HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

Office Use Only
Chart #: _____
Appt Date: _____

Patient Information Form

Name: _____ **Nickname**: _____
First MI Last

Mailing Address: _____ **City/State**: _____ **Zip Code**: _____

Date of Birth: _____ **Age**: _____ **Gender**: _____ **SSN#:** _____

Email Address: _____ ***By providing your email, you agree to receive communication including a company newsletter. If you wish to opt-out of this indicate here. No, thanks*** ☐

Phone Number (home): _____ **Phone Number (cell):** _____

Phone Number (work): _____ **Employer**: _____

Preferred Contact: Phone / Text / Email **Preferred Language**: _____

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

Ethnic Group (circle one): Hispanic or Latino / Not Hispanic or Latino

Marital Status (circle one): Minor / Single / Married / Widowed / Divorced / Separated

Insured Party Name: _____ **Insured Party Employer and Phone:** _____

Responsible Party (Guarantor) Name: _____ **Guarantor DOB**: _____

Guarantor Street Address: _____ **City/State**: _____ **Zip Code**: _____

Guarantor Primary Phone: _____ **Guarantor Work Phone**: _____

IF THE PATIENT IS A MINOR OR DEPENDENT, COMPLETE THIS SECTION:

Primary Parent's Name: _____ **DOB**: _____
First MI Last

Street Address: _____ **City/State**: _____ **Zip Code**: _____

SSN#: _____ **Employer**: _____ **Primary Phone**: _____

Patient lives with (circle one): Both parents / Mother / 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 the primary provider to perform 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, administration of local anesthesia, 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**: _____

Emergency Contact

Nearest Friend or Relative NOT living with you: _____ **Relationship**: _____

Primary Phone: _____ **Alternate Phone**: _____

Advanced Practice Providers (APPs): This office employs Nurse Practitioners and Physician Assistants. Occasionally and/or routinely your visit will encompass evaluation/treatment by our Advanced Practice Providers as either a component of your visit, or, if necessary, in place of the physician on staff. Our APP's work closely with and are supervised by our physician in all aspects of your care.

PLEASE COMPLETE INSURANCE INFORMATION ON REVERSE

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**
   If yes, identify: _____
6. Are you covered by a commercial HMO/PPO, which makes Medicare secondary insurance? **YES NO**

It is the policy of this office to review the accuracy of this information annually.

ONE TIME AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Heartland Dermatology Center, PA for any services furnished to me by their providers. I authorize any holder of medical information about me to release to Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient Signature: _____ **Date**: _____

MEDIGAP PAYMENT AUTHORIZATION (Secondary Insurance)

I hereby authorize payment of my Medigap benefits from _____ to Heartland Dermatology Center, PA for all claims on my behalf. This authorization applies to all services until it is revoked by me or my representative.

Patient Signature: _____ **Date**: _____

INSURANCE AUTHORIZATION AND PAYMENT POLICY

Primary Insurance: _____ **Secondary Insurance**: _____

Policy Holder: _____ **Policy Holder**: _____

Policy Holder SSN#: _____ **Policy Holder SSN#**: _____

Policy Holder DOB: _____ **Policy Holder DOB**: _____

Relationship to Patient: _____ **Relationship to Patient**: _____

1. I understand Heartland Dermatology Center is a participating provier 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 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. It is your responsibility to check with your insurance company regarding our contract prior to your appointment.

Patient 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 options unless I have determined to pay for services in full at time of service.
3. I understand this means Heartland Dermatology Center may call and leave a message on voicemail 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) TO ACCESS ANY INFORMATION CONCERNING MY HEALTHCARE:**
   _____ Patient must initial: _____

Patient signature: _____ **Date**: _____