amend to contents of the form. I understand that the records/information released will not be further disclosed for any purpose other than as stated in this Authorization.

_____ _____

PRINT Patient Name Print Name of Authorized Representative

_____ _____ _____

Patient or Authorized Representative Signature Relationship Date

Patient unable to sign. Verbal consent given. Reason: _____

HARTSOUGH DERMATOLOGY
BOARD CERTIFIED DERMATOLOGIST
Nicole A. Hartsough, M.D.
7402 East Riverside Boulevard
Phone (815) 226-9642 Loves Park, IL 61111 Fax (815) 226-9672

Authorization to Release Medical Information to Members of Your Family or Other Individuals

In accordance with Federal government privacy rules implemented through the Health Insurance Portability and Accountability Act of 1966 (HIPAA), in order for your physician or the staff of Hartsough Dermatology to discuss your condition with members of your family or other individuals that you designate other than your *Primacy Care Doctor*, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

1. ____ **I authorize** Hartsough Dermatology to verbally release any or all information concerning my medical care to the following individuals:

Name (Please Print)	Relationship	Telephone Number
Name (Please Print)	Relationship	Telephone Number

____ **I <u>do not</u>** authorize Hartsough Dermatology to release any information concerning my care to any individual.

.....

2. **<u>Voice Mail</u>**

____ **I authorize** Hartsough Dermatology to leave a detailed voice mail on any phone number I provide.

____ **I do not** authorize Hartsough Dermatology to leave a detailed voice mail.

.....

PRINT Patient Name

Print Name of Authorized Representative

Patient or Authorized Representative Signature

Relationship

Date

Patient unable to sign. Verbal consent given.
Reason:

Hartsough Dermatology

Medical History Form

Patient Name:_____ Today's Date: _____

Date of Birth_____ Age____

Reason for today's visit:_____

How long have you had this problem? _____ Affected Locations _____

Past Medical History – Do you have now, or have you ever had diseases or conditions of:

Cardiovascular	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Coronary Heart Disease	☐	☐	Inflammation of veins	☐	☐	Chest Pain	☐	☐
Blood Clots	☐	☐	Pace Maker	☐	☐	Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐	High Blood Pressure	☐	☐			

Lungs	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Bronchitis	☐	☐	Emphysema	☐	☐	Asthma	☐	☐
Chronic Morning Cough	☐	☐	TB (tuberculosis)	☐	☐			

Endocrinology	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Recent Hair Loss	☐	☐	Thyroid Disease	☐	☐	Diabetes	☐	☐
Recent weight loss or gain	☐	☐						

Other	**YES**	**NO**		**YES**	**NO**		**YES**	**NO**
Gastrointestinal Problems	☐	☐	Kidney Disease	☐	☐	Dialysis	☐	☐
Arthritis/Joint Problems	☐	☐	Blood Diatheses	☐	☐	Anemia	☐	☐
Hepatitis	☐	☐	Aids Risk	☐	☐	Fainting	☐	☐

Cancer: **Yes** ☐ **No** ☐ If yes, type_____ Date _____

Has anyone in your family had skin cancer? **Yes** ☐ **No** ☐

If yes, what type: _____and who, _____

List any other diseases or conditions:_____

List any surgical procedures for the last 2 years: _____

Skin

When you are exposed to the sun do you: Tan, never burn ☐ Tan more than burn ☐

Burn more than Tan ☐ Burn never tan ☐

Do you have a history of specific skin disease? **Yes** ☐ **No** ☐

If yes, please list _____

Do you develop Keloids (large scars) after injury to the skin? **Yes** ☐ **No** ☐

Do you bleed/bruise easily? **Yes** ☐ **No** ☐

Do you have problem with poor wound healing? **Yes** ☐ **No** ☐

Have you ever had dental or local anesthesia? **Yes** ☐ **No** ☐

Have you had any negative reaction to anesthesia? **Yes** ☐ **No** ☐

If yes, what was the reaction? _____

Social History

Do you use tobacco? **Yes** ☐ **No** ☐ If yes how much per day? _____

Drink Alcohol? **Yes** ☐ **No** ☐ If yes how many per day? _____

Do you use street drugs? **Yes** ☐ **No** ☐ If yes what? _____ How often? _____

Have you been exposed to HIV (Aids)? **Yes** ☐ **No** ☐

Women

Are you pregnant or nursing? **Yes** ☐ **No** ☐ Due Date: _____

Type of Birth Control _____

Completed By: Patient ☐ Medical Assistant ☐ _____

Signature of Patient, Parent or Guardian: _____ Date _____

Reviewed By:_____ Date _____

Patient name sticker

Date: _____

MEDICATION LOG

Are you allergic to any medications? Please list here:

Name of Medication

Are you currently taking any medications? Please list here:

Name of Medication	Strength

Please list what conditions are being treated with the above medications? _____

_____

_____

Family Doctor: _____

What do you weigh? _____ How tall are you? _____ Are you allergic to latex? _____

If female, are you pregnant or nursing? ___ Do you use birth control? ___ Type _____

Do you or a member of your family have a history of melanoma or other skin cancer? _____

Do you take blood thinners or aspirin? _____ Occupation _____

Do you or any blood relatives have hay fever or allergies to pollen or animals? _____

Do you or any blood relatives have asthma or eczema? _____

Have you had any other medical problems in the past? _____

_____

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