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**PATIENT INFORMATION** Appointment Date _____

Last Name: _____ First Name: _____ M.I. _____

Billing Address: _____

City State/Zip: _____ Preferred Phone: _____ Alternate Number: _____

DOB/Age_____ SSN _____ Gender ___ Marital Status _____ Race _____

Preferred Language _____ Occupation _____ Employer _____

Primary Care Physician (PCP) _____ Pharmacy/Location _____

Email Address_____

How did you hear about McDaniel Dermatology? _____

Whom may we thank for referring you? _____

**INSURANCE INFORMATION/RESPONSIBLE PARTY**
***(IF APPLICABLE, PLEASE GIVE ALL INSURANCE CARDS TO THE RECEPTIONIST)***

Is the patient covered by insurance? _____ If yes, are there multiple insurers? _____

If applicable, please list the filing order _____

Insured/Responsible Party _____ Preferred Phone _____ DOB _____

SSN_____ Relationship to Patient _____

**IN CASE OF EMERGENCY**

Who may we contact? _____ Relationship to patient? _____

Best contact number: _____ Alternate Number: _____

- I authorize and request that insurance benefits be paid directly to McDaniel Dermatology should we elect to bill my insurance company.
- I understand that I am financially responsible for any balance if not covered by insurance.
- I authorize the release of my Personal Health Information to the referring physician, my insurance company, and laboratories, if applicable, for the purpose of treatment, payment, clinical management and administrative duties.
- I have been given the opportunity to review and/or receive a copy of McDaniel Dermatology & Skin Surgery Institute's Notice of Privacy Practices.

_____ _____

Patient/Parent signature Date

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## Past Medical History

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

***Please circle all that apply to you in each section***

| | | | | |
|---|---|---|---|---|
| Anxiety | Leukemia | GERD | Stents | Hypertension |
| Depression | Asthma | Lymphoma | Hepatitis | Colon Cancer |
| Hypothyroidism | Kidney disease | BPH | Radiation Treatment | HIV/AIDS |
| Arthritis | Lung cancer | Hearing Loss | Breast Cancer | Stroke |
| Diabetes | Atrial fibrillation | Prostate Cancer | Seizures | COPD |
| Hypercholesterolemia | Coronary Artery disease | Hyperthyroidism | Bone Marrow Transplant | Glaucoma or Macular degeneration |

Other: _____

### SKIN SURGERIES

| | | | |
|---|---|---|---|
| Skin Biopsy | Basal Cell Carcinoma | Melanoma | Squamous Cell Carcinoma |

Other: _____

### SKIN DISEASE HISTORY

| | | | | |
|---|---|---|---|---|
| Dry Skin | Actinic Keratosis | Precancerous Moles | Flaking or Itching Scalp | Blistering Sunburns |
| Poison Ivy | Psoriasis | Eczema | Rosacea | Melanoma |
| Acne | Hay Fever/Allergies | Basal Cell Carcinoma | Squamous Cell Skin Cancer | |

Other: _____

### FAMILY HISTORY

| | | |
|---|---|---|
| Do you have a family history of melanoma? | yes _____<br>no _____ | If yes, which relative? |

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## MEDICATIONS

| Current medications? | Are you allergic to any medications? |
|---|---|
| | |

## SOCIAL HISTORY

| Currently smokes | Has smoked in the past | Never smoked |
|---|---|---|

## ALCOHOL USE

| Everyday Drinker | Social Drinker | Never Drinker |
|---|---|---|

Any recreational drug uses? _____

## ROS

| | | | | |
|---|---|---|---|---|
| any new allergies | changing moles | problems with bleeding | problems with scarring (hypertrophic or keloid) | immunosuppression |
| rash | depression | blood thinners | Rapid heartbeat with epinephrine | artificial joints within the past two years |
| allergy to lidocaine | yeast infections with antibiotics | artificial heart valve | premedication prior to procedures | artificial heart valve |
| allergy to adhesive | allergy to topical antibiotic ointments | pacemaker or defibrillator | pregnant | planning a pregnancy |

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**Supplemental Patient Intake**

*Due to new requirements from the US Department of Health and Human Resources, we are requesting that all patients complete the following questionnaire.*

PATIENT NAME: _____ TODAY'S DATE:_____

DATE OF BIRTH: _____ SEX: □ Male □ Female

**Melanoma:**

Have you ever been diagnosed with Melanoma? □ YES □ NO

If YES, did you ever have an X-ray, CT Scan, MRI, or PET Scan? □ YES □ NO

**Tobacco Use:**

Please choose the option that best describes your tobacco use:

□ Never □ Current smoker □ Previous smoker □ Less than 100 cigarettes in lifetime

For current tobacco users, select the option that best describes use:

□ 1-3 cigarettes per day □ Up to 1 pack per day □ 1-2 packs per day □ 2 or more packs a day

**Vaccinations:**

In the past year, did you receive the following vaccinations?

Flu vaccine: □ YES □ NO

COVID-19 vaccine: □ YES □ NO

*(65 YRS OLD AND OVER ONLY)* Pneumonia vaccine: □ YES □ NO

**Pain:**

Aside from general aches (i.e. muscle, head, tooth), are you currently experiencing any pain?

□ YES □ NO

If yes, please circle the number that corresponds with the amount of pain you are currently in:

1 2 3 4 5 6 7 8 9 10

**<u>AGE 65 AND OVER ONLY:</u>**

Do you have one of the following?

□ Power of Attorney (Surrogate Decision Maker) □ Living Will (Advance Care Plan) □ None

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**Request for Medical Treatment**

I, _____, have presented to McDaniel Dermatology & Skin Surgery Institute to obtain medical treatment for myself or my child.

I understand that in order to adequately treat or diagnose my condition, I may need to have a biopsy performed or have a lesion frozen with liquid nitrogen, removed with a curate, surgically excised, or burned off. Some risks are associated with these procedures including scarring that may look worse than the original scar, lightening or darkening of the skin, bleeding, infection, and a change in sensation. Some insurance companies may not include procedures as part of an office visit. If the procedure is done, according to your insurance plan, it may fall under a procedure deductible and you will have to pay according to your plan.

If Dr. McDaniel feels that one of these procedures is necessary for me or my child's treatment, she will discuss this with me before proceeding with the procedure. I will be given the opportunity to ask any questions about the procedure as well as refused the recommended procedure.

I am also aware that if a biopsy or culture is done, it will be sent to an outside laboratory where it will be processed and filed to my insurance. Therefore, according to my personal insurance plan, I may have additional fees from the lab.

By signing this, I knowledge that I have read and understand above information.

_____ _____

Patient/Parent signature Date

_____ I authorize McDaniel Dermatology & Skin Surgery Institute to give my test results to:

_____

Provide Name & Contact Information

---

_____ I do not authorize my results to be given to anyone other than myself.

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## Office Policies

**Late Policy:** At McDaniel Dermatology our doctors and staff strive to be on time. To help our office run smoothly, we ask that if you are running more than 10 minutes late, please call us to let us know as we may need to reschedule your appointment.

**Missed Appointments:** If you need to cancel or reschedule an appointment, we kindly request that you give our office 24-hour notice. If we do not receive a 24-hour notice, there will be a $30.00 cancellation fee billed to the patient or responsible party. If a surgical appointment is missed it will result in a $250.00 cancellation fee. Please note: Patients who continuously miss their appointments without giving proper notice to our office staff will be discharged from our practice after the third violation.

**Gift Certificates:** Gift certificates must be present at the time of service. The gift certificates are nonrefundable and nontransferable. McDaniel Dermatology is not responsible for any lost or stolen gift certificates. Our gift certificates are only valid 1 year from the date of purchase.

**Deposits:** McDaniel Dermatology and Skin Surgery Institute does require deposits for certain procedures and cosmetic procedures. This deposit is non-refundable.

**Billing and Insurance:** It is the patient's responsibility to understand and acknowledge their insurance plan's policies. There are a few different insurance plans and each one has its own reimbursement policies. It is your responsibility to let us know of any specific requirements within your plan. We accept most major insurance plans and will file the claims, including secondary insurance to the plans we participate in.

All co-payments and deductibles are collected at the time of service. If you have not met your deductible, we require you to pay a percentage of the contracted fee amount at the time of service, you will receive a bill for the remaining balance. It is essential to understand that most insurance companies consider all procedures (freezing warts, biopsies, etc.) to be applied to your deductible if your plan has one. If your insurance company denies your bill, you will be held responsible for the balance. If you do not have any insurance or if you are having a cosmetic procedure done, the fees will be collected in full at the time of service. If your insurance changes, it is your responsibility to inform our office at least 24 hours before your appointment to make sure we are an in-network provider. Failure to do so may result in you having to reschedule your appointment and receive a $30.00 cancellation fee.

*You may receive a separate bill for any laboratory test or pathology services that Dr. McDaniel or Dr. Martin may order.

**Payment:** We accept the following forms of payment in our office: cash, Visa, Mastercard, American Express and Discover. (We do not accept check)

**Returned check fee/collections:** There will be a $30.00 charge for all returned checks/NSF. If it is necessary to collect unpaid fees for services rendered, you will be responsible for the charges assessed by the collection service, legal counsel, or court.

I have read and understand the financial policy of the practice and I agree to comply by its terms.

_____ _____

Print Name Date

_____

Signature of Patient or Responsible Party

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## Cancellation and No-Show Policy

We strive to provide excellent care to all our patients. We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment, you must provide at least 24-hour notice. You must provide 48-hour notice for a surgical appointment to avoid a $250.00 no-show fee. This will enable us to accommodate another patient who is waiting for an appointment.

Patients who do not show up for a scheduled appointment, and who have not contacted our office at least the day before the appointment will be considered a **no show**.

- Appointments which are not canceled within 24/48 hours will be charged a $30 fee. Procedure cancellations require two-day notice; without notification they are subject to a $250 cancellation fee or the retention of the deposit.

- This fee is a charge for the patient, not the insurance company, and is due at the time of the missed appointment.

- Patients who no-show three times in a 12-month period will be dismissed from the practice and will be denied future appointments.

- All product sales and exchanges are non-refundable and non-negotiable.

We do realize certain circumstances can change at the last minute. If you were unable to make a scheduled appointment due to extenuating circumstances, please contact our office at 985-277-5463 and we may be able to waive the no-show fee.

_____ _____

Patient Name Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

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**Patient Authorization for Release of Protected Health Information**

By signing this authorization, I authorize McDaniel Dermatology & Skin Surgery Institute to use and/or disclose certain protected health information (PHI) about me to _____*(name of entity to receive this information).* This authorization permits McDaniel Dermatology & Skin Surgery Institute to use and/or disclose the following individual's identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of services, level of detail to be released, origin of information, etc.):

_____

The information will be used or disclosed for the following purpose:

_____

If requested by the patient, purpose may be listed as "at the request of the individual."

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____ *(expiration date or defined event).*

_____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Patient's Name/Date of Birth Date

_____
Print Name of Patient or Legal Guardian

**Patient/Guardian to be provided with a signed copy of this authorization.**

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# - AUTHORIZATION TO RELEASE HEALTH INFORMATION -

| | | |
|---|---|---|
| Patient Name | | Date of Birth |
| Social Security Number | | |
| Address | | |
| | | |

| | |
|---|---|
| * Provider authorized to release the Health Information (the "Provider"): | *(Name of releasing entity)* |
| * Entity to receive the Health Information (the "Recipient"): | *(Name of receiving entity)* |
| Recipient's Address: | *Address* |
| | *Attention:* |

| | | | |
|---|---|---|---|
| * Dates of service of the Health Information that is covered by this authorization: | | | |
| | Start date: | End date: | |
| | Start date: | End date: | |
| * Health Information related to the patient to be released under this authorization: | | | |
| | Complete health record | | |
| | Discharge summary | | Progress Notes |
| | History & physical examination | | Laboratory tests |
| | Consultation reports | | X-ray report |
| | Other (Please specify): | | |
| The following information will be released when included in the above unless you indicate otherwise: | | | |
| | Do not release any AIDS of HIV test results | | Do not release any records of psychiatric care |
| | Do not release any records of alcohol/substance abuse treatment | | |
| | Other: | | |
| | If checked, this authorization allows the Provider to use or disclose your information for marketing purposes and the Provider receives direct or indirect renumeration from a third party for that marketing use or disclosure. | | |
| | If checked, this is a conditional authorization, and you will not receive the following services unless you sign this authorization *(describe any consequences of refusing to sign):* | | |

| |
|---|
| * Purpose of disclosure: |

| |
|---|
| * Authorization expiration date or event: |

| | |
|---|---|
| * *Patient's Signature* | *Date* |
| * *Personal representative's signature (if necessary)* | *Date* |
| *Note: If signed by a "personal representative" of the patient, please complete the Personal Representative section on the back.* | |

*Not to be used for release of genetic test.*

# Cosmetic Interest Questionnaire

Date: _____

Patient Name:_____ Date of Birth: _____

When I look in the mirror, I am not concerned, somewhat concerned, or very concerned about the appearance of my wrinkles.

| *Not Concerned* | | *Somewhat Concerned* | | *Very Concerned* |
|---|---|---|---|---|
| 1 | 2 | 3 | 4 | 5 |

I am interested in a skincare routine that is most appropriate for my skin type and age.
◯ YES ◯ No thanks

I am interested in learning about anti aging products and or procedures.
◯ YES ◯ No thanks

**Please indicate the aesthetic treatments and procedures that interest you. Please check all that apply.**

- ☐ Skin care advice
- ☐ Facial lines and wrinkles
- ☐ Sun spots/Age spots/Freckles
- ☐ Facial redness / Blotchy skin
- ☐ Sun damage to neck and declotee
- ☐ Length/fullness of eyelashes
- ☐ Professional skin-care products
- ☐ Hair removal
- ☐ Topical wrinkle treatments
- ☐ Skin rejuvenation
- ☐ Thin lips
- ☐ Silkpeel/Microdermabrasion
- ☐ Dermal fillers for fine lines and wrinkles
- ☐ Botox/Dysport (Botulinum toxin A)
- ☐ Mineral makeup
- ☐ Sunscreen advice
- ☐ Acne treatment
- ☐ Droopy eyelids
- ☐ Other (please specify):_____

**PLEASE MARK THE DIAGRAM TO INDICATE YOUR CONCERNS**