McDANIEL
DERMATOLOGY & SKIN SURGERY INSTITUTE
medical · mohs surgery · cosmetic

109 NEW CAMELLIA BLVD STE #200
COVINGTON, LA 70433

PATIENT INFORMATION

Patient Name: _____ Title: Mr./Mrs./Dr./Other: _____ Suffix:_____

Gender: _____ Date of Birth: _____ Social Security #: _____ Mailing

Address: _____City: _____ State: _____ Zip: _____

Preferred Phone (Cell,Work,Home): _____ Can leave a message? Y___ N____

Primary Care Physician: _____ Email: _____

How did you hear about McDaniel Dermatology?:_____

Pharmacy _____

EMEREGENCY CONTACT

Name: _____ Relationship to Patient:_____ Phone:_____

INSURANCE INFORMATION

SEND STATEMENT TO: (If different from above)

Name:_____ Title: Mr./Mrs./Dr./Other:_____ Suffix:_____

Mailing Address: _____ City:_____ State:_____ Zip:_____

Preferred Phone: (Cell, Home, Work): _____

PRIMARY INSURANCE

Insurance Company: _____ ID#_____ Group#_____

Insurance Name(Subscriber): _____ DOB:_____ SSN_____

SECONDARY INSURANCE

Insurance Company: _____ ID#_____ Group#_____

Insurance Name(Subscriber): _____ DOB:_____ SSN_____

Patient's Relationship to Insured (Subscriber) SELF SPOUSE CHILD OTHER

I herby authorize that the above listed insurance company to pay directly to McDaniel Dermatology due me, as provided in the above unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge amounts due from me. Outstanding greater than 90 days will be eligible for collections. I authorize McDaniel Dermatology to release information to the insurance company for my claims to be paid. Please attach a copy of my insurance card.

Signature: _____ 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 family member/individual to receive this information)*. This authorization permits McDaniel Dermatology & Skin Surgery Institute to use and/or disclose the following individuals identifiable health information above me (specifically describe the information to be used or disclosed, such as date(s) of services, level detail to be released, origin of information, etc,):

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 treated with liquid nitrogen, removed with 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/ Dr. Martin 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 my questions about the procedure as well as refuse 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 acknowledge that I have read and understand above information.

_____ _____

Signature of Patient or Legal Guardian | Relationship to Patient

_____ _____

Patient's Name/Date of Birth | Date

_____

Print Name of Patient or Legal Guardian

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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 5 minutes late, please call us to let us know as we may need to reschedule your appointment .

CANCELLATION/ NO SHOW POLICY

If you need to cancel or reschedule an appointment, we kindly request that you give our office a 24-hour notice. If we do not receive a 24-hour notice, there will be a $50 cancellation fee billed to the patient or responsible party. If a surgical appointment is missed, it will result in a $250 cancellation fee. Please note: Patients who continuously miss their appointments without giving proper notice to our office, will be discharged from our practice after the third violation. INITIAL:_____

GIFT CERTIFICATES

Gift certificates must be present at the time of service. The gift certificates are non refundable and non transferable. 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 & Skin Surgery Institute does require deposits for certain procedures and cosmetic procedures. This deposit is non- refundable.

BILLING AND INSURANCE

It is the patients' responsibility to understand and acknowledge their insurance plans policies. There are a many 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 claim, 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 the full 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 notify us may result in you having to reschedule your appointment and receive a $50 cancellation fee. You may receive a separate bill for any laboratory test or pathology services that Dr. McDaniel or Dr. Martin may order.

FINANCIAL POLICY

I hereby authorize that the listed insurance companies to pay directly to McDaniel Dermatology due me, as provided in the unexpired policy. I will pay all charges in excess of whatever sums may be allowed by my insurance and acknowledge amounts due from me, outstanding greater than 90 days will be eligible for collections. I hereby acknowledge that if I am to use a credit/debit card, I will be assessed a 3% processing fee. ** ALL PRODUCT SALES ARE FINAL**

COSMETIC VS MEDICAL NECESSITY

Your medical insurance DOES cover the discussion and treatment of medically necessary conditions. If you are not sure about a skin issue/lesion- please DO ask about it. Requests are frequently made to remove lesions that are NOT medically necessary or to discuss cosmetic issues. In these cases, after we have concluded the regular office visit, the medical assistant or nurse will provide you with a fee schedule for any non-covered issues. If you desire to treat any non-covered issues, we will try our best to complete the service same day. There will be some cases in which a separate or follow up appointment will be scheduled to complete the desired service.

I, the undersigned, understand the office procedures and policies as noted above. I have had the chance to have all my questions answered in my satisfaction and agree to abide by the policies above.

Patient Name (Print)	Signature	Date

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NEW PATIENT QUESTIONNAIRE

Weight:_____ Height:_____

Reason for today's visit: _____

Your Past Skin History

	Previous Treatments	Treating Physician
Abnormal Moles		
Flaking or Itching Scalp		
Blistering Sunburns		
Poison Ivy		
Psoriasis		
Eczema		
Rosacea		
Actinic Keratosis (Pre-Cancers)		
Acne		
Basal Cell Carcinoma		
Squamous Cell Carcinoma		
Melanoma		
Dry Skin		
Keloids		

Your Past Social History

	YES	NO		
Do you smoke?			For how long?	Year Started:
If not, have you ever smoked?			Year Started:	Year Ended:
Do you drink?			How much?	
Any Recreational Drugs?			Explain	
Pregnancy/Planning a Pregnancy/Breastfeeding?			Explain	
Family history of Melanoma?			If yes, which relative?	
Flu Vaccine?				
Covid Vaccine?				
Pneumonia Vaccine?				
Do you have a Power of Attorney?				
Do you have a Living Will?				
Occupation?				

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Have you ever had any of the following medical problems?	Yes	No	Please give us any details
Anxiety			
Arthritis			
Asthma			
Atrial Fibrillation			
BPH			
Cerebrovascular Accident			
COPD			
Coronary Arteriosclerosis			
Depression			
Diabetes			
High Blood Pressure			
End Stage Renal Disease			
Epilepsy			
GERD			
Hearing Loss			
HIV/AIDS			
High Cholesterol			
Hyperthyroidism			
Hypothyroidism			
Hepatitis			
Leukemia			
Malignant Tumor			
Radiation			
Bone Marrow Transplant			
Colon Cancer			
Stroke			
Heart Attack			
Parkinsons Disease			
Tuberculosis			
Glaucoma or Macular Digeneration			
Pacemaker/Defibrillater			
Artificial Joints within the last 2 years			
Artificial Heart Valve			

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Your Past Surgical History (Last 10 Years)

Surgery/Hospitalization	Date

Please list your medications:

Please list your allergies:

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 decletee
- ☐ 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