Clearline DERMATOLOGY

PATIENT INFORMATION FORM

Last Name:_____ **First Name**:_____ **MI**:_____

Date of Birth:_____ **Sex**: ☐ Male ☐ Female ☐ Other:_____

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

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

Email:_____ **Employer:** _____

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widow(er)

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

(Check all that apply) ☐ Home Phone ☐ Cell Phone ☐ Work Phone ☐ Email

Primary Care Doctor – Name:_____ **Phone #**:_____

Referring Doctor – Name:_____ **Phone #**:_____

EMERGENCY CONTACT

Name:_____ **Relationship**:_____

Phone #:_____

INSURANCE INFORMATION

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

Policy Holder Last Name:_____ **Policy Holder First Name**:_____ **MI**:_____

Insurance Carrier:_____ **Policy #**:_____

Secondary Policy and Holder: ☐ YES ☐ NO

Policy Holder Last Name:_____ **Policy Holder First Name**:_____ **MI**:_____

Insurance Carrier:_____ **Policy #**:_____

PHARMACY INFORMATION

Pharmacy Name:_____ **Phone #:**_____

I authorize CLEARLINE DERMATOLOGY, LLC to contact pharmacies for the purposes of prescribing medications and verifying prescription medication history.

Patient or Legal Guardian Signature:_____ **Date:**_____

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PATIENT MEDICAL HISTORY FORM

Name:_____ **Date of Birth:**_____ **Date:**_____

Medication or other Allergies:_____

Medications & Supplements (including over-the-counter):

Name	Dosage	Frequency	Purpose

Personal Skin Cancer History

Basal Cell Carcinoma····· ☐ Yes ☐ No

Melanoma····· ☐ Yes ☐ No

Squamous Cell Carcinoma····· ☐ Yes ☐ No

If *Yes*, what year:_____

Body location:_____

Family Melanoma History

DIRECT FAMILY MEMBERS

Parent, Siblings, Children ☐ Yes ☐ No

If *Yes*, which relative(s):

_____

_____

Personal Medical History

High Blood Pressure····· ☐ Yes ☐ No

High Cholesterol····· ☐ Yes ☐ No

Diabetes····· ☐ Yes ☐ No

Hyper/Hypothyroid····· ☐ Yes ☐ No

Bleeding Condition····· ☐ Yes ☐ No

Depression/Anxiety····· ☐ Yes ☐ No

Immunosuppression····· ☐ Yes ☐ No

Artificial Joint····· ☐ Yes ☐ No

Artificial Heart Valve····· ☐ Yes ☐ No

Pacemaker····· ☐ Yes ☐ No

Hepatitis/HIV····· ☐ Yes ☐ No

Other:_____

Pediatric

Height:_____ **Weight:**_____

Social History

Smoking/Tobacco Use····· ☐ Yes ☐ No How much/How long:_____

Alcohol Use····· ☐ Yes ☐ No How much/How often:_____

Are you pregnant? ····· ☐ Yes ☐ No Are you nursing? ····· ☐ Yes ☐ No

Patient or Legal Guardian Signature:_____ **Date:**_____

Clearline DERMATOLOGY

PATIENT CONSENT AND ACKNOWLEDGEMENT FORM

Patient Name:_____ **Date of Birth:**_____

AUTHORIZATIONS

(Please initial by each statement in acknowledgment)

_____ I authorize the release of information needed to process claims and direct payment of medical benefits to CLEARLINE DERMATOLOGY, LLC. I confirm that the information I've provided is accurate.

_____ I understand that payment is due at the time of service. Accepted forms include cash, check, Visa™, or Mastercard™. For major procedures or hospitalizations, insurance will be filed after pre-verification, and I am responsible for any deductibles, non-covered services, and co-pays. Interest may be charged on overdue balances. My signature below confirms my understanding and agreement.

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

_____ I consent to the use and disclosure of my protected health information (PHI) by CLEARLINE DERMATOLOGY, LLC for treatment, payment, and healthcare operations (TPO). I have reviewed the Notice of Privacy Practices.

_____ I allow the practice to leave messages or send communications (phone, mail, email) related to my care, appointments, billing, or lab results, marked Personal and Confidential.

_____ I understand I may request restrictions on PHI use. While the practice may not be obligated to agree, if it does, it will comply. I may revoke this consent in writing at any time, except where disclosures have already occurred.

CONSENT FOR MINOR SURGERY/PROCEDURES

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***.

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
- Blistering
- Permanent loss of pigmentation
- Scarring
- Redness
- Infection
- 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 three (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:**_____

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FINANCIAL POLICY

Patient Name:_____ **Date of Birth:**_____ **Date:**_____

Thank you for choosing Clearline Dermatology, LLC. We are committed to providing excellent care. This policy explains your financial responsibilities. Please ask if you have questions. It is your responsibility to notify us of any changes to your contact, insurance, or personal information.

Please review and initial each section:

_____ COPAYS, CO-INSURANCE & DEDUCTIBLES
Bring your insurance card to every visit. All copays and past-due balances are due at check-in. Deductibles and co-insurance apply to visit and procedures and will be billed accordingly. Parents/guardians of minors are responsible for all charges. If you need financial assistance, please contact us before your appointment to discuss options.

_____ MEDICAL PROCEDURES
In-office procedures (e.g., freezing/cryotherapy or biopsies) are billed separately from your visit.

_____ COSMETIC FEES & PAYMENT
Cosmetic services are not covered by most insurance plans. These fees are due at the time of service and may be billed in addition to a medical visit.

_____ INSURANCE CLAIMS
We submit claims as a courtesy. You are responsible for any remaining balance after insurance processes your claim. It is your responsibility to confirm network participation, provide complete insurance information, and obtain required referrals before your visit. Insurance estimates are not guarantees of payment. If insurance pays you directly, you must forward payment to us.

_____ SELF-PAY ACCOUNTS
Patients without insurance or with non-participating plans are considered self-pay. Payment is due at the time of service.

_____ CANCELLATIONS
Please cancel appointments at least 24 hours in advance. Missed or late-cancelled visits incur a $50 fee for medical appointments and $100 fee for cosmetic or surgical appointments. These fees must be paid before rescheduling.

_____ RETURNED CHECKS
A $35 fee applies to returned checks, payable by cash or credit card.

_____ OUTSTANDING BALANCES
Accounts must remain current. Unpaid balances may be sent to collections and may result in dismissal from the practice.

_____ ASSIGNMENT OF BENEFITS
A authorize direct insurance payments to Clearline Dermatology, LLC and accept responsibility for any amounts not covered.

_____ LABORATORY FEES
Lab tests may be billed separately by outside labs. Biopsies are processed in-house, but final readings are done by a pathologist at a separate lab, which may send a separate bill.

I have read, understood, and agree to the above financial policy.

Patient or Legal Guardian Signature:_____ **Date:**_____

Clearline DERMATOLOGY

Patient Name:_____ **Date of Birth:**_____

AGE 65+ ONLY

Do you have an ***advance care plan/living will?*** ☐ Yes ☐ No ☐ Decline to specify

If you answered 'Yes' above, do you have a healthcare proxy? ☐ Yes ☐ No

Healthcare Proxy Designee Name: _____ Phone #: _____

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 services.

Patient Signature:_____ **Date:**_____

Clearline DERMATOLOGY

HIPAA RIGHT OF ACCESS FORM

(Optional)

Authorization to Release Information to Family Members / Friends

HIPAA Authority for Right of Access: 45 C.F.R. § 164.524

I, _____, give permission to Clearline Dermatology, LLC and its healthcare providers to share my protected health information described below to the following individual(s):

	Name	***Relationship to Patient***	***Phone #***
1	_____	_____	_____
2	_____	_____	_____
3	_____	_____	_____
4	_____	_____	_____

I authorize Clearline Dermatology, LLC to share the following health information (*please check either A or B*):

☐ A. **All medical records** (including but not limited to diagnoses, lab tests, prognosis, treatment, and billing for all conditions), **OR**

☐ B. **Medical records EXCLUDING the following:**

- ☐ Communicable diseases (including HIV/AIDS)
- ☐ Other (*please specify*): _____

I understand that my health record can be shared via electronic record/provider portal, hard copy, or another way that is mutually agreed upon between my provider and designee.

This authorization shall be effective until (*Check one*):

☐ All past, present, and future periods, **OR**

☐ Date or event: _____

NOTE: You may revoke this authorization at any time by notifying Clearline Dermatology, LLC in writing.

_____ _____

PRINTED Name of Person Giving this Authorization **Date of Birth**

_____ _____

SIGNATURE of the Individual Giving this Authorization **Date**

Clearline DERMATOLOGY

Patient Name:_____ **Date**:_____

Date of Birth:_____ ☐ I decline to answer the questions below

Please indicate your current nicotine habit

- ☐ Never Nicotine User
- ☐ Former Nicotine User
- ☐ Current Nicotine User → Please specify below:
  - ☐ Tobacco ☐ Vapor ☐ Dip/Chew

Do you currently experience or have future concerns about any of the following?

- ☐ Food Insecurity
- ☐ Housing Instability
- ☐ Transportation Needs
- ☐ Utility Difficulties
- ☐ Interpersonal Safety
- ☐ None of the above
- ☐ Decline to answer

Patients 65+ Only

Do you have a surrogate decision-maker? ☐ Yes ☐ No ☐ Decline to answer

If 'Yes', please provide the information below:

Name:_____ Phone:_____

Do you have a living will? ☐ Yes ☐ No ☐ Decline to answer

If 'Yes', please provide the information below:

Contact Information of the Individual in Possession of the Living Will

Name:_____ Phone:_____