Jasper Dermatology

87 19th St W, Ste 200
Jasper, AL, 35501
Phone: (205) 705- 3100 / Fax: (205) 705- 3173

Patient Intake Form

Patient Demographics

Last Name:	First Name:	DOB:
Address:		SS#:
Email:		Phone #:
Okay to Leave Voicemail: ☐ Yes ☐ No		
Emergency Contact:		Relationship to You:
Email:		Phone #:
Referral Source:		

Primary Insurance

Insurance Name:	
Member ID:	Group Number:
Policyholder's Name:	Effective Date:
Relationship to Policyholder:	Policyholder DOB:
Policyholder Phone #:	

Secondary Insurance

Insurance Name:	
Member ID:	Group Number:
Policyholder's Name:	Effective Date:
Relationship to Policyholder:	Policyholder DOB:
Policyholder Phone #:	

Medical History

Primary Care Provider:	Phone #:

Please Check all that apply:

Skin Cancer History:

- ☐ Basal Cell Carcinoma
- ☐ Squamous Cell Carcinoma
- ☐ Melanoma
- ☐ Family History of Melanoma
  If yes, relationship:

Medical History:

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Arthritis/Joint Pain
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Seasonal Allergies
- ☐ Anxiety
- ☐ Bleeding Condition
- ☐ Blood Clots
- ☐ Cancer
- ☐ COPD
- ☐ Cold Sores
- ☐ Depression
- ☐ Diabetes
- ☐ Dysplastic Nevi of Skin
- ☐ Eczema
- ☐ Hepatitis/HIV
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyper/Hypothyroid
- ☐ Immunosuppression
- ☐ Lupus
- ☐ Pacemaker
- ☐ Psoriasis
- ☐ Pruritus of Scalp
- ☐ Seizures
- ☐ Stroke
- ☐ Sunburn of Second Degree
- ☐ Sensitivity to Local Anesthesia
- ☐ None

Pregnancy

Are you pregnant or nursing?	☐ Yes	☐ No

Allergies

☐ Yes ☐ No If yes, list here:

Pharmacy

Pharmacy Name:	Phone #:

Medications

List all known prescriptions, over the counters, herbals, and vitamin/mineral/dietary (nutritional) supplements. *Attach list if more room is needed.*

Medication	Dose	Frequency

Surgeries

List past surgical history.*Attach list if more room is needed*

Social History

Tobacco Use:	☐ Yes	☐ No	☐ Former
Alcohol Use:	☐ Yes	☐ No	If yes, how often?
Do you wear sunscreen?	☐ Yes	☐ No	If yes, what SPF?
Do you use a tanning bed?	☐ Yes	☐ No	

By my signature below, I certify that the information I have provided above is complete, accurate and truthful to the best of my knowledge.

_____ _____

Signature Date

Authorizations

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to JASPER DERMATOLOGY, LLC. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in the form of cash, check, Visa™, or Mastercard™. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre verified and you will be asked to pay any unmet deductible, non-covered service, and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

_____ _____

Signature Date

Patient Consent for Use and Disclosure of Protected Health Information

With my consent JASPER DERMATOLOGY, LLC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO) in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rules. Please refer to JASPER DERMATOLOGY, LLC' Notice of Privacy Practices for a more complete description of such uses and disclosures. I have received and reviewed the Notice of Privacy Practices prior to signing this consent. JASPER DERMATOLOGY, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to JASPER DERMATOLOGY, LLC Privacy Officer at 87 19th St W, Ste 200, Jasper, AL 35501. With my consent JASPER DERMATOLOGY, LLC may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others. With my consent JASPER DERMATOLOGY, LLC may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent JASPER DERMATOLOGY, LLC may e-mail my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that JASPER DERMATOLOGY, LLC restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to JASPER DERMATOLOGY, LLC' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent JASPER DERMATOLOGY, LLC may decline to provide treatment to me.

_____ _____

Signature Date

Consent For Minor Surgery/Procedures

(Biopsy, Cryosurgery, Intralesional Steroid Injections, Candida Injections, Cantharidin Application, Hyfrecation, Scissor Snip Removal)

I authorize my Jasper Dermatology provider to perform a minor surgery to include a biopsy, cryosurgery, intralesional steroid injection(s), Candida injection(s), cantharidin application, hyfrecation, or scissor snip removal to treat or evaluate a skin condition at the discretion of your provider. Please review and sign the consent form below. You will be given time to discuss the procedure if the provider deems a minor surgery/procedure is necessary or an option. This will serve as a standing consent for this and any and all future treatments, however verbal consent will always be obtained prior to any treatment.

_____ _____

Signature Date

Proposed Treatment

I understand that a biopsy requires obtaining a sample of tissue and is a surgical procedure. As in any surgical procedure, there are certain risks including bleeding, post-operative pain, infection, reactions to sutures, anesthetics or topical antibiotics, and scarring. Although all reasonable efforts will be made to minimize the possibility of these potential complications, no guarantees can be made since many factors beyond the control of the physician/provider (such as the degree of sun damage or patient compliance with post-operative instructions) affect the ultimate healing. A pathologist will examine the tissue obtained in this biopsy procedure. I understand I may receive a separate bill from the pathologist or laboratory for this microscopic examination. Complications of applying liquid nitrogen, hyfrecation, cantharidin application, and candida injections to the skin may include (but are not limited to): • Pain/irritation • Redness • Scarring • Blistering • Infection • Permanent loss of pigmentation • Intralesional steroid injection has the above risks as well as the risk of skin atrophy (thinning of the skin leaving a depression)* Jasper Dermatology will attempt to contact you by phone three (3) times to deliver results. If we are unable to reach you, we will send a certified letter to the address on file. After completing these actions, we will take no further steps to contact you with results.

_____ _____

Signature Date

Cancellation of Appointments/Assignment of Benefits

No-shows and late cancellations prevent other patients from receiving care. Jasper Dermatology, LLC requires a 24 hour notice for appointment cancellations so that we can offer the appointment to another patient who needs to be seen. There is a fee of $50 for medical appointments that are missed and/or not cancelled. There is a fee of $100 for cosmetic or surgical appointments that are missed and/or not cancelled. This fee must be paid before rescheduling the missed appointment.

I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to Jasper Dermatology, LLC. I understand that I am responsible for any amount not covered by insurance.

I have read, and I understand the above information. I agree to comply with these financial policies.

_____ _____

Signature Date

HIPAA

Authorization to Release Information to Family Members / Friends

This form is optional and allows patients to authorize disclosure of protected health information to spouses, significant others, parents (of non-minors), adult children or any other designee. In accordance with HIPAA, Jasper Dermatology, LLC is not allowed to share patient protected health information without the patient's consent except as stated by law. NOTE: You may revoke this authorization at any time by notifying Jasper Dermatology, LLC in writing.

I, _____, direct Jasper Dermatology, LLC to disclose and release my protected health information described below to the following individual(s):

Name	Relationship to Patient	Phone Number

_____ _____

Signature Date

Financial Policy

Thank you for choosing Jasper Dermatology, LLC as your healthcare provider. We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware of and understand our financial policy. Please ask if you have any questions about our fees, policies, and your responsibilities. It is your responsibility to notify our office of any patient information changes (e.g., address, name change, insurance policy, etc). INSURANCE CLAIMS, CHARGES, AND PAYMENTS The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of your appointment. We accept cash, checks, Visa, Mastercard, American Express, and Discover. If you have an insurance deductible or coinsurance, any and all office visit and/or procedure charges will apply towards your deductible, and you will be billed accordingly. If a patient is a minor (18 years of age and below) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian assumes responsibility for any payment due at the time of service. If you are unable to pay for necessary medical care, you may be eligible for a payment plan. It is your responsibility to inform us of your financial need prior to your visit. Please ask to discuss arrangements with our billing department. As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of the claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all of the services provided to you. If your insurance requires referrals to specialists, it is your responsibility to make sure we are in network with your plan and obtain a referral PRIOR to your appointment. Failure to obtain a valid referral may hold you responsible for any payments incurred for services rendered. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to, those charges above the usual and customary allowance. If we are out of network and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately. Self-pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay accounts are payable at the time of service. Any medical procedures (e.g., liquid nitrogen "freezing" treatment or biopsies) performed in our office are considered separate, billable charges in addition to your office visit charge. Certain procedures and services provided during your medical visit are not covered by most insurance companies. These are considered cosmetic procedures. It is your responsibility to understand that you may have cosmetic fees in addition to your medical visit. These fees are due at the time of service. Most laboratory charges, such as blood work, cultures, and pathology tests, ordered through our office are billed directly to your insurance by the laboratory processing the test. If you receive a statement from the pathologist laboratory, we request that you contact them directly to resolve any billing questions. It is our policy that all accounts remain current. In the event that a patient balance remains outstanding and no resolution can be made, your account may be sent to a collections agency and/or you may be discharged from the practice. The charge for returned checks is $35 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

_____ _____

Signature Date