MILLER DERMATOLOGY
SURGICAL & LASER CENTER

Please Note If this form is not filled out completely, we will not be able to submit to your insurance.

UPDATE INITIALS

Today's Date: _____/_____/_____ Patient Date of Birth: _____/_____/_____ _____

Patient Name: _____ _____ _____ _____
FIRST M.I LAST

Address: _____ _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Home Number: _____ Work Number: _____ Cell Number:_____ _____

**** MAY WE LEAVE MESSAGES WITH MEDICAL INFORMATION AT THE NUMBERS LISTED ABOVE? ☐ Yes ☐ No ****

Gender: ☐ Male ☐ Female Marital Status: ☐ D ☐ M ☐ S ☐ W _____

SSN# _____ Email address: _____ _____

Occupation: _____ Employer:_____ _____

Emergency Contact & relation to patient: _____ Contact Number: _____ _____

Any family members who are patients here? If so, please list: _____ _____

Who is financially responsible for this account? _____

Guarantor Contact Number(s): _____ Guarantor Date of Birth: _____/_____/_____

Guarantor Address: _____ _____ _____ _____
STREET CITY STATE ZIP CODE

Please list the name(s) and phone number(s) of all those that you give us permission to speak to regarding your care here:_____

_____

MEDICAL HISTORY

Are you allergic to any medications? ☐ Yes ☐ No Any other Allergies? ☐ Yes ☐ No

If yes, please list: _____ If yes, please list:_____

_____ _____

_____ _____ _____

Are you taking any medications? (Prescribed/Over the Counter) ☐ Yes ☐ No If yes, please list: _____

_____

_____

What is your preferred Pharmacy? _____ Location: _____ _____

Who is your Primary Care Physician? _____ Contact Number:_____ _____

Are you seeing any other Physicians currently? If so, please list: _____

_____ _____

Do you or any family member have a history of skin cancer? If so, who and what kind?_____

_____

_____

General medical history: _____

_____

_____

SIGNATURE:_____ Relationship to Patient: _____

PAST MEDICAL HISTORY: CHECK ALL THAT APPLY

ALLERGY/IMMUNO.	CARDIO-VASCULAR	SKIN	GE/GU	EYES/NOSE/EARS	PULMONARY
☐ Food Allergy ☐ Hay Fever ☐ Lupus ☐ Rheumatoid Arthritis ☐ Scleroderma ☐ Vasculitis	☐ High Cholesterol ☐ High Triglycerides ☐ Hypertension ☐ Heart Attack ☐ Blood Clots/DVT	☐ Acne ☐ Eczema ☐ Herpes ☐ Keloids ☐ Melanoma ☐ Skin Cancers ☐ Warts ☐ Ulcers ☐ Cold Sores	☐ Hemorrhoids ☐ Hiatal Hernia ☐ Hepatitis ☐ Stomach Ulcer ☐ Renal failure/dialysis ☐ Kidney Stones	☐ Cataracts ☐ Glaucoma ☐ Deafness ☐ Sinus issues	☐ Asthma ☐ Emphysema ☐ Tuberculosis
PSYCHIATRIC	**MUSCULO-SKEL**	**ENDOCRINE**	**BLOOD**	**NEUROLOGIC**	**OTHER**
☐ Anxiety ☐ Depression ☐ Dementia	☐ Arthritis ☐Injury	☐ Diabetes ☐ Hypothyroid ☐ Hyperthyroid	☐ Anemia ☐ Transfusions	☐ Stroke ☐ Dementia	☐_____ _____ _____ _____ _____ _____

SYSTEMS REVIEW: CHECK ALL THAT APPLY

GENERAL	CARDIO-VASCULAR	ENT	GU	ALLERGY/IMMUNO.	PSYCHIATRIC
☐ Appetite change ☐ Chills ☐ Dizziness ☐ Excess thirst ☐ Fatigue ☐ Fever ☐ Night Sweats ☐ Nausea or Vomiting ☐ Weight Change	☐ Chest pain/tightness ☐ Heart murmur ☐ Legs swelling ☐ Palpitations	☐ Bleeding gums ☐ Dry mouth ☐ Mouth ulcers ☐ Sinus Drainage ☐ Hard of hearing ☐ Ringing in ears	☐ Blood in urine ☐ Discharge ☐ Painful urination	☐ Watery eyes ☐ Sneezing	☐ Memory problems ☐ Panic attacks ☐ Suicidal thoughts ☐ Suicide attempt ☐ Anxiety ☐ Depression ☐ Dementia
PULMONARY	**EYES**	**GI**	**ENDOCRINE**	**MUSCULO-SKEL**	**NEUROLOGIC**
☐ Shortness of breath ☐ Wheezing	☐ Dry eyes ☐ Light sensitivity ☐ Yellowing of eyes	☐ Black/bloody stools ☐ Constipation ☐ Diarrhea ☐ Heartburn ☐ Stomach pain ☐ Trouble swallowing	☐ Abnormal hair growth ☐ Flushing ☐ Menstrual problem	☐ Back pain ☐ Joint pains ☐ Joint swelling ☐ Leg cramps	☐ Blackouts ☐ Headaches ☐ Numbness

HEMATOLOGIC	**SKIN**	**OTHERS**			
☐ Bleeding tendencies ☐ Easy bruising ☐ Swollen lymph node(s) ☐ Anemia	☐ Blisters ☐ Itching ☐ Lesions/growths ☐ Nail changes ☐ Pigment loss ☐ Sun sensitivity ☐ Changing moles	☐ X-ray therapy ☐ Chemotherapy			

Blood borne illness or sexually transmitted disease. (Check all that apply)	**Surgical History (Check all that apply)**	**Social History**
☐ HIV/AIDS ☐ Hepatitis ☐ Herpes: Genital or Oral ☐ Other:_____	Do you need antibiotics before procedures? ☐ Yes ☐ No ☐ Pacemaker/Defibrillator ☐ CABG (Bypass) ☐ Heart valve repair or replaced: Left/Right ☐ Knee replacement: Left/Right ☐ Hip replacement ☐ Appendectomy ☐ Hysterectomy ☐ Other	☐ Smoke: #/packs/day _____ ☐ Drink alcohol: drinks/day_____ ☐ Recreational Drugs: _____ _____ _____ ****FEMALES ONLY**** Are you pregnant? ☐ yes ☐ no Trying to conceive? ☐ yes ☐ no Breastfeeding? ☐ yes ☐ no On hormonal replacement therapy? ☐ yes ☐ no

FAMILY HISTORY: CHECK ALL THAT APPLY (RELATION EXAMPLE: Mother, Father, Grandmother/Father)

☐ Diabetes	Relation:	☐ Basal Cell Skin Cancer	Relation:
☐ High Cholesterol	Relation:	☐ Squamous Cell Cancer	Relation:
☐ Cancer	Relation:	☐ Melanoma	Relation:
☐ Asthma	Relation:	☐ Lupus	Relation:
☐ Eczema	Relation:	☐ Hypertension	Relation:
☐ Arthritis	Relation:	☐ Heart Disease	Relation:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

USES AND DISCLOSURES OF HEALTH INFORMATION TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Miller Dermatology uses and discloses your protected health information for treatment, payment and health care operations. Some examples of when our office may use or disclose your health care information for these purposes include:

- Sharing test results with other health care providers for confirmation of diagnosis.
- Providing your diagnosis or other information about your health to your insurance provider or our billing service to obtain payment for the health care services we provide.
- Reviewing information as part of our quality improvement program.

Other Uses and Disclosures

Miller Dermatology may also use or disclose your protected health information, in compliance with guidelines outlined by law, for the following purposes:

- Provide you with information related to your health.
- Contacting you regarding appointments, information about treatment alternatives, or other health related services.
- Incidental uses or disclosures (e.g., listing your name on a sign in sheet, etc.).
- Compliance with all laws (including reports of suspected abuse, neglect or violence).
- Providing certain specified information to law enforcement or correctional institutions.
- Providing information to a coroner, medical examiner, funeral director, or organ procurement organization.
- Public health activities when requested by public health authority or the FDA.
- Responding to health oversight agencies.
- Responding to court or administrative tribunal orders, subpoenas, discover request or other lawful process.
- Research activities.
- When necessary to avert a serious threat to health or safety.
- Military affairs, veterans' affairs, national security, intelligence, Department of State, or presidential protective service activities.
- Providing information regarding your location, general condition or death to public or private disaster relief agencies.
- Informing a family member, other relative or close friend when: Information is relevant to the individual's involvement with your care.
- To assist in your health care (e.g. pick-up prescription or other documents, note follow up care instructions, etc.).

Authorization for Other Uses

Miller Dermatology will make other uses or disclosure of your protected health information only after obtaining your written authorization. If you authorize a use not contained in this notice you may revoke your authorization.

Your Rights Regarding the Privacy of your Health Information

Subject to limitations outlined by law, you have certain rights related to use and disclosure of your protected health information, including the right to:

- Request restrictions on certain uses or disclosures. However, Miller Dermatology is not obliged to agree to requested restrictions.
- Receive confidential communications of protected health information.
- Inspect and copy your protected health information with some limited exceptions.
- Amend your health information.
- Receive an accounting of disclosures of your health information.
- Obtain a copy of this notice.

Miller Dermatology Regarding the Privacy of your Health Information

Subject to limitations outlined by law, Miller Dermatology has certain duties related to your protected health information, including:

- Miller Dermatology is required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information.
- Miller Dermatology is required to abide by the terms of the privacy notice that is currently in effect.
- Miller Dermatology reserves the right to change the privacy practice described in this notice and to make such change effective for all protected health information. Revised notice will be posted in our office and available upon request.

Concerns

If you believe your privacy rights have been violated, you may make a complaint by contacting Miller Dermatology or the Secretary for the Department of Health and Human Services. NO individual will be retaliated against for filing a complaint.

Acknowledgement

I acknowledge that I received a copy of this notice regarding the use and disclosures of my health information.

X: _____ _____ _____/_____/_____

Signature **Printed Name** **Date**

MILLER DERMATOLOGY
SURGICAL & LASER CENTER

I, _____, understand that all services rendered to me by the providers at Miller Dermatology are my financial responsibility, and that the provider will bill my insurance company as a courtesy. MILLER DERMATOLOGY IS NOT CONTRACTED WITH MEDICAID, MEDICARE, TRICARE, VA, CHAMPUS OR HUMANA.

I agree to pay my office co-pay amount (if applicable) and 20% of any remaining amount owed at the time of my visit. I have been given the opportunity to pay my estimated deductible and coinsurance at the time of service. I authorize my insurance company to pay my benefits directly to Miller Dermatology and I understand that I will be fully responsible for any outstanding balance on my account. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional charges over and above the insurance payment.

I am aware that I am responsible for any balance from any procedures/treatments that have been denied (especially that involve Botox® or lasers), REGARDLESS OF if my insurance company has stated that they approve said procedures/treatments.

If I cannot provide my insurance card at the time of visit, I will pay IN FULL and will be given the proper paperwork to submit to insurance myself.

I have chosen to assign benefits, knowing that the claim must be paid within all state or federal prompt payment guidelines. I will provide all relevant and accurate information to facilitate the prompt payment of the claim by your insurance company.

I authorize the provider to release any information necessary to adjudicate the claim and understand that there may be associated costs for providing information beyond what is necessary for the adjudication of a clean claim.

I also understand that should my insurance company send payment to me directly; I will forward the payment to Miller Dermatology within 72 hours. I agree that if I fail to send the payment to Miller Dermatology and they are forced to proceed with the collections process, I will be responsible for any cost incurred by the office to retrieve their monies. Any violations of this agreement will, at the provider's election, terminate patient charge privileges with Miller Dermatology and bring any balance owed by me, the patient, to Miller Dermatology to be due and payable immediately.

I authorize Miller Dermatology to initiate a complaint or file an appeal to the insurance commissioner or any payer authority for any reason on my behalf, and I personally will be active in the resolution of claims delay or unjustified reductions or denials.

_____ _____

Signature of Patient/Policy Holder **Date**

INSURANCE INFORMATION

If you do not have the following information readily available at the time of your visit you will be asked to pay your visit in full. Please present the card to the front desk. We only submit to a maximum of two insurances. Proper paperwork can be given to you to submit to any remaining insurance yourself.

PRIMARY INSURANCE

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Identification Number: _____ Insurance Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____

Subscriber Social Security Number: _____ Subscriber Contact Number: _____

Subscriber's Relationship to the Patient: ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT/GUARDIAN** ☐ **OTHER**_____

SECONDARY INSURANCE

Insurance Company Name: _____ Insurance Phone: _____

Insurance Company Address: _____

Insurance Identification Number: _____ Insurance Group Number: _____

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Subscriber Address: _____

Subscriber Social Security Number: _____ Subscriber Contact Number: _____

Subscriber's Relationship to the Patient: ☐ **SELF** ☐ **SPOUSE** ☐ **PARENT/GUARDIAN** ☐ **OTHER**_____

I attest that the above information is accurate, and I understand Miller Dermatology's office policies.

X: _____ _____ _____/_____/_____

Signature Printed Name Date