the
dermatology
center

Dear New Patient,

Our physicians and staff would like to welcome you to our practice!

We are happy to say that your physician or other healthcare professional has scheduled you in our clinic for a New Patient appointment. As a New Patient you will need to complete the enclosed paperwork and bring to your scheduled appointment along with: list of current medications, photo ID, insurance cards, and if applicable, legal guardianship forms. **You will be responsible for payment of any copays, coinsurance amounts, and/or deductible amounts as required by your insurance at the time of service.** If you do not have health insurance we ask that you call our office prior to your appointment so we may inform you what will be required at the time of service.

Our physical location is: **7900 Dallas Street Fort Smith, AR 72903.**

It is helpful to arrive at least 15 minutes prior to your appointment time to complete your registration. If an appointment confirmation call is not received within 48 hours of the appointment, please contact our office. Any appointments that can not be confirmed within this time will be cancelled and you will need to reschedule. We look forward to seeing you and participating in your medical care.

Sincerely,

The Dermatology Center, PLLC

G. Luke Lewis, MD | P. Craig Stites, MD
Bryce Bass, PA-C | Melanie Myers, PA-C | Matt Patton, MS, MPA, PA-C
7900 Dallas Street | Fort Smith, AR 72903 | 479-242-6647(MOHS) | thedermcenterfs.com

TDC PATIENT REGISTRATION FORM

Patient Legal Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Circle one: Married/ Single/Divorced/ Widowed

Birth Sex: M / F (**TDC requires you to identify your birth sex for medication management purposes**)

Address: _____
Street City, State, Zip

Phone Number: (_____)_____-_____ Email address: _____

Employer Name: _____ Primary Care Physician: _____

Person responsible for bill (If patient is under 18 years of age)

Guarantor Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ Relationship to Patient (Circle one): Mother Father Other

Address: _____ _____
Street City, State, Zip

Phone number: (_____)_____-_____ Email address: _____

Employer: _____ Sex: M / F

Who to call for an emergency:

Name: _____ Address: _____

Phone Number: (_____)_____-_____ Relationship: _____

May we discuss your medical information with this person? (Circle one) YES NO

Insurance coverage: Primary

Plan Name: _____ I.D. Number: _____

Group Number:_____ Policy Holder: _____

Policy Holder's Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Relationship to patient: _____

Insurance coverage: Secondary

Plan Name: _____ I.D. Number: _____

Group Number: _____ Policy Holder: _____

Policy Holder's Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Relationship to patient: _____

Benefits Assignment

I hereby authorize the assignment of benefits (payments) directly to The Dermatology Center for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles, and non-covered services are due at the time of service. I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature: _____ Date: _____

Medical History Form

Patient Name: _____ **DOB:** _____ **Date:** _____

Pharmacy Name and Location: _____

Primary Care/Referring Physician: _____ **Check if NO PCP** _____

What is the reason for your visit today: _____

Height _____ **Weight** _____

Medical History: (Please check all that apply)

___ Anxiety
___ Arthritis
___ Asthma
___ Atrial Fibrillation (Irregular Heartbeat)
___ Bone Marrow Transplant
___ BPH (Benign Prostatic Hyperplasia)
___ Breast Cancer
___ Colon Cancer
___ Pulmonary Disease/COPD
___ Thyroid Disease
___ Bowel Disease
___ Heart Attack
___ Connective Tissue Disease
___ Seasonal Allergies
___ Immunosuppressed
___ Depression
___ Diabetes
___ End Stage Renal Disease
___ GERD (Reflux Disease)
___ Hearing Loss
___ Hepatitis
___ Hypertension (High Blood Pressure)
___ Hypercholesterolemia (High Cholesterol)
___ HIV/AIDS
___ Kidney Disease
___ Anemia
___ Emphysema
___ Keloids
___ Parkinson's Disease
___ Cirrhosis (Liver Disease)
___ Leukemia
___ Lung Cancer
___ Lymphoma
___ Pacemaker/Defibrillator
___ Prostate Cancer
___ Radiation Treatment
___ Seizures
___ Stroke
___ Heart Disease
___ Stomach Ulcers
___ Blood Clots
___ Plastic Surgery
___ Heart Murmur
___ MS
___ Neuropathy
___ Other _____

Past Surgical History: (Please check all that apply)

___ Kidney Removed
___ Lumpectomy
___ Colostomy
___ Ovaries removed
___ Heart valve replacement
___ Spleen removed
___ Hip replacement (Year: _____)
___ Mastectomy
___ Liver Transplant
___ Gallbladder removed
___ Angioplasty
___ Prostate removed
___ Testicles removed
___ Knee replacement (Year: _____)
___ Kidney Transplant
___ Colectomy
___ Coronary artery bypass
___ Pancreas removed
___ Heart transplant
___ Hysterectomy
___ Other: _____

Skin Disease History: (Please check all that apply)

___ Acne
___ Actinic Keratosis
___ Flaking/itchy scalp
___ Hay fever/allergies
___ Melanoma
___ Dry Skin
___ Eczema
___ Psoriasis
___ Squamous Cell Carcinoma
___ Other _____
___ Poison Ivy
___ Precancerous moles
___ Basal Cell Carcinoma
___ Blistering Sunburns

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 MALIGNANT MELANOMA? ___ Yes ___ No

If yes, which relative(s): _____

****PLEASE COMPLETE THE INFORMATION ON THE BACK OF THIS FORM****

SOCIAL HISTORY:

Smoking status: ___ Current every day smoker ___ Current someday smoker
___ Former smoker ___ Never smoker

Alcohol use: ___ None ___ < 1 drinker per day ___ 1-2 drinks per day ___ 3 or more drinks per day

Do you use IV drugs: ____ Yes ____No **Illicit drug use:** ____ Yes ____ No

Occupation: _____

MEDICATIONS (PLEASE LIST ALL CURRENT MEDICATIONS OR PROVIDE A LIST TO THE RECEPTIONIST):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

CHECK HERE IF NO MEDICATIONS: _____

DRUG ALLERGIES:

_____

_____

_____

CHECK HERE IF NO KNOWN DRUG ALLERGIES: _____

ALERTS: (Please check all that applies)

____ Allergy to adhesives
____ Allergy to latex
____ Allergy to lidocaine
____ Allergy to topical antibiotic ointment
____ Breastfeeding
____ Fainting
____ MRSA
____ Pregnant or planning pregnancy
____ Rapid heartbeat with epinephrine

If you are 65 or older, have you had the pneumonia vaccination? ____ Yes ____ No
Have you had the flu vaccination? ____ Yes ____ No
Do you have an advanced directive? ____ Yes ____No
Have you had a TB test within the last year? ____ Yes ____ No
If yes, please list the date and place: _____

Are you currently experiencing any of the following?

Symptoms	YES	NO
Do you have problems with bleeding?		
Do you have problems with healing?		
Do you have problems with scarring?		
Do you currently have a rash?		
Do you have any new skin lesions?		
Do you have any changing skin lesions?		
Do you have a fever?		
Do you have chills?		
Do you have unintended weight loss?		
Do you have fatigue?		

TDC PATIENT FINANCIAL POLICY

Our goal is to help you achieve and maintain optimum health for a lifetime. So that we may better serve you, please read and sign below. We appreciate the confidence you have placed in us as professionals.

We accept cash, personal checks, Visa, MasterCard, Discover, and Care Credit as payment for services.

Patients are required to complete all requested paperwork yearly. Insurance cards and your photo ID must be presented before services are rendered. Insurance information is to be updated annually or at any time insurance coverage changes. Your insurance will be verified prior to an appointment and you will be notified of the benefits. The information received will be used to estimate the out of pocket expense for the visit. Due to the overwhelming number of insurance plans, it is impossible for our front desk to guarantee coverage by any individual plan. It is the patient's responsibility to verify whether we are a participating provider for your network prior to treatment.

Please understand that it is ultimately the patient's responsibility for payment of services. If insurance cards are not provided, you are responsible for all charges on the date of service. We do collect copayments, deductibles, and coinsurances at the time of service. If your insurance company or other benefit program does not pay what was expected, you are responsible for the remaining amount. Payment will be due within 30 days of being notified of the balance.

Insurance will be filed for all primary insurance in a timely manner. We file secondary insurance except Medicaid with a commercial policy.

If the patient's insurance plan requires a referral, it is the patient's responsibility to ensure that a current referral is on file with our office. If a current referral is not on file, the patient may choose to pay out of pocket for the visit or reschedule the appointment to allow time for the referral to be received.

After a balance has reached 90 days past due, we will turn your account over to an outside collection agency for further action. The patient will be responsible for any charges incurred in such action and will not be scheduled back in the office until the balance has been paid.

If a check is returned to the office due to insufficient funds or a closed account, the original check amount plus a $30 returned check fee must be received within 30 days from the date the check was returned to avoid further late fees or collection action.

Please be aware that some services provided may be non-covered services under your policy. It is the patient's responsibility to be aware of the individual policy restrictions and guidelines. The Dermatology Center will not enter into a dispute with an insurance company, but we can assist you if you are having difficulties.

Note: Pathology charges are separate from office visit charges. Some specimens require specialized testing and charges are determined once the pathologist reviews the case. In some instances, the case is referred to an outside organization. The statement may be from our office or from an outside pathology office.

The Dermatology Center, PLLC will not treat a minor as a new patient without the presence of a parent or guardian. In some instances, a written consent can be put on file for follow up appointments. The treating

provider reserves the right to refuse treatment without the presence of a parent or guardian even with a written consent. The financial responsibility falls under the parent seeking treatment.

If you are unable to keep your appointment, please give our office a 24 hour notice of cancellation. If you fail to give a 24 hour notice, you may be charged a $50.00 fee. Your insurance does not reimburse for this fee. You are fully responsible for this fee. This fee will need to be paid prior to rescheduling the appointment. The Dermatology Center may terminate care if there are repeated no show appointments, last minute cancellations, or late arrivals. A fee will not be charged for weather related cancellations.

By signing below, I am confirming that I have read the TDC Financial Policy, had an opportunity to ask questions, was provided a copy if so requested, and fully understand the terms.

I certify that I have read and understand the "TDC Financial Policy" and agree to all terms and conditions as stated above. I understand that it is my sole responsibility to verify insurance coverage and I am ultimately responsible for payment in full for any balances. I understand that the amount collected is based off of information received from the insurance company and is only an estimate. I understand quotes are not a guarantee of payment or benefits and are subject to the terms and conditions of my insurance. I understand that I may be billed for amounts after the insurance company processes the claim. I understand that the information that I have given today is correct to the best of my knowledge. I also understand that it is my responsibility to inform The Dermatology Center of any changes associated with my insurance status. Even though I may have health insurance coverage, I understand payment for services is ultimately my responsibility. I understand that payment for service is due at the time service is rendered.

Patient Signature: _____ Date: _____

TDC NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides detailed information on how we may use and disclose protected health information about you. You have the right to review our Notice before signing this consent. The terms of our Notice may change. If we change our Notice, a revised copy can be obtained at any time by going to our website at www.thedermcenterfs.com or you may request a copy at any time at the office.

Was a copy of the Notice of Privacy Practices provided to you? YES NO

What is your preferred method of contact? (Circle one) Phone Email Text
If email was chosen, what is the email address? _____

May we leave a detailed message on your voicemail? YES NO

May we text/email you appointment reminders? YES NO

Do you give our office permission to discuss your medical information with other family members: (Circle one)
YES NO If yes, please provide the names and phone numbers below:

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

I hereby acknowledge that I have received a copy of The Dermatology Center's Notice of Privacy Practices. I have been given the opportunity to review, understand, and consent to this practice's policy as written.

Print Patient Name: _____ Date: _____

Signature of patient (or responsible party):_____