RESOLUTE
DERMATOLOGY
SKIN CANCER SPECIALISTS

FORM
New Patient Information

PATIENT REGISTRATION

Patient Name (First, MI, Last) _____ DOB _____

Preferred Name (Ex: Christopher "Chris")_____Patient Social Security # _____

Address:_____

City, State, Zip:_____ Gender: MALE FEMALE

Race: _____ Ethnicity: NON-HISPANIC HISPANIC DECLINE TO ANSWER

Primary Language Spoken in the Home: _____

Pharmacy _____ Address _____

Emergency Contact (Outside of the Home) _____ Phone _____

Email Address: _____

Primary Care Physician:_____ Address: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

Name _____

Relationship to Patient _____

DOB _____ SSN _____

[ ] Same as Patient

Address _____

Phone: _____

Employer: _____

INSURANCE INFORMATION

Primary Insurance: _____ ID # _____ Group # _____

Subscriber: _____ DOB: _____ SSN_____

Employer: _____ Relationship to patient: _____

Secondary Insurance: _____ ID # _____ Group # _____

Subscriber: _____ DOB: _____ SSN_____

Employer: _____ Relationship to patient: _____

FORM

Patient Intake Form

Name: _____

RESOLUTE DERMATOLOGY
SKIN CANCER SPECIALISTS

Have you met our providers before? Yes No *If Yes, Welcome back!*
If No, Welcome to our new clinic. We are looking forward to your visit.

How did you hear about us? Advertisement Online Search Self/ Friend Referred _____

Reason for today's visit: _____

Skin areas involved: _____

How long has the problem been present? _____

Any prior treatment? No Yes _____

Any prior biopsy? No Yes

If yes, when? _____ By whom? _____

CIRCLE ALL THAT APPLY TO TODAY'S PROBLEM

A change in the following...

Quality	**Symptoms**		**Frequency**
size	bleeding	itching	no symptoms
elevation	tingling	infection	occasional
color	pain	ulceration	constant
other	other		

FAMILY SKIN CANCER HISTORY

No Yes (If yes, list relative and type)

_____

VACCINATIONS

Have you received the pneumococcal vaccine?

No Yes

Flu (influenza) Vaccine this season? No Yes

SOCIAL HISTORY

Tanning bed use: No Yes

Sunscreen use: No Yes

Current Occupation or Retired:

_____

Alcohol use: No Yes

if yes, amount per week _____

Smoking/Cigar/Other: No Yes Former

PAST MEDICAL HISTORY

Personal history of skin cancer? No Yes, circle type

None Melanoma Basal Cell Carcinoma

Squamous cell carcinoma Other _____

Have you ever had Mohs surgery? No Yes

Do you have an organ transplant? No Yes

If yes, what type? _____

Do you have a pacemaker? No Yes

Do you have a defibrillator? No Yes

Do you have an artificial heart valve? No Yes

Do you take antibiotics before dental procedures? No Yes

Do you have any artificial joints? No Yes

If yes, type/when was your surgery? _____

Have you been diagnosed with:

HIV / AIDS No Yes

Hepatitis B No Yes

Hepatitis C No Yes

Other Major illness, hospitalizations and surgeries

_____

Signature of Patient or Responsible Party: _____ Date: _____

RESOLUTE
DERMATOLOGY
SKIN CANCER SPECIALISTS

Patient Name: _____ Date of Birth:_____

Allergies: N Y

if yes, please list what you are allergic to and reaction

_____ _____

_____ _____

_____ _____

Medication Name	Dosage	Frequency	Start Date	Prescribing Doctor

RESOLUTE
DERMATOLOGY
SKIN CANCER SPECIALISTS

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

PATIENT AUTHORIZATION FOR USE/DISCLOSURE OF PERSONAL HEALTH INFORMATION

I understand that as part of my healthcare, Resolute Dermatology originates and maintains health records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information is utilized to plan my care and treatment, to bill for services provided to me, to communicate with other healthcare providers and other routine healthcare operations.

Resolute Dermatology *Notice of Privacy Practices* provides specific information and a complete description of how my personal health information (PHI) may be used and disclosed. I have been given the opportunity to review a copy of the Notice of Privacy Practices, located in the waiting room and understand that I have the right to review the notice prior to signing this authorization.

I understand that I have the right to restrict the use and/or disclosure of my personal health information for treatment, payment, or healthcare operations and that Resolute Dermatology is not required to agree to the restrictions requested. I may revoke this authorization at any time in writing except to the extent that Resolute Dermatology has already taken action in reliance on my prior consent. This consent is valid until revoked by me in writing .

I acknowledge that Resolute Dermatology provided me with a written copy of its *Notice of Privacy Practices*.

I also acknowledge that I have been afforded the opportunity to read the *Notice of Privacy Practices* and ask questions.

If you would like to designate any individuals to have access to your private health information please list them below:

Name _____ Relationship _____

Please list any other restrictions on the use/or disclosure of your personal health information:

_____

Full Name (please print): _____ Date of Birth: _____

Signature of Patient or Responsible Party: _____ Today's Date: _____

RESOLUTE
DERMATOLOGY
SKIN CANCER SPECIALISTS

PATIENT ACKNOWLEDGEMENT and AUTHORIZATIONS

Authorization for Treatment: With your signature below, Resolute Dermatology is hereby authorized to conduct examination, perform procedures as are medically required and administer treatment and medications as deemed necessary or advisable.

Authorization for Release of Information: With your signature below, Resolute Dermatology and its selected lab are hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billings agents, insurance carriers, employer's workers compensation insurance company, other third-party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other intermediaries responsible for payment for services rendered. The release of information consent may be revoked at any time by giving written notice. If release of information if refused, the patient will be held responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits: With your signature below, Resolute Dermatology is given all rights, title and interest to the medical and/or surgical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits including Medicare Part B. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all payments and charges, whether or not they are paid by my insurance. I hereby authorize said assignee to release any necessary information to secure the payment.

I have read the Financial Policy and Authorizations. I understand that there is no guarantee or assurance as to the results that may be obtained from any treatment. I understand the terms and conditions outlined herein as confirmed by my signature below.

Printed Name: _____

Date of Birth: _____

Signature of Patient or Responsible Party _____

Date Signed: _____

RESOLUTE
DERMATOLOGY
SKIN CANCER SPECIALISTS

PHOTOGRAPHIC/AUDIO-VIDEO AUTHORIZATION AND RELEASE

By my signature below, I authorize Resolute Dermatology, and its employees or agents, to photograph/record (hereafter referred to as photographic, recording, or electronic reproductions) in connection with the dermatologic procedure(s) he has performed or may perform. I authorize the use of any such photographic or electronic reproductions of me for purposes of my treatment, educational endeavors, and quality assurance review. To the extent that I am not identifiable from such photographic or electronic reproductions, they may be used for any purpose, including but not limited to dissemination to physicians, health professionals, and members of the public for scientific or educational purposes or publication in newspapers, magazines, and other public media as may be deemed appropriate by Resolute Dermatology.

I understand that I may refuse to consent to the taking of any photographic or electronic reproductions that are not intrinsic to operation or procedure without prejudice to my care. Neither I, nor any member of my family, will be identified by name in any form of publication. Wherever possible, the photos will be cropped to show only the pertinent information, but not personally identifying information.

I understand that in some circumstances, the photographs may portray features that will make my identity recognizable. I have entered into this agreement in order to assist scientific treatment, education, public relations and/or charitable goals and hereby waive any right for compensation for these uses. I and my successors and assignees hereby hold Resolute Dermatology, its employees, and any other person participating in my care and their successors and assignees, harmless against any claim for injury or compensations resulting from the activities authorized by this consent.

Full Name (please print): _____

Signature of Patient or Responsible Party: _____ Today's Date: _____

RESOLUTE
DERMATOLOGY
SKIN CANCER SPECIALISTS

Financial Policy

We are honored you have chosen us as your dermatology healthcare provider and want to provide you and your family with economical high quality care. Our team is here to help file your medical claims and guide you through the insurance process. It is important that you provide the team with your insurance and demographic information to facilitate reimbursement. We are contracted with the majority of insurers at standard rates and any co-pays, deductibles, or non-contractually covered expenses are the responsibility of patients.

If you do not have insurance, or your information is unavailable, you will be considered Self-Pay and payment arrangements will be required at time of service.

Medicare: Resolute Dermatology is proud to be a Medicare Part B Provider. Patients are responsible for any Medicare co-insurance, deductibles or services rendered that are not covered by Medicare.

Medicaid: Resolute Dermatology does not currently participate in Medicaid

Managed Care Plans: Some insurance plans require a referral from a Primary Care Physician (PCP) or pre-certification before treatment can be rendered. It is the patient's responsibility to ensure we have this approval prior to their visit. If a referral or pre-certification has not been obtained in advance, all charges/payments will be the responsibility of the patient or the appointment will need to be rescheduled.
Commercial Plans: Resolute Dermatology has established fees that are usual and customary for dermatology services in this area. If we are contracted with your insurance carrier, their fee schedule will determine the amount due for services provided. All co-pays and deductible payments are due at the time of service.

Non-Covered Services: Some services offered by Resolute Dermatology are considered cosmetic and/or not deemed medically necessary. These services are not covered or paid by insurance.

Laboratory Services: Some services, such as biopsies or surgery, require specimens be sent to a laboratory for processing. The patient may receive a separate bill from the laboratory used. The patient is responsible for payment for all laboratory services not covered by insurance.

Self-Pay: Patients who do not have insurance coverage are considered to be self-pay. Self-pay patients will be required to make payment arrangements prior to services being rendered.

Payment Arrangements: Resolute Dermatology may consider payment arrangements for those patients who need assistance in meeting their account obligation. Resolute Dermatology reserves the right to set the terms, conditions and to charge interest for any payment arrangement.

Deductibles: Insurance deductibles will be collected at the time of service and/or prior to all surgical procedures

RESOLUTE
DERMATOLOGY
SKIN CANCER SPECIALISTS

Credit Cards: Resolute Dermatology accepts Visa, MasterCard, American Express, Discover, Google Pay, and Apple Pay. Debit cards and cash are also accepted. Personal checks are not a preferred form of payment.

Care Credit: Resolute Dermatology is proud to participate in and offer Care Credit financing. Please feel free to discuss this offering with our front desk team.

Returned Check Policy: Resolute Dermatology will charge a twenty-five dollar ($25.00) fee for each check returned by our bank for non-sufficient funds.

Account Refunds for Overpayment: Accounts with $50.00 or less overpayment will remain a credit to the patient's account. Any overpayment of $50.01 or more will be refunded to the patient via check by Resolute Dermatology if all accounts are current.

Disability / FMLA / Other Forms: Resolute Dermatology will charge a twenty-five dollar ($25.00) fee for the completion of each form. Multiple forms are $25.00 per form. Payment is required prior to the completion.

Missed Appointment Fees: Resolute Dermatology may charge a fee for missed office visit appointments when the patient fails to give appropriate notification. A cancellation notice must be received twenty-four (24) hours in advance of the scheduled appointment.

A fifty dollar ($50.00) charge may be applied for failure to meet this requirement. A one hundred dollar ($100.00) charge may be applied for missed surgery/procedure appointments.

Collection Agencies: Any account that is not paid in full within **90 days** of service will be sent to collections. Resolute Dermatology contracts with the collection agency, AIH Receivables. Should it become necessary for Resolute Dermatology to send a patient's account to collections, the patient will be responsible for any and all fees associated with the collection effort of the account. This includes a minimum additional 28% fee and may include reasonable attorney fees, court costs, collection charges and interest. If an account is sent to AIH Receivables it may negatively impact a patient's credit score.

Business Office Contact: Resolute Dermatology contracts with Modmed BOOST for all medical billing services. Their number will be provided on request and patients should not hesitate to call with any inquiries.

Signature of Patient or Responsible Party _____

Date Signed: _____