aura
DERMATOLOGY

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

***Please present ALL Insurance cards and Drivers License to the receptionist. If patient is a minor, and you are not the legal guardian, please speak with the receptionist immediately. Thank you.**

Patient Information: Please Complete All Fields Using Legal Names of the Parties Involved.

Name: (First)_____ (MI)_____ (Last)_____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female Marital Status: Single Married Div Widow

Mailing Address:_____

City: _____ State: _____ Zip: _____ Social Security#:_____

Home Phone: _____ Cell: _____ Email:_____

Emergency Contact Name: _____ Emergency Contact Phone: _____

Pharmacy Name: _____ Town: _____Phone#:_____

Primary Doctor Name: _____ Town: _____Phone#:_____

Referring Physician _____Town: _____ Phone#:_____

New Patients: How did you hear about us? _____

Primary InsurancePlan:_____ID#_____

Primary Insurance Plan Holder's Name:_____ DOB:_____ Relationship:_____

Mailing address of Plan Holder if different from patient: _____

Home Phone of Plan Holder: _____ Cell phone of Plan holder:_____

Secondary Insurance Plan: _____ID#_____

Secondary Insurance Plan Holder's Name:_____ DOB:_____ Relationship to patient:_____

Patient Release: MUST BE SIGNED BY PATIENT OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I understand I am responsible for co-insurances, copayments and deductibles. If I am not insured or Aura Dermatology does not participate in my plan I am responsible for payment in full at the time of service

I certify that I hereby authorize Aura Dermatology, its providers and staff to provide my minor child in my absence with examinations and basic treatments following the initial visit for which additional consents are not required I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

I agree to receive news and information about the practice via email, which may include offers and announcements for special events or offers from the practice and my physician. _____ (initial)

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ Date: _____

Name of Legal Guardian if applicable: _____

Patient Name: _____ DOB: _____

Our goal is to provide you and your family with the very best care in a warm, supportive environment. We wish to provide you with information that helps us to maintain this goal and through our Patient Policies. These Policies manage expectations and assure understandings to develop a long-lasting relationship. We have updated our financial policies for your review below. We remain available for any questions you may have.

Appointment Cancellations and No Shows

- I understand late cancellations or missing an appointment keeps other patients from being seen.
- I understand failure to give 24-hours' notice of cancellation for a medical appointment will result in a charge of $50; failure to provide 24-hours' notice for a surgical or cosmetic procedure may result in a charge of $150 or forfeit of my cosmetic deposit or one treatment in my cosmetic package.
- These charges cannot be billed to my insurance company.
- This fee will be charged to the credit card on file.

Late Arrivals for Appointments

- I understand Aura Dermatology will do its best to accommodate me should I arrive late for an appointment. I understand arriving late means I have forfeited my appointment time and will need to wait to be worked back into the schedule if possible or be placed with another provider who may have availability. I also understand that there may be times when these accommodations are not available and I will be asked to reschedule my visit.

Copayments, Deductibles and Coinsurance and Balances

- All balances are due in full within 30 days of my first billing.
- Any balance remaining unpaid after 90 days without attempted resolution will be considered for collection.
- Should my account be sent to collections, I understand that I will be responsible for an additional 25% administrative collection fee plus any attorney/court fees that may be added to my account during efforts to obtain payment.
- I am responsible for any bank fees associated with returned check fees plus a $25.00 administrative processing fee. Any returned check must be paid in full via credit card or cash within 15 days of notification or legal efforts to collect balance will be instituted.

Referrals

- **It is my responsibility to know if my insurance plan requires a referral to see a specialist and I will obtain referrals, track usage, and verify that Aura Dermatology has referrals in their office prior to my visit.**
- I understand that should I fail to have a valid referral for my visit, Aura Dermatology is not authorized to treat me. I will need to reschedule my appointment or sign a referral waiver.
- I understand that attempting to contact the referral office to obtain or inquire about my referral at the time of my visit to Aura Dermatology will not allow me sufficient time to keep my scheduled appointment and, by doing so, will forfeit my scheduled time at Aura Dermatology.

Insurance Policies

- I will confirm that my insurance is up to date at each visit. If there is a change in my insurance, I will provide a valid insurance card or temporary printout at the time of my visit.
- My insurance carrier may consider certain routine services in dermatology to be surgical in nature and separate co-insurance, deductibles, or co-payments may apply. **Each insurance plan is different, and I understand that it is my responsibility to understand my policy and what will be covered.**
- If the insurance or referral information I present at the time of my visit is not correct, I will be responsible for all charges incurred.

Pharmacies

We will try to send your prescriptions to the pharmacy of your choice. Should your insurance require pre-authorization, we will automatically transfer your prescription to a specialty pharmacy for processing.

Minor Patients

As a practice with a significant Pediatric and Adolescent population, we recognize the stress a family may encounter navigating children's health care under the best of circumstances. We also recognize this can be even more difficult in families where the parents are not together. We are here to treat and support you and your children, not to be encumbered in legal issues and responsibilities of the family.

- I understand that ***a legal guardian*** MUST ACCOMPANY my child under the age of 18 to their initial appointment.
- I understand that ***a legal guardian*** MUST ACCOMPANY my child under the age of 18 to subsequent appointments where additional consent will be required.
- I understand that significant information is needed at the initial visit and treatment plans are created, it is essential that a parent/legal guardian be present at the initial visit.***Children without a legal guardian at their initial visit will be rescheduled***. Notes from legal guardians with permission to treat are not accepted.
- I acknowledge that grandparents, older siblings, stepparents, etc. are not considered legal guardians without a court document that must be presented at the time of service.
- I understand that, unless documents are provided to the contrary, both parents are supposed to make the appointment and treatment decisions for their child. Disagreements about the treatment approach are discussed between the parents.
- **I understand that ALL copayments are due at the time of service, regardless of which parent is responsible for medical coverage. We are not a party to your divorce settlement. We will collect the payment owed by the parent bringing the child to the visit.** If the divorce decree requires the other parent to pay all or part of the costs of treatment, it is the responsibility of the authorizing parent to collect from the other parent.
- **I understand that there may be times when I may allow my teen to be unaccompanied for a follow-up visit and that all payments due at the time of service will be handled by me prior to the visit or by credit card on file for my children.**

Insurance Inquiries

- From time to time I may receive a letter from my insurance company requesting information about my coverage.
- I understand that claims will not be paid without me providing this information.
- I will respond to all insurance inquiries within 30 days of receipt or I may be responsible for the full balance.

Credit Card on File

- We have implemented a policy that requires a credit card to be kept on file. As you know, today's healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured.
- Similar to hotels and car rental agencies, a credit card number is required at check-in and the information will be held securely until your insurance has paid its share and we have received an EOB. At that time, you will receive a statement.
- If the patient balance is not paid within 30 days of the statement date, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you.
- This will in no way compromise your ability to dispute a charge or challenge your insurance company's payment determination.

Cosmetic Deposits

A significant amount of time is reserved for our patients' cosmetic appointments, and therefore a $500 deposit is required for certain cosmetic procedures, payable at the time of scheduling. All Cosmetic and Esthetician services will also require a card on file to schedule your appointment. Your deposit will be charged immediately and posted as a credit to your account. The deposit will be applied to the total charges on the day of your treatment. Cancellations/rescheduling more than 24 business hours in advance will be refunded or applied to the new appointment in full. Changes made with less than 24 business hours notice may result in a cancellation fee.

Signature of Patient or Legal Guardian: _____ **Date:** _____

Name of Legal Guardian: _____ **Relationship:** _____

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Patient Name: _____ **DOB:**_____

HIPAA

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Aura Dermatology from discussing appointments, medications, test results or treatment plans with anyone other than the patient.

Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. **This becomes especially important if your spouse or adult children assist with making appointments for you or if you are an adult college student away at school and your parents assist with prescriptions and appointments**.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information about you. Should you wish to update the names below, please ask the receptionist for a HIPAA form.

Please place a check mark next to the following methods we may use to contact you regarding your appointments and medical information and indicate below any persons authorized to speak with our office on your behalf.

You may leave a message	**Regarding Appointments**	**Regarding Medical info**
Home Answering Machine	_____	_____
Mobile phone Voice Mail	_____	_____
Mobile text	_____	_____
Work Phones	_____	_____
With another person that may answer	_____	_____
Information through the mail	_____	_____
Information through email	_____	_____

Name of Individual (please print)	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

Patient/ Guardian Signature: _____ **Date:** _____

I acknowledge and understand the above HIPAA policies and understand I may request a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

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Patient Name: DOB: Height: Weight:

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp Hay Fever/ Allergies Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

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Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No
Do you have a family history of Melanoma? Yes No
If yes, which relative(s)?
_____

Medications: (Please enter all current medications *including* **dosage** and **frequency**)
_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____

Social History: (Please circle all that apply)
Cigarette Smoking:

Currently Smokes
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Family History (Only first-degree relatives)
_____
_____

ALERTS: (please circle all that apply)
Allergy to Adhesive
Allergy to topical antibiotics
Artificial joint replacement
Defibrillator
Pacemaker
Rapid heartbeat with epinephrine
Allergy to lidocaine
Artificial heart valve
Blood thinners
MRSA
Require antibiotics prior to a surgical procedure
Are you pregnant or currently trying to get pregnant?

Have you received the Flu Vaccine? Yes No

65 and older:
Do you have an Advanced Care Plan? Yes No
If yes please provide the name and relation of the surrogate decision maker:
Name:_____Relation:_____

Have you received the Pneumonia Vaccine? Yes No