aura
DERMATOLOGY

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 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: _____ **Town:** _____ **Phone#:**_____

Primary Doctor Name: _____ **Town:** _____ **Phone#:**_____

Referring Physician: _____ **Town:** _____ **Phone#:**_____

New Patients: How did you hear about us? _____

Primary Insurance Plan: _____ **ID#**_____

Primary Insurance Plan Holders Name: _____ **DOB:** _____ **Relationship:** _____

Mailing Address of Plan Holder if Different From Patient _____

Phone of Plan Holder: _____

Secondary Insurance Plan: _____ **ID#**_____

Secondary Insurance Plan Holders Name: _____ **DOB:** _____ **Relationship:** _____

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

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 <u>for which additional consents are not required.</u> 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 **<u>OR</u>** LEGAL GUARDIAN SIGNATURE: _____ Date:_____

Name of Legal Guardian if applicable: _____

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 of 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 **$150**; failure to provide 48-hours' notice of cancellation for a surgical or cosmetic procedure may result in a charge of **$250** 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 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.

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.

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 48 business hours in advance will be refunded or applied to the new appointment in full. Changes made with less than 48 business hours notice may result in a cancellation fee.

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.

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.

PATIENT **OR** LEGAL GUARDIAN SIGNATURE: _____ Date:_____

Name of Legal Guardian if applicable: _____

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

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 trom 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 Voicemail	☐	☐
Cellphone Voicemail	☐	☐
Mobile Text	☐	☐
Work Phone	☐	☐
Home Mail	☐	☐
Email	☐	☐
With another person that may answer	☐	☐

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

PATIENT **OR** LEGAL 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.

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

Height:_____ **Weight:**_____

Medical History: (Please circle all that apply)

Anxiety	Coronary Artery Disease	Hepatitis	Radiation Treatment
Arthritis	Depression	High Blood Pressure	Seizures
Asthma	Diabetes	High Cholesterol	Stroke
Atrial Fibrillation	End Stage Renal Disease	History of HIV/AIDS	Thyroid Problems
Bone Marrow Transplant	GERD	Leukemia	Other:_____
COPD	Hearing Loss	Lymphoma	NONE

Past Surgical History: (Please list below)

_____

_____

Skin Disease: (Please circle all that apply)

Acne	Eczema	Precancerous Moles
Actinic Keratoses	Flaking or Itchy	Psoriasis
Basal Cell Skin Cancer	Melanoma Skin Cancer	Squamous Cell Skin Cancer
Blistering Sunburns	Scalp Hay Fever/Allergies	NONE
Dry Skin	Poison Ivy	Other:_____

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

_____ Dose: _____ Freq: _____

_____ Dose: _____ Freq: _____

_____ Dose: _____ Freq: _____

_____ Dose: _____ Freq: _____

_____ Dose: _____ Freq: _____

Allergies: (Including any medication allergies)

_____

_____

_____

Social History:

Cigarette Smoking:

Current Smoker

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

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)?_____

65 and older:

Do you have an Advanced Care Plan? Yes No N/A

If yes, please provide the name and relation of the surrogate decision maker:

Name: _____ Relation: _____ Phone#: _____

Have you received the Pneumonia Vaccine? Yes No N/A

If the patient is a minor:

Has the patient had a meningococcal vaccine (serogroups A, C, W, Y), on or between the patient's 11th and 13th birthday? Yes No N/A

Has the patient had a tetanus, diphtheria toxoids and acellular pertussis vaccine (Tap) on or between the patient's 10th and 13th birthday? Yes No N/A

Has the patient had at least two HPV vaccines (with at least 146 days between the two) OR three HPV vaccines on or between the patient's 9th and 13th birthday? Yes No N/A

Alerts:(Please circle all that apply)

Allergy to Adhesive
Allergy to Topical Antibiotics
Allergy to Lidocaine
Artificial Joint Replacement
Defibrillator
Pacemaker
Rapid Heartbeat with Epinephrine
Artificial Heart Valve
Blood Thinners
MRSA

Require Antibiotics Prior to a Surgical Procedure
Pregnant or Currently trying to get Pregnant
Currently Breastfeeding
NONE
Other:_____