MUSICK DERMATOLOGY | SKINCEUTICALS ADVANCED CLINICAL SPA

STEVE E. MUSICK, M.D. • ANGELA E. NAUMAN-MUSICK, APRN, CNP
ELIZABETH C. RIDLEY, PA-C • KATHRYN LINDSAY COBB, FNP-BC
MOLLY A. BRADDOCK, PA-C • JENNIFER L. ADAMS, PA-C
4948 BENCHMARK CENTRE DRIVE
SWANSEA, IL 62226
PHONE#: (618) 628-2588 FAX#: (618) 628-1363
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 forms 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.

ALL MISSED APPOINTMENTS OR RESCHEDULES WITHOUT ANY ATTEMPT TO CONTACT THE OFFICE AT A MINIMUM OF 24 HOURS PRIOR TO A SCHEDULED VISIT WILL RESULT IN A $40.00 NO-SHOW FEE WHICH MUST BE PAID BEFORE RESCHEDULING.

Please note that effective August 1, 2023, there will be a 3% convenience fee for credit card transactions. Should you wish to utilize your debit or HSA cards, there will be no processing fee.

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.

(Please Print) Patient ID #: _____

PATIENT REGISTRATION

Date: _____ Date of Birth: ____/____/_____ Sex: Male / Female

Name: _____ Home Phone: _____

Street: _____ Cell Phone: _____

City: _____ State: _____ Zip: _____ Email: _____

Patient SSN: _____-_____-_____ Primary Care Provider: _____

Occupation: _____ Referred By Physician: Yes / No

Employer: _____ Physician Name: _____

Spouse's/Parent's Name: _____ Preferred Pharmacy: _____

Spouse's/Parent's Employer: _____ Pharmacy Phone Number: _____

PAST/FAMILY/SOCIAL HISTORY

Latex Allergy: Yes / No Allergy to Local Anesthetic (Xylocaine): Yes / No

Chronic Illness(s): _____

Past Surgeries: _____

Do you have any artificial joints? Yes / No Mitral valve prolapse or artificial heart valve? Yes / No

Do you have a pacemaker/defibrillator? 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 the space below.

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/Frequent Urination? ..... Yes / No
Muscle or Joint Paint? ..... 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

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

(Please Print)

BILLING INFORMATION

Payment of insurance copay or for any cosmetic services is expected the day that services are rendered.

Responsible Party (person responsible for any remaining balance due) Example: Self / Parent / Guardian

Name: _____ Relationship: _____ Date of Birth: ____/____/____

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

SSN: ____-____-_____ Phone Number: _____ Home / Cell

Primary Insurance Name: _____ Amount of copay: $_____

Name: _____ Relationship: _____ Date of Birth: ____/____/____

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

SSN: ____-____-_____ Phone Number: _____ Home / Cell

Secondary Insurance Name: _____

Name: _____ Relationship: _____ Date of Birth: ____/____/____

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

SSN: ____-____-_____ Phone Number: _____ Home / Cell

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Musick Dermatology & Advance Clinical Spa, 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 & Advanced Clinical Spa, LLC for medical services rendered to me.

ALL INSURANCE AND MEDICARE

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

NO-SHOW APPOINTMENT POLICY

I hereby authorize Musick Dermatology & Advanced Clinical Spa, LLC to charge my account a $40.00 no-show fee for scheduled medical visits without calling and cancelling/rescheduling the appointments within 24 hours of the appointment date.

PROTECTED HEALTH INFORMATION

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

***Patient Signature/Parent of Legal Guardian:** _____ **Date**: _____

DATE: _____ ID#: _____

MUSICK DERMATOLOGY | SKINCEUTICALS ADVANCED CLINICAL SPA

PATIENT NAME: _____

DATE OF BIRTH: _____

Please list any **drug allergies** we should be aware of:
(if the patient does not have any drug allergies, please write NONE)

_____

MEDICATIONS

Please provide all current prescriptions and over-the-counter drugs.
If patient is not taking any medications, please write NONE.

Date last reviewed: (Nurses and Providers ONLY)

Name of Medication	Dosage (ie: 20mg)	Route of Administration (ie: orally or topically)	Frequency (ie: once daily)

_____ _____ _____ _____ _____ _____ _____ _____ _____

_____ _____ _____ _____ _____ _____ _____ _____ _____

ID #: _____

MUSICK DERMATOLOGY | SKINCEUTICALS ADVANCED CLINICAL SPA

PATIENT NAME: _____

ADDRESS: _____

EMAIL: _____

PHONE NUMBER: (_____) _____ - _____

Can we leave a message with the number provided above regarding appointment/test results?
YES / NO

PATIENT INFORMATION RELEASE

I authorize the person(s) listed below to have access to my medical information. These people may call and speak with the nurse/doctor about my case.

I have the right to terminate this agreement at any time by informing the staff in writing.

(If there is no one you would like your information released to, please write none in the first box.)

AUTHORIZED PERSON(S)	RELATIONSHIP TO PAITENT	PHONE NUMBER

Signature of Patient or Legal Representative confirming above information is correct:

Name: _____ **Date:** _____ / _____ / _____

HIPAA PATIENT CONSENT FORM

Musick Dermatology & Advanced Clinical Spa, 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 located at 4948 Benchmark Centre Drive, Swansea, IL 62226 or (618) 628-2588.

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

By signing this form, you consent to Musick Dermatology & Advanced Clinical Spa, 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 & Advanced Clinical Spa, 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 & Advanced Clinical Spa, LLC has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Musick Dermatology and advanced Clinical Spa, 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 & Advanced clinical Spa, 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 & Advanced Clinical Spa, 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:** ___/___/_____