GERIA DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

Date: _____

Last Name: _____ Middle Initial: _____ First Name: _____
Address: _____ City: _____ State: ___ Zip: _____
Home Phone: _____Cell Phone: _____
Occupation: _____ Office Phone: _____
SSN: _____ Marital Status: _____ Sex: M/F
Birthday: _____ Age: _____ Email: _____

Emergency Contact

Name: _____ Phone: _____
Relationship: _____

Primary Physician

Name: _____ Phone: _____

Pharmacy

Pharmacy Name: _____ Location: _____

Referred By

Doctor: _____ Friend: _____ Internet: ___ Insurance: ___ Other: _____

Insurance Information

Primary Insurance:_____ Policy Holder:_____ Relationship: _____
Insured DOB: _____ Insured SSN: _____
Policy #: _____ Group #: _____ Referral YES/NO
Policy Holder Address: _____ Same as Above: ____
Secondary Insurance: _____ Policy Holder: _____ Relationship: _____
Insured DOB: _____ Insured SSN: _____
Policy #: _____ Group #: _____ Referral YES/NO

Signature:_____ **Date:** _____

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Date: _____

Medical History

Name (first & last): _____ DOB:_____
Reason for today's visit: _____

Past Medical History: (Please check all that apply)

___ Asthma
___ Autoimmune Disease
___ Arthritis (specify)_____
___ Kidney Disease
___ Hepatitis
___ High Cholesterol
___ Radiation (specify)_____
___ Seizures
___ Pacemaker
___Organ/ Bone Marrow Transplant
___ Artificial Joint
___ History of fainting
___ Anxiety
___ Depression
___ Diabetes
___ GERD
___ HIV/ AIDS
___ Hypertension
___ Thyroid Problems (specify)_____
___ Chemotherapy (specify)_____
___ Stroke
___ Defibrillator

Other: _____

Skin History:

___ Skin Cancer (specify)_____
___ Melanoma (location/ year) _____
___ Eczema
___ Atypical Moles
___ Hives
___ Seasonal Allergies
___ Scarring/ Keloids
___ Actinic Keratosis (pre- cancers)
___ Cancer (specify) _____
___ Psoriasis
___ Herpes Simplex (cold sores)
___ MRSA
___ Bleeding/ Clotting Disorders

Family History of Melanoma/ Skin Cancer: Yes/ No (specify) _____
Past Surgical History/ Hospitalizations:

_____

Medications (prescriptions, over the counter, vitamins, supplements):

_____

Allergies:_____
Allergies to Bacitracin/ Latex/ Epinephrine/ Adhesives: (circle if applicable) Yes/ No

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Marital Status (Circle One):
Single/ Married/ Divorced/ Domestic Partner/ Separated/ Widowed

Social History:
Tobacco: Yes/ No Former smoker: Yes/ No If yes, how much? _____
Alcohol: Yes/ No/ Occasional If yes, _____ drinks per day/ week
IV Drugs: Yes/ No If yes, what? _____ How often? _____

Sun History:
Do you wear sunscreen? Yes/ No If yes, what SPF? _____
Have you ever used a tanning booth? Yes/ No If yes, how often? _____
Have you had sunburns in the past? Yes/ No If yes, estimate how many? _____

Patients 65 and older:
Do you have a health care proxy? Yes/ No
Do you have a living will? Yes/ No
Did you have the pneumonia vaccine? Yes/ No?

Female Patients:
Are you pregnant? Yes/ No Date of last menstrual period? _____
Are you nursing? Yes/ No

Signature:_____ **Date:** _____

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Office Financial Policy

By signing this document, I am agreeing to the terms of this Financial Policy.

PAYMENT AT TIME OF SERVICE: Payment is due in full at the time of service unless you are covered by Medicare or an insurance company with which we participate. You will be charged a $25 service fee for any returned checks, no exceptions.

INSURANCE: Patients will be asked to present their insurance card to the receptionist for copying upon check-in at the office each time they are seen for medical services. Please make it a point to bring your insurance card with you each time that you visit our office. Claims not paid within 45 days by your insurance company will become your responsibility. You will receive a statement for these services and you will need to contact your insurance company for reimbursement. For those patients covered by insurance plans with which we ARE participating providers, all co-payments, deductibles and non-covered services are due at time of service. We will file the insurance claim to the insurance company. In the event that your insurance coverage changes to a plan with which we ARE NOT participating providers, we will require payment in full at the time of service and we will file your claim to the insurance company as a courtesy. Any charges that are not paid by your insurance company are your responsibility. Your insurance policy is a contract between YOU and your insurance company. Any pre-certifications of procedures or testing are your responsibility. Please let us know in advance if your insurance company requires this.

COLLECTIONS: Please note, if payment is not received from either you or your insurance company within 60 days from the date of service(s), your account will be considered delinquent and subject to referral to an outside collection agency

Signature:_____ **Date:** _____

Responsible Party Name (if different from patient): _____

Signature:_____

Relationship to Patient: _____

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HIPAA Authorization and Consent

HIPAA PRIVACY RULE OF PATIENT AUTHORIZATION AGREEMENT

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations(§164.508(a))

I understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment and any plans for future care or treatment.
I under stand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my healthcare;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine healthcare operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the Notice of Privacy Practices that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity.

I have the right to review this facility's notice prior to signing this authorization.

I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

HIPAA PRIVACY RULE OF PATIENT CONSENT AGREEMENT

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations(§164.506(a)) I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- This facility, reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested; **(continued next page)**

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- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this facility is not required by law to agree to the restrictions requested.
- I may revoke this consent in writing at any time, except to the extent that this facility, has already taken action in reliance thereon.
- It is this facility's procedure to share Protected Health Information with labs, x-rays, consulting physicians, and hospitals. We will call the pharmacy of your choice regarding your prescriptions. We will only exchange minimum necessary Protected Health Information for each transaction.

Signature:_____ **Date:** _____

Responsible Party Name (if different from patient): _____

Signature:_____

Relationship to Patient: _____

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Insurance Signature On File

I certify that the information given by me in applying for Insurance and/or Medicare payment is true and correct. I authorize my doctor to act as my agent in helping me obtain payment of my Insurance and/or Medicare benefits, and I authorize payment of these benefits to Dr. Aanand N. Geria on my behalf for any services and materials furnished.

I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits payable to related services. If I have other health insurance coverage (as indicated in Item 9 of the HCFA-1500 claim form or electronically submitted claim), my signature authorizes release of the above medical information to the insurer of agency shown, and authorizes my doctor to act as my agent, as above.

Signature:_____ **Date:** _____

Responsible Party Name (if different from patient): _____

Signature:_____

Relationship to Patient: _____

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No Show Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care. Therefore, patients who do not show up for their appointment without a call to cancel at least 24 hours before the appointment time will be considered as NO SHOW. Geria Dermatology, LLC has the right to charge a fee of $50.00 for all missed appointments ("no shows"). *Additional fees may be charged if the missed appointment was surgical or cosmetic in nature.* "No Show" fees will be billed to the patient. This fee is not covered by insurance and must be paid in full prior to your next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all our patients. By signing below, you acknowledge that you have received this notice and understand this policy.

Signature:_____ **Date:** _____

Responsible Party Name (if different from patient): _____

Signature:_____

Relationship to Patient: _____

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Credit Card on File Policy

Geria Dermatology requires a credit card be kept on file. This card will only be charged in the event of a no-show or outstanding balance after 3 statements have been sent. We value your privacy and securely keep your payment information encrypted and stored in accordance with HIPAA guidelines. Once entered, we do not have access to your full card number information.

I hereby authorize Geria Dermatology to charge the credit card on file automatically for payments owed to my account for services rendered at their office. I agree to update any information regarding this account.

Signature:_____ **Date:** _____

Responsible Party Name (if different from patient): _____

Signature:_____

Relationship to Patient: _____

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Consent to be Photographed

I consent for medical photographs to be taken of me by the staff or representatives of Geria Dermatology. I understand that the images will be placed in my medical record and may be used for evaluation by employees of Geria Dermatology. I understand the photographs captured will not be used for social media or promotional purposes. I also give permission for transfer of these photographs via a encrypted email exclusively for the purposes of third-party diagnostics, treatment and continuing medical care (e.g. communication with my primary care physician). If I wish to withdraw my consent in the future, I may do so with a written request.

Signature:_____ **Date:** _____

Responsible Party Name (if different from patient): _____

Signature:_____

Relationship to Patient: _____