goodman DERMATOLOGY P.C.

MEDICAL HISTORY

Goodman Dermatology, P.C. is pleased that you have chosen us for your healthcare needs. The information you provide in this form will assist us in attending to your healthcare needs more effectively and efficiently. It is important that you provide us with any changes or updates (address, insurance company, etc.) each time you see us. For more information about the products and services we offer, please speak with a member of our staff.

Patient_____Date _____

Reason for today's visit _____

How did you hear about us? _____ Referring Physician _____

Pharmacy_____Phone_____Address_____

Current medication	**Y**	**N**	
Do you currently take any medications?	☐	☐	If yes, please list:
Do you have any allergies to food or medication?	☐	☐	If yes, please list:
Are you currently on any prophylactic antibiotics?	☐	☐	If yes, please list:
Do you drink alcohol?	☐	☐	If yes, what: Amt per day
Do you currently use IV drugs?	☐	☐	If yes, what: Amt per day
Have you ever been exposed to HIV/AIDS?	☐	☐	Have you ever had a blood transfusion? Y☐ N☐
Have you ever had dental anesthesia (Novacaine)?	☐	☐	Any adverse reaction? Y ☐ N☐
Are you allergic to Latex?	☐	☐	

Skin	**Y**	**N**	
Have you ever had skin cancer?	☐	☐	If yes, location(s):
Family history of skin cancer?	☐	☐	Relationship:
Do you currently use skin care products?	☐	☐	If yes, what:

When exposed to sun, do you : ☐ Tan ☐ Tan & Burn ☐ Burn

List any other disease or condition we should be aware of: _____

List surgical procedures performed within the last 6 months: _____

Please mark all the conditions that you have or have had:

☐ Arthritis	☐ Asthma	☐ Blood clots in legs	☐ Chronic Bronchitis
☐ Diabetes	☐ Lupus	☐ Hay Fever	☐ Heart disease
☐ History of Mental Illness	☐ Hives	☐ Kidney Disease	☐ Tuberculosis
☐ Ulcers of the stomach or bowel	☐ Valley Fever	☐ Hepatitis:	☐ Other:

Please answer the following questions	**Y**	**N**		**Y**	**N**
Do you smoke?	☐	☐	Do you have a pacemaker?	☐	☐
Do you have artificial joints, pins or screws?	☐	☐	Do you require antibiotics prior to surgery?	☐	☐
(Women) Are you pregnant?	☐	☐	If no, date of your last menstrual		
Are you breast feeding?	☐	☐	Are you trying to conceive?	☐	☐

WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF FINANCIAL & OFFICE POLICIES

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Please print patient's name: _____

A Statement of Financial Policies for Our Patients

First, please allow us to welcome you to our office. We hope to make your visits as enjoyable as possible. Unfortunately, aside from the emotional and physical impact of any medical treatment, there is all too often a degree of financial impact as well. We would like to ease your financial burden as much as possible. Your review of our financial policies at this time will greatly assist us in avoiding future misunderstandings and will make everyone's experience that much more pleasant.

AGREEMENT TO PAY: The undersigned accepts that all patient responsibilities will be collected same day of service and accepts the fee charged as a lawful debt and promises to pay said fees including the cost of collections, attorney fees, and court costs if such be necessary.

SIGNATURE ON FILE

I authorize release of information to all insurance companies and permit this copy of my signature to be kept on file for processing medical claims for myself/or said child(ren). I understand that all responsibility for payment for medical services provided in this office for myself or said child(ren) is mine. I also understand this office has no contract or connection with my medical insurance company. I agree to pay my deductible and any portion of the medical fee not covered by my medical insurance plan at the time of service. I will notify this office if I have a change in my medical coverage.

_____ _____
Signature of Patient/ Parent / Guardian Date

PAYMENT OPTIONS

For your convenience, we accept Visa, MasterCard, Discover, and American Express, as well as Debit. We do not accept checks. Our extended payment plan is available through CareCredit as well for transactions over $250.

I acknowledge that I have read the above office policy to their entirety.

Patient or Guardian Signature_____ Date_____

WRITTEN ACKNOWLEDGEMENT FORM
RECEIPT OF NOTICE OF PRIVACY PRACTICES

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I, _____, have (1) received a copy Notice of the
Patient Name

Privacy Practices of Goodman Dermatology, P.C. or

(2) been offered a copy of Goodman Dermatology, P.C Notice of the Privacy Practices but declined to accept a copy.

_____ The Patient refused to accept a copy of the Notice of Privacy Practices and refused to sign an acknowledgement that it was offered to the patient.

_____ _____
Signature of Patient Accepting Date

**We reserve the right to charge a fee of $25, at the provider's discretion, for medical records released to any individual patient, practice, or any third party company.

Patient Privacy Questionnaire:

1. Please list the family members or other persons, if any, whom we may inform about your general medical condition & diagnosis (including treatment, payment and health care operations).
   _____
   _____
   _____

2. Please list the family members or other persons, if any who have permission to bring your minor child.
   _____

3. Can confidential messages (i.e appointment reminders) be left on your telephone answering machine or email? (This will not include any biopsy that are not benign) ___Yes ___No

   EMAIL ADDRESS: _____

   _____
   Signature of Patient or Parent/Legal Guardian DATE

   _____
   Print Name of Parent/Legal Guardian Relationship

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Cancellation Policy/No Show Policy & Account Balances
For Provider Appointments and Surgery

1. **Cancellation / No Show Policy for Provider Appointments**

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

- **If an appointment is not cancelled/rescheduled by 10:00 am the day before your appointment you will be charged a fifty dollar ($50) fee.**
- **To cancel/reschedule a Monday appointment call our office by 2:00 pm on Friday.**

***This will not be covered by your insurance company and must be paid BEFORE being seen at your next appointment.**

2. **Scheduled Appointments**

We understand that delays can happen, however we must try to keep the other patients and providers on time.

- **If a patient is 10 minutes past their scheduled time they could be seen by a different provider.**

3. **Cancellation / No Show Policy for Surgery/Mohs**

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

- **If Surgery/Mohs is not cancelled at least 5 days in advance you will be charged a hundred dollar ($100) fee.**

***This will not be covered by your insurance company and must be paid BEFORE being seen at your next appointment or reschedule your Surgery/Mohs.**

4. **Account Balances and Services**

Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Insurance

Patients with balances that are owed must pay their account balance to zero (0) prior to future appointments being made. If you are in collections your balance must be paid in full prior to scheduling an appointment. Our office does offer care credit for payment plans.

Self-Pay

- We require that patients with self-pay balances pay their account balances to zero (0) prior to receiving further services by our practice.
- A fifty dollar ($50) deposit must be made when scheduling an appointment. This will be applied to services rendered. If you no show your appointment this will be applied to your no show fee and another fifty dollar ($50) deposit will need to be paid before scheduling another appointment.

Additional Services

- For scheduled aesthetician services payment must be made in full at time of scheduling. See no show/cancellation policy above.
- For scheduled cosmetic services payment must be made in full at time of scheduling, additional procedures will be collected prior to procedure. See no show/cancellation policy above.
  Note no show / cancellation fee is a hundred dollar ($100) for cosmetic services.

_____ _____ __/____/___

Print Name Patient | Signature Patient/Guardian | Date