Today's Date: _____ *Rev. 02/2018*

**YARDLEY DERMATOLOGY ASSOCIATES**
**PATIENT MEDICAL INFORMATION FORM**

Name: _____ DOB: _____ Age: _____

Reason for today's visit (include location on the body, duration of problem, description of symptoms (painful, itching, bleeding, etc.), and treatments used in the past): _____

_____

Were you referred by a doctor to have specific skin problem(s) evaluated? ☐ Yes ☐ No

*Doctor Name:* _____

*Doctor Address:* _____

**MEDS/ALL**

Medication Allergies: _____

Medications & Supplements: _____

_____

**PMH**

Present or Past Medical Problems/Major Surgical Procedures: _____

_____

_____

Past or Present History of:

| | | | | | |
|---|---|---|---|---|---|
| *Artificial Joint* | ☐ *Yes* | ☐ *No* | *Radiation/X-Ray Treatment* | ☐ *Yes* | ☐ *No* |
| *Artificial Heart Valve* | ☐ *Yes* | ☐ *No* | *Bone Marrow or Organ Transplant/* | ☐ *Yes* | ☐ *No* |
| *Pacemaker* | ☐ *Yes* | ☐ *No* | *Immunosuppression* | | |
| *Bleeding Condition* | ☐ *Yes* | ☐ *No* | | | |
| *Hepatitis/HIV* | ☐ *Yes* | ☐ *No* | Pregnant or Planning Soon? | ☐ *Yes* | ☐ *No* |
| *Heart Valve Infection* | ☐ *Yes* | ☐ *No* | | | |

**ROS**

Are you experiencing symptoms or problems related to:

| | | | | | |
|---|---|---|---|---|---|
| *Fever/Unintentional Weight Loss* | ☐ *Yes* | ☐ *No* | *Stomach/Intestines* | ☐ *Yes* | ☐ *No* |
| *Eyes Ears/Nose* | ☐ *Yes* | ☐ *No* | *Kidney/Bladder* | ☐ *Yes* | ☐ *No* |
| *Heart* | ☐ *Yes* | ☐ *No* | *Muscles/Bones/Joints* | ☐ *Yes* | ☐ *No* |
| *Lungs* | ☐ *Yes* | ☐ *No* | *Neurological/Seizures/Headaches* | ☐ *Yes* | ☐ *No* |
| *Hormones* | ☐ *Yes* | ☐ *No* | *Emotional/Psychiatric Illness* | ☐ *Yes* | ☐ *No* |

**SKIN CA**

Personal History of Skin Cancer (type, location, & date): _____

Do You Have a History of:

| | | | | | |
|---|---|---|---|---|---|
| *Blistering Sunburn* | ☐ *Yes* | ☐ *No* | *Numerous or Irregular Moles* | ☐ *Yes* | ☐ *No* |
| *Tanning Bed Use* | ☐ *Yes* | ☐ *No* | | | |

**FH**

Family History of:

| | | | | | | |
|---|---|---|---|---|---|---|
| *Melanoma* | ☐ *Yes* | ☐ *No* | *Relationship:* | ☐ *Parent* | ☐ *Sibling* | ☐ *Child* |
| *Allergies/Hay Fever/Asthma/Eczema* | ☐ *Yes* | ☐ *No* | *Relationship:* | ☐ *Parent* | ☐ *Sibling* | ☐ *Child* |
| *Psoriasis* | ☐ *Yes* | ☐ *No* | *Relationship:* | ☐ *Parent* | ☐ *Sibling* | ☐ *Child* |

**SH**

Occupation: _____

Do You Have a History of:

| | | | | | |
|---|---|---|---|---|---|
| *Smoking/Tobacco Use* | ☐ *Yes* | ☐ *No* | *Drug Abuse* | ☐ *Yes* | ☐ *No* |
| *Alcohol Abuse* | ☐ *Yes* | ☐ *No* | | | |

*Rev. 02/2018*

**YARDLEY DERMATOLOGY ASSOCIATES**
**PATIENT INFORMATION FORM**

# PLEASE PRINT CLEARLY

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Policy/Holder Change

## PATIENT INFORMATION

Last Name: _____ First Name: _____ Middle Initial: ___

DOB: _____ Sex: ☐ Male ☐ Female

Address: _____ City: _____ State: _____ Zip: _____

Phone #: _____ SS#: _____

Employer/School: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widow

## INSURANCE POLICY HOLDER INFORMATION

Policy Holder: ☐ Self ☐ Spouse ☐ Parent/Legal Guardian

☐ Other: _____

Last Name: _____ First Name: _____ Middle Initial: ___

DOB: _____ Sex: ☐ Male ☐ Female

Address: _____ City/State: _____ Zip: _____

Phone #: _____ SS#: _____

Employer: _____

Secondary Insurance Policy: ☐ YES ☐ NO

Last Name: _____ First Name: _____ Middle Initial: ___

DOB: _____ Sex: ☐ Male ☐ Female Phone #: _____

Address: _____ City/State: _____ Zip: _____

## PHARMACY INFORMATION

Pharmacy: _____ Phone #: _____

# YARDLEY DERMATOLOGY ASSOCIATES
# PATIENT CONTACT FORM

**I would like to receive my courtesy appointment reminder via:** ☐ Home Phone ☐ Work Phone ☐ Cell Phone

Yardley Dermatology Associates has my permission to:

☐ **YES** ☐ **NO** **Contact me at home** #: _____

☐ YES ☐ NO Leave a detailed voicemail message

☐ YES ☐ NO Leave a detailed message a household/family member

Household/Family member(s) name(s): _____

_____

☐ **YES** ☐ **NO** **Contact me by cell phone** #: _____

☐ **YES** ☐ **NO** **Contact me at work** #: _____

☐ YES ☐ NO Leave a detailed voicemail message

☐ YES ☐ NO Leave a detailed message with a staff member

Staff member(s) name(s): _____

_____

☐ **YES** ☐ **NO** **Contact me by e-mail**

E-mail: _____

☐ YES ☐ NO Leave appointment reminders via e-mail in addition to a phone reminder

☐ **YES** ☐ **NO** **Discuss my medical history with anyone other than myself**

(In addition to those specified by law to carry out treatment, payment, and healthcare operations)

Name(s): _____

_____

**Emergency Contact**

Name: _____

Phone #: _____

**Primary Care Physician**

Name: _____

Phone #: _____ Did Your PCP refer you? ☐ YES ☐ NO

_____ _____

Signature of Patient or Legal Guardian Date

_____

Printed Name of Patient

*Rev. 2/2018*

# YARDLEY DERMATOLOGY ASSOCIATES
# PATIENT CONSENT FORM

Patient Name (print): _____ DOB: _____

Legal Guardian Name (print): _____

## AUTHORIZATIONS

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to YARDLEY DERMATOLOGY ASSOCIATES. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa™, or Mastercard™. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered service, and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

Patient or Legal Guardian Signature: _____ Date: _____

## PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent YARDLEY DERMATOLOGY ASSOCIATES may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to YARDLEY DERMATOLOGY ASSOCIATES' Notice of Privacy Practices for a more complete description of such uses and disclosures. I have received and reviewed the Notice of Privacy Practices prior to signing this consent. YARDLEY DERMATOLOGY ASSOCIATES reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to YARDLEY DERMATOLOGY ASSOCIATES Privacy Officer at 903 Floral Vale Blvd. Yardley, PA 19067. With my consent YARDLEY DERMATOLOGY ASSOCIATES may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others. With my consent YARDLEY DERMATOLOGY ASSOCIATES may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent YARDLEY DERMATOLOGY ASSOCIATES may e-mail my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that YARDLEY DERMATOLOGY ASSOCIATES restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to YARDLEY DERMATOLOGY ASSOCIATES' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent YARDLEY DERMATOLOGY ASSOCIATES may decline to provide treatment to me.

Patient or Legal Guardian Signature: _____ Date: _____

## MEDICARE HEALTH INSURANCE FORM

I request that payment of authorized Medicare benefits be made either to me or on my behalf to YARDLEY DERMATOLOGY ASSOCIATES for any services furnished to me by YARDLEY DERMATOLOGY ASSOCIATES. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Patient or Legal Guardian Signature: _____ Date: _____

# YARDLEY DERMATOLOGY ASSOCIATES
# FINANCIAL POLICY

NAME: _____ DOB: _____ DATE: _____

Thank you for choosing Yardley Dermatology Associates as your health care provider. We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware of and understand our financial policy.

Please ask if you have any questions about our fees and policies and your responsibilities. It is your responsibility to notify our office of any patient information changes (e.g. address, name change, insurance policy, etc).

***PLEASE INITIAL ON EACH LINE AFTER READING EACH SECTION OF THE FINANCIAL POLICY:***

_____ **COPAYS, CO-INSURANCE, & DEDUCTIBLES**

The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of your appointment. We accept cash, checks, Visa, Mastercard, American Express, and Discover. If you have an insurance deductible or co-insurance, any and all office visit and/or procedure charges will apply towards your deductible, and you will be billed accordingly. If a patient is a minor (18 years of age and below) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian assumes responsibility for any payment due at the time of service.

If you are unable to pay for necessary medical care, you may be eligible for financial assistance or a payment plan. It is your responsibility to inform us of your financial need **prior** to your visit. Please ask to discuss arrangements with our billing department.

_____ **MEDICAL PROCEDURES**

Any medical procedures (e.g. liquid nitrogen "freezing" treatment or biopsies) performed in our office are considered separate, billable charges in addition to your office visit charge.

_____ **COSMETIC FEES & PAYMENT**

Certain procedures and services provided during your medical visit are not covered by most insurance companies. These are considered cosmetic procedures. It is your responsibility to understand that you may have cosmetic fees in addition to your medical visit. These fees are due at the time of service.

_____ **INSURANCE CLAIMS**

As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of the claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. **If your insurance requires referrals to specialists, it is your responsibility to obtain that referral PRIOR to your appointment. Failure to obtain a valid referral may hold you responsible for any payments incurred for services rendered.** Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to, those charges above the usual and customary allowance. If we are out of network and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately.

***(CONTINUED ON NEXT PAGE)***

*(CONTINUED FROM PREVIOUS PAGE)*

_____ **SELF-PAY ACCOUNTS**

Self-pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay accounts are payable at the time of service.

_____ **CANCELLATION OF APPOINTMENTS**

Yardley Dermatology Associates requires a 24-hour notice for appointment cancellations so that we can offer the appointment to another patient who needs to be seen. There is a fee of $50 for medical appointments that are missed and/or are not previously cancelled. There is a fee of $100 for cosmetic appointments that are missed and/or are not previously cancelled. This fee must be paid before rescheduling the missed appointment.

_____ **RETURNED CHECKS**

The charge for returned checks is $30 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

_____ **OUTSTANDING BALANCE POLICY**

A medical practice, like any business, depends on timely payments. It is our policy that all accounts remain current. In the event that a patient balance remains outstanding and no resolution can be made, your account may be sent to a collection agency and/or you may be discharged from the practice.

_____ **ASSIGNMENT OF BENEFIT**S

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to Yardley Dermatology Associates. I understand that I am responsible for any amount not covered by insurance.

_____ **LABORATORY FEES**

Most laboratory charges, such as blood work, cultures, and pathology tests, ordered through our office are billed directly to your insurance by the laboratory processing the test. In the case of biopsies performed in our office, Yardley Dermatology utilizes our in-house lab to process the specimens. We then send the slides to a separate lab where a pathologist reads the slide and makes a diagnosis. These two steps are billed independently from each other. If you receive a statement from the pathologist laboratory, we request that you contact them directly to resolve any billing questions.

***I have read and understand the above information and agree to comply with these financial policies.***

_____ _____

*Printed Name of Patient or Legal Guardian* *Date*

_____ _____

*Patient Name (If different from above)* *Date*

_____ _____

*Signature of Patient or Legal Guardian* *Date*

☐ ***Free Skin Care Consultation***

Please check here if you would like to arrange a Consultation with one of our estheticians to discuss Skin care products and/or treatments we offer.

Preferred Phone #: _____

E-mail: _____

**MIPS 2021 Patient Questionnaire**

**Date**: _____.

**Patient Name**: _____. **Date of Birth**: _____.

**Primary Care Physician:** _____. **I do not have a PCP**

**Referring Physician:** _____. **I do not have a referring physician**

**Please Answer All Applicable Questions**

**Please describe your tobacco habits**

- Never Tobacco User
- Former Tobacco User
- Current Everyday Tobacco User
- Current Occasional Tobacco User

**Have you received a flu vaccine?**

- Yes → Please provide date (month/year) _____/_____.
- No → Please choose reasoning below
  - Allergy to eggs
  - Cultural/Spiritual belief
  - Decline to receive vaccination(s)

**Patients 65+ Only**

**Have you ever received a pneumonia vaccine?**

- Yes → Please circle which vaccine below and provide year vaccine was received.
  - PCV13 / Prevnar 13 → Year: _____.
  - PPSV23 / Pneumovax23 → Year: _____.
- No

**Do you have a health care proxy?**

**Proxy (medical power of attorney) – A person named to make medical decisions on your behalf if you are no longer able to do so.*

- Yes → Please provide details below
  - Name: _____.
  - Phone Number: _____.
- No
- Decline

**Do you have a living will?**

** Living will – A written statement of a person's desires regarding their medical treatment if that person is no longer able*
*to express informed consent*

- Yes → Please Explain: _____.
- No
- Decline