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www.musickdermatology.com

Dear Patient,

Welcome to our dermatology practice and thank you for choosing us as your skin care providers. For your appointment to go as smoothly as possible, we ask that you take a few moments to prepare the following:

1) *Complete the enclosed Patient Registration & HIPPA form and bring it to your appointment. Failure to return the form will increase your wait time at the office.*

2) *Bring your current insurance card(s), photo ID, and current list of medications.*

3) *If your health plan requires a REFERRAL, please obtain one and bring it to your appointment.*

4) *All minors, under the age of 18, must be accompanied by a parent/legal guardian for the first visit. If parent/legal guardian cannot accompany the minor, an adult (over the age of 18) must be present and have written consent from parent/legal guardian for treatment.*

◆ **ANY <u>NEW PATIENT</u> THAT MISSES THEIR INITIAL APPOINTMENT, WITHOUT CONTACTING THE OFFICE TO CANCEL, WILL NOT BE ALLOWED TO RESCHEDULE THEIR APPOINTMENT.** ◆

Please Note - Once established, any missed appointments without contacting the office to cancel, will be subject to a $40.00 missed appointment fee and subject to dismissal from our practice.

We look forward to seeing you at your scheduled visit with us. If you have any questions or concerns, please call our office and we'll be happy to assist you.

HIPAA PATIENT CONSENT FORM

Musick Dermatology, LLC Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, a new Notice will be available at the reception desk or you may obtain a revised copy by contacting our office at 4932 Benchmark Centre Dr., Swansea, IL 62226 or (618)628-2588.

You have the right to request that Musick Dermatology, LLC restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. Musick Dermatology, LLC is not required to agree to this restriction, but if we do, Musick Dermatology, LLC shall honor that agreement.

By signing this form, you consent to Musick Dermatology, LLC's use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Musick Dermatology, LLC provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- Musick Dermatology, LLC has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Musick Dermatology, LLC reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but Musick Dermatology, LLC does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Musick Dermatology, LLC may condition receipt of treatment upon the execution of this Consent.

Name of Patient: _____

Signature of Patient or Legal Representative _____ **Date:** ___/___/___

If signed by someone other than the patient:

Print Name: _____

Relationship to Patient (if other than patient): _____ **Date:** ___/___/___

PATIENT REGISTRATION

(Please print)
Date:_____ Acct:_____

Name_____
Last First (MI)

Street_____

City_____ State_____ Zip_____

Patient SSN_____

Occupation_____

Employer_____

Emergency contact: Other than spouse/parent

Name_____ Phone_____

Date of Birth_____

Home Phone_____

Cell Phone_____

Work Phone_____

Email_____

Spouse's/Parent's Name_____

Spouse's/Parent's Employer_____

Personal Physician_____

Referred By_____

PAST/FAMILY/SOCIAL HISTORY

Drug Allergies_____

Latex Allergy Yes/No

Allergy to Local Anesthetic(Xylocaine) Yes/No

CurrentMedication_____

_____

Chronic Illness_____

Past Surgeries_____

Do You Have Any Artificial Joints? Yes/No

Mitral valve prolapse or artificial heart valve? Yes/No

Alcohol Intake_____

Smoking History_____

Family Diseases_____

Family History of Skin Cancer_____

REVIEW OF SYSTEMS

Do you have any recent problems with the following? If yes, please describe in this space

Fevers/Chills/Weight loss?.....Yes/No
Sore eyes/Dry eyes?.....Yes/No
Sores in mouth or nose?.....Yes/No
Chest Pain/Leg Swelling..... Yes/No
Nausea/ Diarrhea.....Yes/No
Burning Urination/Frequent urination?..Yes/No
Muscle or joint pain?.....Yes/No
Numbness of feet/ Dizziness?.....Yes/No
Depressed/ Anxious Mood?.....Yes/No
Fatigue/ Cold Intolerance?.....Yes/No
Swollen lymph glands?.....Yes/No
Runny nose/Stuffy head/Asthma?.....Yes/No

FULL EXAM

We will provide a full-body skin examination if you choose Yes/No.
This service is particularly recommended if you have a history of blistering sunburns, more than 40 moles or if anyone in your family has had skin cancer

PLEASE COMPLETE THIS FORM FRONT AND BACK (TURN OVER TO CONTINUE)

BILLING INFORMATION

Payment of insurance copay or for any cosmetic services is expected the day services are rendered.
We accept MasterCard/Visa/Discover/AmericanExpress/Check/Cash

Responsible Party (Person responsible for any remaining balance due)

Name_____Relationship_____ Date of Birth_____

Phone #_____ SSN_____

Street Address_____ City_____State_____Zip_____

PRIMARY INSURANCE NAME _____ Amount of Co-pay_____

POLICYHOLDER'S INFORMATION:

Name_____Relationship_____ Date of Birth_____

Home Address _____City_____ State _____Zip_____

SSN _____ Home # _____ Cell # _____

SECONDARY INSURANCE NAME _____

POLICYHOLDER'S INFORMATION:

Name_____Relationship_____ Date of Birth_____

Home Address _____City_____ State _____Zip_____

SSN _____ Home # _____ Cell # _____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Musick Dermatology, LLC. for services rendered by the physician or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance, and if necessary reasonable attorney and court fees incurred to collect said professional fees due to Musick Dermatology, LLC. for medical services rendered to me.

ALL INSURANCE AND MEDICARE

I hereby authorize Musick Dermatology, LLC. to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

PROTECTED HEALTH INFORMATION

I hereby authorize Musick Dermatology, LLC. to release or obtain from other physicians and medical facilities whatever records are necessary for my continued care.

*Patient Signature,Parent or Legal Guardian_____DATE_____

I hereby authorize Musick Dermatology, LLC. to discuss any medical information for the treatment of my care. Person(s) to whom information may be disclosed: spouse, parent(s), legal, guardian, or other.

_____ _____

Name of person/relationship Name of person/relationship

*Patient Signature,Parent or Legal Guardian_____DATE_____