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.**

INITIALS

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

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: _____ _____ _____/_____/_____

Janine D. Miller, M.D. Inc.

PATIENT FINANCIAL POLICY

Welcome to Janine D. Miller, M.D. Inc. our office is so happy to help you with your healthcare needs. We proudly accept many **Blue Cross Blue Shield, Aetna, Medicare, and VA insurance plans.** A clear understanding of our financial policy helps us focus on your care and treatment success.

Contract & Responsibility	Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim; however, all charges are ultimately your responsibility regardless of insurance coverage.
Insurance Information	I am responsible for providing current and accurate insurance information at every visit. Failure to provide correct information may result in the full balance becoming my immediate responsibility.
Network & Verification	It is my sole responsibility to verify that **Janine D. Miller, M.D. Inc.** is in-network. If my plan (including VA) requires a referral or authorization, I must ensure it is in place before my visit.
Evaluation & Management Services	Janine D. Miller, M.D., Inc. is a specialty dermatology practice and does not bill visits as preventive or routine wellness services. (Example: Total body skin exams, skin cancer screenings, and routine mole checks are billed as problem-focused or diagnostic services; not preventive physicals.)
Claim Cooperation	I agree to promptly respond to all requests from my insurance company to ensure claims are processed promptly. This includes updates for Coordination of Benefits (COB). If a claim is denied due to my lack of response, I am responsible for the full balance. I understand Janine D. Miller M.D. Inc. Will provide any information necessary from the provider to process a claim.
Payments & Fees	I am responsible for paying all **co-payments, deductibles, and coinsurance** at the time of service. We accept cash, check, and major credit cards. A **$30.00 fee** applies to returned checks.
Medical Records	A medical record fee may be assessed for the processing, copying, and mailing of records.
Cosmetic Services	Payment for cosmetic procedures and known non-covered services is **due in full at the time of service**. These services will not be billed to insurance.
No-Show Policy	We require **48 hours' notice** for cancellations. We understand true emergencies happen; however, failure to provide notice or "no-showing" **may result in a $50.00 fee**.
Minor Children	The parent/guardian who brings a minor child to the office is responsible for payment. We do not act as a mediator in disputes between parents/guardians regarding medical payments.
Medicare (ABN)	For Medicare patients: I may be asked to sign an Advance Beneficiary Notice (ABN) for services generally not covered, confirming my responsibility if Medicare denies the claim.
Assignment of Benefits	I authorize my insurance carrier to pay Janine D. Miller, M.D. Inc. directly. I am ultimately responsible for any balance not covered by my insurance company.

Our team is here to support you. If you have any questions regarding your insurance or a specific bill, please do not hesitate to ask; we are always happy to assist you.

Patient/Guarantor Acknowledgment:

I have read, understood, and agreed to the terms of this Financial Policy.

Signature: _____ **Date:** _____

Printed Name: _____

MILLER DERMATOLOGY
SURGICAL & LASER CENTER

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