HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

PATIENT INFORMATION FORM

Chart # _____
Date _____

PLEASE COMPLETE ALL INFORMATION FULLY (please print)
PATIENT NAME

Last _____ First _____ Middle Initial _____Nickname_____

Address_____ Home Phone _____
Street City State/Zip code

Birth Date _____ Age _____ Primary Phone _____ Cell Phone_____

SSN _____ Sex: ☐Male ☐Female Employer_____ Work Phone _____

Ethnicity (please circle one) Hispanic or Latino Not Hispanic or Latino **Contact Preference** Phone Text Email

Race (please circle one) White Black/African American Indian Asian Native Hawaiian Hispanic Other

Preferred Language _____

Status ☐ Minor ☐Single ☐Married ☐Widow ☐Divorced ☐ **Email**:_____

Insured Party _____ Employer _____ Work Phone_____

Responsible party_____ DOB _____ Home Phone _____

Address _____ Work Phone_____

IF PATIENT IS A MINOR OR DEPENDENT

Father's Name: Last _____ First _____ Middle Initial _____

Address _____ Home Phone _____
Street City State/Zip code

Birth Date _____ SSN _____ Employer _____ Work Phone _____

Mother's Name: Last _____ First _____ Middle Initial _____

Address _____ Home Phone _____
Street City State/Zip code

Birth Date _____ SSN _____ Employer _____ Work Phone _____

Lives with both parents ☐ Lives with Mother ☐ Lives with Father Other _____

PLEASE CHOOSE ONE OF THE FOLLOWING OPTIONS:

☐ ☐ If I choose not to accompany my minor child or dependent to his/her follow-up appointments, I authorize Dr. Shaffer or his appointee to perform the treatments and/or procedures necessary to deliver appropriate healthcare. I understand this will include evaluation and management for the presenting problem. I understand it may also include prescription of medication, application of liquid Nitrogen, as well as other minor procedures.

☐ ☐ I will accompany my minor child or dependent to his/her follow-up appointments. I understand if I do not accompany him/her, he/she will not be seen.

(Parent or Guardian Signature) _____ Date_____

Nearest friend or relative NOT living with you _____ Relationship _____

Home Phone _____ Work Phone _____

PHYSICIANS ASSISTANTS: This office employs Nurse Practitioners and Physicians Assistants. Occasionally and/or routinely your visit will encompass evaluation/treatment by our Nurse Practitioners or Physicians Assistants as either a component of your visit or, if necessary, in place of the physician on staff. Our APRN's and PA's work closely with and are supervised by our physician in all aspects of your case.

Referring Doctor _____ City _____ Phone _____
Last Name First Name

Family Doctor _____ City _____ Phone _____
Last Name First Name

PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE SIDE

(TO BE COMPLETED FOR ALL MEDICARE PATIENTS ONLY)

1. Are you a veteran? Yes No
   a. Did the VA refer you here for treatment? **Yes No**
   b. Do you have a VA "fee basis ID card? **Yes No**
2. Do you have a Federal Black Lung Card? **Yes No**
3. Is this medical condition due to an accident of any kind? **Yes No**
   If yes, was it: ____ Work related; ____ Auto; ____ Injured in own home; Other _____
4. Are you covered by an employer's health insurance through your own employment or that of a family member? **Yes No**
   If yes, does that employer have more than 20 employees? **Yes No**
5. Have you recently joined a Medicare Advantage Plan? **Yes No**

INSURANCE AUTHORIZATION AND PAYMENT POLICY

Primary Insurance _____	Secondary Insurance_____
Policy Holder _____	Policy Holder _____
His/Her SS #_____Date of Birth _____	His/Her SS #_____Date of Birth _____
Relationship to the Patient _____	Relationship to the Patient _____

1. I understand Heartland Dermatology Center is a participating provider with BC/BS, Medicare, PHC, Coventry, WPPA, UHC Kancare, United Healthcare, HPK network, and TriCare. I am responsible for any amounts not covered by any insurance or other party.
2. I understand that all co-pays are due at the time of service.
3. I understand I may request a payment plan prior to seeing the provider.
4. I request that payment of benefits be made on my behalf to Heartland Dermatology Center for any services furnished by their providers.
5. I hereby authorize Heartland Dermatology Center to furnish information to insurance carriers concerning my illness and treatments.
6. I understand and verify all information is correct to the best of my knowledge.
7. **TRICARE PATIENTS**: If a referral is required it is your responsibility to ensure our office receives this prior to your appointment.
8. **ALL OTHER INSURANCES**: If our office is not assigned or contracting with your insurance company, you will be required to pay for all services rendered to you. If you are not sure if we are a contracting provider it is your responsibility to check with your insurance company prior to your appointment.

Patient's Signature: _____ Date: _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICE

1. I acknowledge that I have had an opportunity to review and/or received Heartland Dermatology Center's "Notice of Privacy Practices."
2. I consent to Heartland Dermatology Center's use and disclosure of my personal health information to carry out treatment, payment and healthcare operations unless I have determined to pay for services in full at the time of service.
3. I understand this means Heartland Dermatology Center may call and leave a message on voice mail or in person in reference to any items that assist in meeting my healthcare needs, such as appointment reminders, insurance items, laboratory results, clinical care information among others. I also understand Heartland Dermatology Center may also mail items to my home or other designated location such as appointment reminders, statements, brochures, and other items.
4. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I understand if I do not sign this consent, Heartland Dermatology Center may decline to provide treatment to me.
5. I WISH TO ALLOW the following person(s) access to any information concerning my health care:

_____ _____ Patient Must Initial:_____

Patient's Signature: _____ Date: _____