ELKHORN DERMATOLOGY

Excellence In Dermatology™ FELLOW

DEMOGRAPHICS & HIPAA PRIVACY NOTICE

PATIENT DEMOGRAPHICS

Name:		Today's Date:	
Street Address:		City/State:	
Zip Code:	Date of Birth:	SSN:	Gender:
Primary Phone:		Alternate Phone:	
Email Address:		Marital Status:	
Preferred Language:	Race:	Ethnic Group:	

***By providing your email address your patient portal will be activated. If you choose to enroll in the patient portal, this will allow your instant access to visit notes, medical history, lab and biopsy results, and allows you to securely communicate with our office staff. You will receive an email with instructions on how to enroll in the patient portal. It is highly recommended that you enroll so that we can provide the absolute best possible skin care!*

Is there anyone (spouse, parent, guardian, family member, etc) with whom you authorize us to share any medical information in the event you are not available to take our call? _____ YES _____NO

EMERGENCY CONTACT INFORMATION

Name:	Phone:	Relationship:

GUARANTOR INFORMATION (REQUIRED FOR PATIENTS UNDER 18)

Responsible Name:		Date of Birth:
Street Address:		City/State
Zip Code:	SSN:	Phone:

PREFERRED PHARMACY

Pharmacy:	Phone:	City/Zip:

REFERRING PROVIDER

Primary Care Provider:	Practice Name:
Referring Provider:	Practice Name:

HOW DID YOU HEAR ABOUT US

If you self-referred please indicate how you heard about us: ___Facebook ___Instagram ___ Google ___ Friends or Family ___ Newspaper ___ Other

304 Boston Square - Georgetown, KY 40324
Phone #: (502) 316-9425 Fax: (502) 316-9451
Website: www.elkhorndermatology.com Email: info@elkhorndermatology.com

ELKHORN DERMATOLOGY

Excellence In Dermatology™ FELLOW

HIPAA PRIVACY NOTICE ACKNOWLEDGEMENT

I, _____ (patient name) acknowledge that I have reviewed and understand the HIPAA privacy policies of Elkhorn Dermatology and have been given the opportunity to receive a copy of these privacy policies.

Patient Name (print): _____
Patient Signature: _____

Parent or Guardian Name (print): _____
Parent or Guardian Signature: _____

Date: _____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES FOR APPOINTMENT REMINDER SYSTEM

By supplying my home phone number, mobile phone number, email address, and any other personal contact information, I authorize my health care provider to employ a third-party automated outreach and messaging system to use my personal information, the name of my care provider, the time and place of my scheduled appointment(s), and other limited information, for the purpose of notifying me of a pending appointment, a missed appointment, overdue skin exam, balances due, lab results, or any other healthcare related function. I consent to receiving multiple messages per day from my healthcare provider, when necessary. I consent to allowing detailed messages being left on my voicemail, answering system, or with another individual, if I am unavailable at the number provided by me. I also authorize my healthcare provider to disclose to third parties, who may intercept these messages, limited protected health information (PHI) regarding my healthcare events.

Patient/Guardian Name (print): _____
Patient/Guardian Signature: _____

304 Boston Square - Georgetown, KY 40324
Phone #: (502) 316-9425 Fax: (502) 316-9451
Website: www.elkhorndermatology.com Email: info@elkhorndermatology.com

ELKHORN DERMATOLOGY

Excellence In Dermatology™ FELLOW

MEDICAL HISTORY FORM

GENERAL INFORMATION:

Patient Name:	Date:
Reason for Visit:	
How can we be praying for you today?:	

PAST MEDICAL HISTORY

	Anxiety		Diabetes		Lung Cancer
	Arthritis		End Stage Renal Disease		Lymphoma
	Asthma		GERD		Prostate Cancer
	Atrial Fibrillation		Hearing Loss		Radiation Treatment
	Bone Marrow Transplant		Hepatitis		Seizures
	BPH		Hypertension		Stroke
	Breast Cancer		HIV/AIDS		NONE
	Colon Cancer		Hypercholesterolemia		Other #1:_____
	COPD		Hyperthyroidism		Other #2:_____
	Coronary Artery Disease		Hypothyroidism		Other #3:_____
	Depression		Leukemia		Other #4:_____

Please list any major surgeries:
Do you have any history of Skin Cancer? _____YES _____NO If yes, what type? ____ Basal Cell ____Squamous Cell ____ Melanoma ____ Other: _____
Please list all current medications (we prefer if you bring your medications with you, or you may provide a list of your meds:
Medication Allergies - please list all known allergies:

304 Boston Square - Georgetown, KY 40324
Phone #: (502) 316-9425 Fax: (502) 316-9451
Website: www.elkhorndermatology.com Email: info@elkhorndermatology.com

ELKHORN DERMATOLOGY

Excellence In Dermatology™ FELLOW

SOCIAL HISTORY:

Have you ever smoked or used tobacco products before? _____YES _____NO If yes, are you currently smoking or using tobacco products? _____ YES _____NO How much do you smoke/use on a daily basis? _____ # of cigarettes ____ # packs per day
How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more alcoholic drinks in a day? _____
Occupation/Type of Work:

QUALITY MEASURES

Do you have an Advanced Care Plan or surrogate decision maker in place? _____ YES _____ NO
Have you received the flu vaccine for this flu season? _____ YES _____ NO If no, why not?

FAMILY HISTORY

Do you have any first-degree relatives (mom/dad, brother/sister) with a history of skin cancer or skin disorders?

REVIEW OF SYMPTOMS

Please check YES or NO for the following:

Y	N	SYMPTOM	Y	N	MEDICAL ALERT
		Fever or chills			Pregnant or planning a pregnancy
		Unintentional weight loss			History of HIV
		Swollen or tender lymph nodes/glands			History of Hepatitis B
		Problems with bleeding			History of Hepatitis C
		Problems with healing/scarring			Personal history of tuberculosis (TB)
					Currently on blood thinners
					Currently have a defibrillator
					Currently have a pacemaker?
					Allergy to adhesive?
					Allergy to Lidocaine
					Artificial Heart Valve
					Artificial joints within the past two years
					History of MRSA
					Require medication prior to procedures

304 Boston Square - Georgetown, KY 40324
Phone #: (502) 316-9425 Fax: (502) 316-9451
Website: www.elkhorndermatology.com Email: info@elkhorndermatology.com

ELKHORN DERMATOLOGY

Excellence In Dermatology™ FELLOW

PATIENT FINANCIAL AGREEMENT

Please read and sign where indicated. This document describes your financial responsibilities.

This is a legally binding contract between Elkhorn Dermatology and you. The words *I, me, my, you, and your* all refer to the patient.

1. I agree to be financially responsible for payment of Elkhorn Dermatology's services. I understand that my copay, deductible, coinsurance, and any outstanding balance is due at the time of service. I further agree that if I am unable to meet my financial obligation that my visit may have to be rescheduled. Elkhorn Dermatology accepts cash, check, and all major credit cards for payment.
2. I agree that any estimate of services is exactly that, an estimate. Actual cost for services may be more or less depending on the services provided and the intensity of care required.
3. I agree to give Elkhorn Dermatology my complete and accurate insurance information for primary and secondary insurance benefits including referral documents from other providers, if needed. I understand that if I fail to give complete and accurate information about my insurance benefits this may result in a denial of my claim or a delay in payment. I agree to pay Elkhorn Dermatology any remaining balance on my account after the insurance claim has been processed.
4. I understand that Elkhorn Dermatology will make every effort to determine my insurance benefits and responsibility prior to being seen. However, I also understand that ultimate responsibility for knowing my copay amount, deductible amount, in-network status, and benefits eligibility belongs to me and NOT to Elkhorn Dermatology. I understand that there may be higher out of pocket costs if Elkhorn Dermatology is determined to be out of network for my insurance plan.
5. I agree that if my insurance benefit requires me to provide a referral and if the referral is not in place before my appointment, that I will pay in advance an estimate of charges for my office visit or reschedule my appointment.
6. I understand that I will be responsible for any missed appointments or any cancelled appointments in which a 24-hour notice was not given. ***There will be a fee of $25.00 for any missed / late cancelled office visits and a $75.00 for any missed / late cancelled office procedures.*** Fees must be paid prior to receiving any additional services.
7. I understand that if I pay by check and that check is returned for any reason that I may be assessed the maximum penalty permitted by law.
8. If I do not have insurance benefits or am receiving cosmetic services, I agree that payment is due at the time services are provided at the conclusion of my visit.
9. I agree to pay any remaining balance on my account for any reason upon receipt of a statement and I understand that when requested, I must give Elkhorn Dermatology my current address and other contact information. I understand that if I fail to pay the balance due on my account this may result in Elkhorn Dermatology taking collection action against me. This may include utilizing an outside collection agency to assist with recovery of the debt. I understand that I am responsible for all collection costs including but not limited to rebilling fees, court costs, attorney fees, and collection agency costs.
10. If my injury is work related or related to an auto accident, I agree to provide the necessary case or policy number for my workers comp or auto insurance claim. If this information is not provided or my insurer determines that they are not liable, then I agree to pay all charges for my visit.
11. I hereby authorize direct payment of medical benefits, including medical benefits for which I am entitled to Elkhorn Dermatology, PLLC. This is a direct assignment of my rights and benefits. This authorization will remain in effect until cancelled by me in writing. A copy of this document is as valid as the original.
12. I authorize the release of any medically necessary information in order to obtain payment and I understand that I am responsible for any costs determined to be patient responsibility by my insurance company.

I have read and understand Elkhorn Dermatology's financial policies and I accept responsibility for the payment of any fees associated with my care.

_____ _____/_____/_____

Patient Signature Date

304 Boston Square - Georgetown, KY 40324
Phone #: (502) 316-9425 Fax: (502) 316-9451
Website: www.elkhorndermatology.com Email: info@elkhorndermatology.com