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**: _____ **Birth Sex**: _____ **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 **Preferred Pronoun:** He / She / They

Gender Identity: Male / Female / Transgender Male / Transgender Female / Genderqueer / Other: _____

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: _____

If the legal guardian is unable to accompany the minor patient to their appointment, who else may accompany the patient to their appointment? _____

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**: _____

HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

Intake and History Form

Patient Name: _____ **Height:** _____ **Weight:** _____

Date of Birth: _____ **Age**: _____ **Gender**: _____ **Preferred Language**: _____

Place of Birth (City, State and Zip): _____

Employer: _____ **Occupation**: _____

Primary Doctor: _____ **Referring Doctor**: _____

Preferred Pharmacy

Name: _____ **Address**: _____ **Phone Number**: _____

What is the main concern for your visit today? _____

What areas of your body are affected? _____

How long have you had this concern? _____

Symptoms (circle all that apply): pain itch bleeding enlargement spreading burning redness embarrassment blistering other: _____

What oral medications have you tried for this concern? _____

What topical medications (prescription or OTC) have you tried? _____

List any other treatments you have used: _____

Which of these products have been helpful? _____

Past Medical History

Select any of the following medical conditions that you currently have or have had:

- ☐ Adverse anesthesia outcome
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia (BPH)
- ☐ Bipolar Disorder
- ☐ Blood Coagulation Disorder
- ☐ Cerebrovascular Accident (CVA)
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Deep Vein Thrombosis (DVT)
- ☐ Depression
- ☐ Diabetes
- ☐ Disease caused by COVID-19
- ☐ Easy Bruising
- ☐ Elevated Blood Pressure
- ☐ End Stage Renal Disease
- ☐ Epilepsy
- ☐ Esophageal Reflux (GERD)
- ☐ Hearing Loss
- ☐ Heart Valve Disorder
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Hepatitis (Type): _____
- ☐ Kidney Disease
- ☐ Leukemia
- ☐ Lupus erythematosus
- ☐ Lymphoma
- ☐ Lung Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Prostate Cancer
- ☐ Paralysis
- ☐ Pneumothorax
- ☐ Pulmonary Embolism
- ☐ Radiation Treatment
- ☐ Rheumatoid Arthritis
- ☐ Transplant of Bone Marrow
- ☐ Seizures
- ☐ Stroke
- ☐ Congestive Heart Failure (CHF)
- ☐ Transplant (Organ): _____
- ☐ Other: _____

Past Surgical History

Select any of the following surgical procedures that you have had:

- ☐ Rectum: Abdominoperineal resection (APR)
- ☐ Joint replacement: Knee (Right / Left / Both)
- ☐ Breast: Biopsy of Breast
- ☐ Prostate: Biopsy of Prostate
- ☐ C-Section
- ☐ Lung: Complete Excision (Right / Middle / Left)
- ☐ Heart: Coronary Artery Bypass Graft (CABG)
- ☐ Kidney: Kidney Transplant
- ☐ Stomach: Gastrostomy
- ☐ Spinal Surgery
- ☐ Ovaries: Tubal Ligation
- ☐ Appendix (Appendectomy)
- ☐ Gallbladder (Cholecystectomy)
- ☐ Colon (Colectomy)
- ☐ Esophagus (Esophagectomy)
- ☐ Liver (Hepatectomy)
- ☐ Heart: Percutaneous Transluminal Coronary Angioplasty (PTCA)
- ☐ Heart: Tissue Graft Heart Valve Replacement
- ☐ Bladder (Cystectomy)
- ☐ Prostate: Transurethral Prostatectomy (TURP)
- ☐ Hysterectomy
- ☐ Kidney Biopsy
- ☐ Laparascopy
- ☐ Lung: Lobectomy (Upper Lobe: Right / Left)
- ☐ Lung: Lobectomy (Lower Lobe: Right / Left)
- ☐ Rectum: Lower Anterior Resection
- ☐ Breast: Lumpectomy (Right / Left / Both)
- ☐ Breast: Mastectomy (Right / Left / Both)
- ☐ Heart: Mechanical Heart Valve Replacement
- ☐ Ovaries (Oophorectomy)
- ☐ Brain Operation
- ☐ Pancreas: Pancreatectomy
- ☐ Kidney: Kidney Stone Removal
- ☐ Liver: Portosystemic Shunt Operation
- ☐ Prostate: Prostatectomy
- ☐ Joint Replacement: Hip (Right / Left / Both)
- ☐ Hernia repair (Type: _____)
- ☐ Small intestine resection
- ☐ Spleen: Splenectomy
- ☐ Stomach: Total Gastrectomy
- ☐ Kidney: Nephrectomy
- ☐ Testicle: Orchidectomy
- ☐ Heart Transplant
- ☐ Liver Transplant
- ☐ Other:

_____
_____
_____
_____
_____

Skin Disease History

Have you had any of the following:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Dry Skin (Asteatosis Cutis)
- ☐ Basal Cell Skin Cancer
- ☐ Poison Ivy
- ☐ Precancerous (Dysplastic) Moles
- ☐ Eczema
- ☐ Asthma
- ☐ Hay Fever / Allergies
- ☐ Malignant Melanoma
- ☐ Flaking or Itchy Scalp
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Other:

_____
_____
_____
_____
_____

Do you wear sunscreen? ◯ **YES** ◯ **NO** **If yes, what SPF?** _____

Do you tan in a tanning salon? ◯ **YES** ◯ **NO**

Do you have a family history of malignant melanoma? ◯ **YES** ◯ **NO** **If yes, which relative?** _____

Do you have a family history of Basal Cell Carcinoma (BCC) or Squamous Cell Carcinoma (SCC)? ◯ **YES** ◯ **NO**
If yes, which relative? _____

Patient Name: _____

Medications

List all current medications (prescription, OTC medications and supplements) including dose and frequency:

Medication Name	Dose	Frequency

Allergies

List all allergies to medications

Social History

Smoking Status (Choose one)

- ☐ Current everyday smoker
- ☐ Current occasional smoker
- ☐ Cigar smoker
- ☐ Former smoker
- ☐ Never smoker

Alcohol Intake (Choose one)

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1 to 2 drinks per day
- ☐ 3 or more drinks per day

How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? _____

Immunizations

For patients 60 and older, have you received the Pneumococcal (Pneumovax) vaccine? ◯ YES ◯ NO

For all patients, have you received the Influenza vaccine this flu season? ◯ YES ◯ NO

Review of Systems

Are you currently or have you recently experienced any of the following (mark all that apply):

- ☐ Diarrhea
- ☐ Nausea
- ☐ Vomiting
- ☐ Fever or chills
- ☐ Fatigue
- ☐ Night sweats
- ☐ Cough
- ☐ Shortness of breath
- ☐ Unintentional weight loss
- ☐ Weight gain
- ☐ Depression
- ☐ Anxiety
- ☐ Pain/burning on urination
- ☐ New onset of joint aches
- ☐ Numbness/weakness

Alerts

Select any of the following that you have (mark all that apply):

- ☐ Allergy to Adhesive
- ☐ Allergy to Lidocaine
- ☐ Allergy to Topical Antibiotic Ointment
- ☐ Artificial Heart Valve
- ☐ Artificial Joint within the past 2 years
- ☐ Blood Thinners
- ☐ Defibrillator
- ☐ Pacemaker
- ☐ MRSA
- ☐ Premedication Prior to Procedures
- ☐ Rapid Heartbeat with Epinephrine
- ☐ Pregnant
- ☐ Planning Pregnancy
- ☐ Breastfeeding

_____ _____

Patient or Patient Representative Signature **Date**

_____ _____

Health Care Provider Signature **Date**

HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

Financial Policy

Payment Information:
Payment to Heartland Dermatology (HDC) is required in exchange for providing healthcare services. We accept cash, checks, and all major credit cards. *All co-payments and outstanding balances must be paid in full at check-in at every appointment.* The balance is due in full within 30 days for each DOS. Any remaining balance after insurance adjustments and remittance will be subject to insurance deductible and will be the patient's responsibility. Past-due patient balances over 90 days are subject to collections. Payment arrangements can be made upon request and approved at the discretion of the A/R Manager. Call 785-827-2500 to request a payment plan.

Insurance Claims & Eligibility:
HDC utilizes a third-party billing company to submit insurance claims; patients may be required to provide information directly to their insurance company for a claim to be processed. To ensure insurance claims are filed accurately, HDC requires a copy driver's license and insurance card upon check-in. Referrals and VA authorizations are the patient's responsibility to obtain. Failure to provide a referral (if applicable), current form of ID and proof of insurance will require payment in full at the time of service until insurance coverage can be verified. If necessary, HDC or the third-party billing company will appeal insurance denials on the patient's behalf; if insurance upholds denial **after 90 days**, the remaining balance will be patient responsibility. Patient must notify HDC of any changes to their insurance or demographic information (address, name change, etc.) to prevent delays in insurance claim filing and unnecessary patient out-of-pocket payments.

Patient is responsible for knowing and understanding their own insurance coverage including co-payment, referral requirements, deductible/coinsurance, and in-network benefits

Self-Pay and Deposit Requirements
Patients are considered Self-Pay if:

1. **Patient does not carry health insurance
2. **HDC is not contracted with patient's insurance carrier
3. Services provided at time of visit are not medically necessary

** Deposit at check in is required, see table below for deposit parameters:

Deposit Amounts for Self-Pay Patients:	
New Patient	$80.50
Established Patient	$62.36

Not-Medically Necessary/Cosmetic Procedures:
All Medicare patients must sign an ABN (Advance Beneficiary Notice) for services deemed *"not medically necessary"* by Medicare. For all other insurance carriers, not-medically necessary procedures are subject to the self-pay fee schedule and payment is due in full at time of service.

No Surprises Act/Good Faith Estimate (GFE):
HDC will produce a *"Good Faith Estimate"* **at the time of visit** if requested by the self-pay patient **PRIOR** to any procedure/treatment. GFE provides a quote for the cost of a procedure/treatment BEFORE services are performed on the day of the visit. Patient can authorize the provider to proceed or halt treatment based upon their current financial situation. Additional details of the No Surprises Act and GFE can be provided to the patient immediately upon request.

Pathology:
To provide optimal and timely patient care, HDC has an in-house pathology lab and Board-Certified Dermatopathologist to process and diagnose patient specimens/biopsies. However, some patient specimens may require special stains and/or third-party second opinions to properly diagnose the condition. HDC utilizes a variety of third-party vendors for these unique situations, these services are billed separately to the patient and are not affiliated with any HDC services.

Non-Medical Fees:
Additional fees may apply to the following:

- Returned Checks ($35)
- Missed Appointments (optional)
- Copy of medical records ($50)

Minors:
For patients under 18, a parent or guardian is responsible for payment. In addition, minors are unable to receive medical treatment without the consent of a parent or legal guardian.

By signing below, I hereby certify that I read and understand the financial policy of HDC and agree to abide by the terms outlined in this document. I authorize HDC and/or their 3rd party billing to release the necessary information to complete and process my insurance claim(s).

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name of Patient or Responsible Party Relationship to Patient

_____ _____
Signature of Witness Printed Name of Witness

HEARTLAND DERMATOLOGY and SKIN CANCER CENTER, PA

No-Show Policy

Heartland Dermatology requests a 24-hour notice if you are unable to make your appointment. This allows us to best serve our patients who may have to wait longer to be seen because of a time slot being occupied and then going unused. We understand your time is valuable and that changes may occur with little notice. To efficiently serve all or our patients we kindly request a 24-hour notice for all cancellations. This provides us enough notice to offer your valuable appointment time to another patient.

Patients who fail to show for their scheduled appointment will be issued a no-show fee. Courtesy reminders, calls, or emails are attempted 24-72 hours before your appointment. Please understand that if you no-show your appointment, you will be billed a no-show fee as listed below. This fee is not covered by your insurance, and it will be your responsibility to pay.

-Medical Visit: $50
-Cosmetic Visit: $75
-Surgical Visit: $100

We require payment on this charge before any future appointment can be made.

Due to the increasing demand for appointments, we enforce this policy to give each one of our patients the best service.

Heartland Dermatology understands that urgent extenuating circumstances can arise that may prevent you from fulfilling your appointment with us. In an event of this nature, please contact our office at 316-612-1833 to discuss possibly waiving the fee.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Printed Name of Patient or Responsible Party Relationship to Patient

_____ _____
Signature of Witness Printed Name of Witness