PAN DERMATOLOGY

Patient Information (please print)

Name:		
Address:		
City:	State:	Zip Code:
Home Phone:	Cell:	
Email:	Permission to text appointment confirmations? Y/N	
Date of Birth:	Sex: M/F	
Name of Emergency Contact:		Phone:
Employer:	Phone:	
City:	State:	Zip Code:
Primary Physician:	Office number:	
Pharmacy:	Phone:	
Referred by:		
Primary Insurance:		
Insurance Name:	Policy Number:	
Policy Holder:	DOB:	Relationship:
Insurance Address:		
Secondary Insurance:		
Insurance Name:	Policy Number:	
Policy Holder:	DOB:	Relationship:
Insurance Address:		
Responsible Party (if patient is under 18 years of age):		
Name:	Relationship:	
Address:	City:	State/Zip:
Phone:		

Patient Name: _____ DOB: _____

Reason for today's visit: _____

_____

_____

PERSONAL HEALTH HISTORY:

Please check all medical problems you have had:

Seasonal Allergies		Heart Murmur		Liver Disease	
Arthritis		Heart Trouble		Melanoma	
Asthma		Heart Valve Replacement		Pacemaker	
Bleeding problems		Hepatitis		Prostate Trouble	
Blistering Sunburn		High Blood Pressure		Psoriasis	
Chicken pox		HIV		Skin Cancer	
Diabetes		Joint Replacement		Tuberculosis	
Eczema		Keloidal Scarring		Ulcer	
Other Medical Problem				Yeast Infection	

Are you pregnant? Y N

Are you breastfeeding? Y N

Last Mammogram? _____

Do you have a healthcare proxy? Y N

Vaccinations: Pneumonia: Y N

Influenza: Y N

Coronavirus: Y N

Current Medications: (include vitamins and dosing information)

_____

_____

_____

Medication Allergies: _____

Occupation: _____ Currently working? Y N

Do you smoke? Y N Do you drink alcohol? Y N Ht: _____ Wt: _____

Family history: please indicate who in your immediate family has had the following conditions:

	FATHER	MOTHER	SISTER	BROTHER	GRANDMOTHER	GRANDFATHER	AUNT	UNCLE
Allergies								
Abnormal moles								
Acne								
Asthma								
Eczema								
Melanoma								
Skin Cancer								
Psoriasis								
Rosacea								

REVIEW OF SYSTEMS-PLEASE CHECK ALL THAT CURRENTLY APPLY

YES	CONSTITUTION	YES	GENITOURINARY
	chills		frequency of urination
	fever		blood in the urine
	weight loss		burning urination
	EYES		MUSCULOSKELETAL
	irritation		joint pain
	double vision		muscle pains
	vision loss		stiffness
			swelling
	EARS,NOSE,THROAT		
	congestion		INTEGUMENTARY
	nasal discharge		skin rash
	hoarseness		
	sore throat		NEUROLOGICAL
	voice change		dizziness
			numbness/tingling
	CARDIOVASCULAR		tremors
	chest pain		
	palpitations		PSYCHOLOGICAL
	swelling		depression
			stress
	RESPIRATORY		
	cough		ENDOCRINE
	shortness of breath		diabetes
	sputum production		thyroid disease
	wheezing		
			HEMATOLOGIC/LYMPH
	GASTROENTEROLOGY		blood clotting problem
	abdominal pain		swollen glands
	constipation		
	diarrhea		ALLERGY/IMMUNOLOGY
	dysphasia/reflux		hay fever
	heartburn		drug allergies
	nausea		

NON-PARTICIPATING INSURANCE

PAN DERMATOLOGY, PC

105 EVERETT RD, ALBANY

If you choose to be seen in our office and Pan Dermatology does not participate with your insurance plan, an estimated amount for non-emergency services is available upon request.

If unforeseen medical circumstances arise when the services are provided, the amount that will be billed for the services may be higher.

As non-participating providers ("out-of-network"), we may charge more than the allowed amount provided by your carrier.

We are providing you the following information to help you understand what your health care plan may not cover If you obtain services from an out-of-network provider.

-Your plan may not cover out-of-network services at all, leaving you to pay the full cost.

-If your plan covers out-of-network services, a higher copay, deductible and/or co-insurance for care may be charged by your insurance. You will be required to pay these higher amounts plus any difference between your plan allowed and what the out-of-network provider charges for the service.

If you are scheduled for hospital admission or outpatient services, you will be provided with the name and telephone of the facility. It is possible that at the time of the scheduled procedure, the hospital or facility, and not Pan Dermatology, PC, will arrange for the services of other physicians. It is not possible for us to know which other physicians may be arranged by the hospital/facility to perform these servies. Please contact the hospital/facility to request information regarding the physician services that will be arranged by the hospital/facility.

Acknowledgement of receipt:

Print Patient Name: _____

Signature: _____ Date: _____

If Legal Representative, indicate relationship to patient: _____

Witnesses Signature: _____

Medical Appointment Cancellation/No Show Policy

Our goal is to provide quality medical care in a timely manner. In order to do so, we have had to implement an appointment cancellation policy.

We understand that there are times when you must miss an appointment due to emergencies or illness. However, when you do not call to cancel an appointment, you prevent another patient from getting much needed treatment.

A "NO SHOW" is someone who misses an appointment without cancelling it 24 hours in advance. If it is necessary to cancel your appointment, we require that you call 1 business day in advance. Appointments are in high demand, and your early cancellation will give another person the ability to have access to timely medical care.

Effective 5/18/2018, any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with the proper notice will be considered a NO SHOW.

Any established patient who fails to show or cancels/reschedules an appointment within 24 hours a SECOND time will be charged a fee of $35. A letter will be sent to you at the time of the second NO SHOW alerting you of your status.

If a THIRD NO SHOW or cancellation/reschedule with no 24-hour notice should occur, you will be dismissed from the practice.

The fee is charged to you, not the insurance company. This fee is due prior to being seen at the time of your next office visit.

If you should experience extenuating circumstances, please contact our office manager to discuss your situation. All fees and dismissals are at the discretion of our office. Your signature at the bottom of this form is acknowledgement of this policy.

Patient Signature

Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

PAN DERMATOLOGY, PC

Credit Policy

Patient Responsibility: Patients are responsible for all charges resulting from treatment provided by Clinic/Physician. As a service to you, we bill most insurance carriers directly. However, primary responsibility for the account is yours. Payment is due within 30 days of the first billing, unless other financial arrangements are made. Established patients with a delinquent balance may be asked for payment at the time of service.

Minors: Patients under 18 years of age will be the responsibility of the custodial parent(s).

Referrals: If your insurances requires a referral, from the Primary Care Provider (PCP), to see a specialist, it is your responsibility to obtain a referral/authorization prior to your appointment..

Insurance Billings: We will, as a courtesy, bill your primary insurance carrier. Providing correct insurance billing information is the responsibility of the patient. If your insurance changes, please present your new insurance information at your next visit.

Medicare: Our physicians are participating providers. Although we bill Medicare as your primary insurer, you may be responsible for billing your supplement insurance. Note: Medicare may be able to bill your supplemental insurance.

Check Returned: It is our office policy to charge all patients a $20.00 fee for checks that are returned,

Authorization to Release Information:

I have read and I accept this policy for my Testing and/or treatment with Pan Dermatology, PC. In obtaining payment for services, I authorize my health care provider, Pan Dermatology, PC, to furnish information from my medical record to any company that may be responsible for payment of all or part of my provider charges, including my insurance companies and their representative, and my employer or union if they are involved in processing the claim.

If I have been referred by, or am being referred to, another health care provider, I authorize Pan Dermatology, PC to release my clinical information to this provider for continuing care.

I also assign Pan Dermatology, PC all payments to which I am entitled for medical expenses related to the services reported herewith. I understand I am financially responsible for all charges/services whether covered by insurance or not. I also understand that balances outstanding for more than 90 days will be subject to a processing fee.

I, OR MY APPOINTED AGENT, HAVE READ, FULLY UNDERSTAND AND AGREE TO THE ABOVE STATEMENTS. I MAY ASK FOR A COPY OF THIS INFORMATION FOR MY RECORDS.

Signature	Date

IF PATIENT IS UNDER THE AGE OF 18 YEARS, OR IS OTHERWISE UNABLE TO SIGN, COMPLETE THE FOLLOWING

Patient is year(s) of age or is unable to sign because:

Relationship to patient:

Sign Below if Disclosure of Information is not authorized:

Therefore, I agree to pay for costs of all treatment and services personally.

Permission for Telehealth Visits

What is telehealth?

Telehealth is another way that we offer to visit with your provider. You can talk to your provider from any place, including your home. This makes it convenient for you when you are unable to come to the office and have an acute problem or need a medication refill. Please note, we will not use this type of visit for full skin exams or more involved cases.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- Sometimes, you use video so you and your provider can see each other.

How does telehealth help me?

- You can address your concern with your provider from the comfort of your home.
- You won't risk getting sick from other people.

Will my telehealth visit be private?

- We will not record visits with your provider.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You can still get an office visit if you decide that you no longer want to continue with the telehealth visit.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, *you may have to pay for both visits.*

Please check one of the boxes and sign below. You may change your decision at any time.

- ○ I give consent to future telehealth visits.
- ○ I do not give consent to future telehealth visits.

_____

Your name (please print) Date

_____

Your signature Date