Clearline DERMATOLOGY

PATIENT INFORMATION FORM

Last Name:_____ First Name:_____ Middle Initial:_____

DOB:_____ SSN:_____ Sex: ☐ Male ☐ Female ☐ Other:_____

Address:_____ City:_____ State:_____ Zip:_____

Cell #:_____ Home #: _____ Work #:_____

Email:_____

Primary Care Doctor Name and Phone Number:_____

Referring Doctor Name and Phone Number:_____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widow

Clearline Dermatology, LLC has my permission to contact me and leave voicemails or personal information via:

☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Emergency Contact

Name:_____ Relationship:_____

Phone #:_____

INSURANCE INFORMATION

Primary Policy Holder: ☐ Self ☐ Spouse ☐ Parent/Legal Guardian ☐ Other:_____

Policy Holder Last Name:_____ Policy Holder First Name:_____ Middle Initial:_____

DOB:_____ Sex: ☐ Male ☐ Female ☐ Other:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ SSN:_____

Employer:_____

Insurance Carrier:_____ Policy #:_____

Secondary Insurance Policy: ☐ YES ☐ NO

Policy Holder Last Name:_____ Policy Holder First Name:_____ Middle Initial:_____

DOB:_____ Sex: ☐ Male ☐ Female ☐ Other:_____

Address:_____ City:_____ State:_____ Zip:_____

Phone #:_____ SSN:_____

Insurance Carrier:_____ Policy #:_____

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PATIENT MEDICAL INFORMATION FORM

Name: _____ Date: _____

Pharmacy name: _____ Number: _____

I authorize CLEARLINE DERMATOLOGY, LLC to contact other pharmacies or third parties for the purpose of collecting and verifying information about prescription medication history. **Signature: _____**

Medications and Supplements:

_____

Medication Allergies: _____

HISTORY OF SKIN CANCER

☐ NONE

SKIN CANCERS	**SKIN CONDITIONS**
☐Basal Cell Carcinoma	☐Acne
☐Melanoma	☐Psoriasis
☐Squamous Cell Carcinoma	☐Eczema

If you have had any of the following skin conditions, provide details below (including treatment date and location)

_____

Do you have a family history of Melanoma? No Yes If yes, which relative(s) _____

PAST OR PRESENT HISTORY

Artificial Joint ☐ Yes☐ No (If yes) _____

Artificial Heart Valve ☐ Yes☐ No (If yes) _____

Pacemaker ☐ Yes☐ No (If yes) _____

Bleeding Condition ☐ Yes☐ No (If yes) _____

Hepatitis/HIV ☐ Yes☐ No (If yes) _____

Immunosuppression ☐ Yes☐ No (If yes) _____

Diabetes ☐ Yes☐ No (If yes) _____

High blood pressure ☐ Yes☐ No (If yes) _____

SOCIAL HISTORY

Tobacco Use ☐ Yes☐ No (If yes) _____

Alcohol Use ☐ Yes☐ No (If yes) _____

AGE 65+ ONLY

Do you have an ***advance care plan/living will***? ☐ Yes ☐ No ☐Decline to specify (if no or decline, continue to next section)

Do you have a healthcare proxy? ☐ Yes ☐ No Designee's Name/Phone Number:

_____

Clearline DERMATOLOGY

AUTHORIZATIONS

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to CLEARLINE DERMATOLOGY, LLC. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa™, or Mastercard™. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered service, and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy

Patient or Legal Guardian Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent CLEARLINE DERMATOLOGY, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to CLEARLINE DERMATOLOGY, LLC' Notice of Privacy Practices for a more complete description of such uses and disclosures. I have received and reviewed the Notice of Privacy Practices prior to signing this consent. CLEARLINE DERMATOLOGY, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to CLEARLINE DERMATOLOGY, LLC. With my consent CLEARLINE DERMATOLOGY, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others. With my consent CLEARLINE DERMATOLOGY, LLC may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent CLEARLINE DERMATOLOGY, LLC may e-mail my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that CLEARLINE DERMATOLOGY, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to CLEARLINE DERMATOLOGY, LLC's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent CLEARLINE DERMATOLOGY, LLC may decline to provide treatment to me.

Patient or Legal Guardian Signature: _____ Date: _____

SOCIAL SECURITY ADMINISTRATION

*(If you **DO NOT** have Medicare, please skip this section)*

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment. (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.) Regulations pertaining to Medicare assignment of benefits also apply.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to CLEARLINE DERMATOLOGY, LLC for any services furnished to me by CLEARLINE DERMATOLOGY, LLC. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service

Patient or Legal Guardian Signature: _____ Date: _____

Clearline DERMATOLOGY

CONSENT FOR MINOR SURGERY/PROCEDURES

(Biopsy, Cryosurgery, Intralesional Steroid Injections, Candida Injections, Cantharidin Application, Hyfrecation, Scissor Snip Removal)

I authorize my Clearline Dermatology provider to perform a minor surgery to include a biopsy, cryosurgery, intralesional steroid injection(s), Candida injection(s), cantharidin application, hyfrecation, or scissor snip removal to treat or evaluate a skin condition at the discretion of your provider. Please review and sign the consent form below. You will be given time to discuss the procedure if the provider deems a minor surgery/procedure is necessary or an option. This will serve as a standing consent for this and any and all future treatments, however verbal consent will always be obtained prior to any treatment.

PURPOSE:

Biopsy is a surgical procedure used to obtain a sample of tissue for microscopic examination to aid the physician in diagnosis. The entire lesion may not be removed in this procedure. Further medical or surgical treatment may be needed when the diagnosis is made.

Cryosurgery is the use of liquid nitrogen to freeze the skin lesions that respond well to sub-zero temperatures. The process freezes potential skin cancers known as actinic keratosis or solar keratosis. The treatment is also used to freeze the virus infections that cause many common warts.

Intralesional steroid injection is an injection of steroid directly into a lesion to address a cutaneous inflammatory process.

Candida injection is the intralesional injection of candida antigen (sensitizing agent) into a lesion to stimulate an immune response, such as a wart.

Cantharidin application is the use of a liquid blistering agent applied directly to a lesion, such as a wart, to stimulate a blister and immune response.

Hyfrecation is a form of electro-surgery using a low powered medical device to directly destroy tissue, such as benign skin growths.

Scissor snip removal uses forceps to grasp the lesion and sharp curved surgical scissors to snip at the base and remove benign skin growths such as skin tags

PROPOSED TREATMENT:

I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician/provider (such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing. A pathologist will examine the tissue obtained in this biopsy procedure. **I understand I may receive a separate bill from the pathologist or laboratory for this microscopic examination**. Complications of applying liquid nitrogen, hyfrecation, cantharidin application, and candida injections to the skin may include (but are not limited to):

- Pain/irritation
- Redness
- Scarring
- Blistering
- Infection
- Permanent loss of pigmentation
- *Intralesional steroid injection has the above risks as well as the risk of skin atrophy (thinning of the skin leaving a depression).

Clearline Dermatology will attempt to contact you by phone 3 times to deliver results. If we are unable to reach you, we will send a certified letter to the address on file. After completing these actions, we will take no further steps to contact you with results.

Patient or Legal Guardian Signature: _____ Date: _____

Clearline DERMATOLOGY

FINANCIAL POLICY

Thank you for choosing Clearline Dermatology, LLC as your health care provider. We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware of and understand our financial policy.
Please ask if you have any questions about our fees and policies and your responsibilities. It is your responsibility to notify our office of any patient information changes (e.g., address, name change, insurance policy, etc.).

PLEASE INITIAL ON EACH LINE AFTER READING EACH SECTION OF THE FINANCIAL POLICY:

_____ **COPAYS, CO-INSURANCE, & DEDUCTIBLES**
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of your appointment. We accept cash, checks, Visa, Mastercard, American Express, and Discover. If you have an insurance deductible or co-insurance, any and all office visit and/or procedure charges will apply towards your deductible, and you will be billed accordingly. If a patient is a minor (18 years of age and below) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian assumes responsibility for any payment due at the time of service.
If you are unable to pay for necessary medical care, you may be eligible for financial assistance or a payment plan. It is your responsibility to inform us of your financial need prior to your visit. Please ask to discuss arrangements with our billing department.

_____ **MEDICAL PROCEDURES**
Any medical procedures (e.g., liquid nitrogen "freezing" treatment or biopsies) performed in our office are considered separate, billable charges in addition to your office visit charge.

_____ **COSMETIC FEES & PAYMENT**
Certain procedures and services provided during your medical visit are not covered by most insurance companies. These are considered cosmetic procedures. It is your responsibility to understand that you may have cosmetic fees in addition to your medical visit. These fees are due at the time of service.

_____ **INSURANCE CLAIMS**
As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of the claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. **If your insurance requires referrals to specialists, it is your responsibility to make sure we are in network with you plan and obtain a referral PRIOR to your appointment. Failure to obtain a valid referral may hold you responsible for any payments incurred for services rendered.** Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to, those charges above the usual and customary allowance. If we are out of network and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately.

_____ **SELF-PAY ACCOUNTS**
Self-pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay accounts are payable at the time of service.

Clearline DERMATOLOGY

_____ **CANCELLATION OF APPOINTMENTS**

No-shows and late cancelations prevent other patients from receiving care. Clearline Dermatology, LLC requires a 24-hour notice for appointment cancellations so that we can offer the appointment to another patient who needs to be seen. There is a fee of $25 for medical appointments that are missed and/or are not cancelled. There is a fee of $75 for cosmetic or surgical appointments that are missed and/or are not previously cancelled. This fee must be paid before rescheduling the missed appointment.

_____ **RETURNED CHECKS**

The charge for returned checks is $35 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

_____ **OUTSTANDING BALANCE POLICY**

It is our policy that all accounts remain current. In the event that a patient balance remains outstanding and no resolution can be made, your account may be sent to a collection agency and/or you may be discharged from the practice.

_____ **ASSIGNMENT OF BENEFITS**

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to Clearline Dermatology, LLC. I understand that I am responsible for any amount not covered by insurance.

_____ **LABORATORY FEES**

Most laboratory charges, such as blood work, cultures, and pathology tests, ordered through our office are billed directly to your insurance by the laboratory processing the test. In the case of biopsies performed in our office, Clearline Dermatology utilizes our in-house lab to process the specimens. We then send the slides to a separate lab where a pathologist reads the slide and makes a diagnosis. These two steps are billed independently from each other. If you receive a statement from the pathologist laboratory, please contact them directly to resolve any billing questions.

I have read and understand the above information and agree to comply with these financial policies.

Patient or Legal Guardian Signature: _____ Date: _____

☐ **Free Skin Care Consultation**

Please check here if you would like to arrange a Consultation with one of our estheticians to discuss skin care products and/or treatments we offer.