

Cassis Dermatology & Aesthetics Center

DATE: _____

PATIENT ID _____

PATIENT INFORMATION

PLEASE PRINT

GENDER (please circle) Male Female

PATIENT _____
FIRST MIDDLE LAST

ADDRESS _____
STREET PO BOXES MUST INCLUDE STREET ADDRESS CITY STATE ZIP COUNTY

BIRTHDATE ____/____/____

HOME PHONE ____/____-____

MARITAL STATUS S M D W O

WORK PHONE ____/____-____ EXT ____

SSN ____/____/____

CELL PHONE ____/____-____

BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

CHECK BOX TO RECEIVE EMAILS ABOUT COSMETIC PROMOTIONS AND SPECIALS EMAIL- _____

RESPONSIBLE PARTY- _____ IF SAME AS ABOVE PLEASE INITIAL _____

ADDRESS- _____

PHONE- ____/____/____ BIRTHDATE- ____/____/____ SSN- ____/____/____

PRIMARY INSURANCE INFORMATION

PLEASE PROVIDER COPY OF INSURANCE CARD

PRIMARY INSURANCE POLICY NAME _____

PRIMARY INSURANCE POLICY NUMBER _____

POLICYHOLDER _____
FIRST MIDDLE LAST

BIRTH DATE OF POLICYHOLDER ____/____/____ RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE INFORMATION

PLEASE PROVIDE COPY OF INSURANCE CARD

SECONDARY INSURANCE POLICY NAME _____

SECONDARY INSURANCE POLICY NUMBER _____

POLICYHOLDER _____
FIRST MIDDLE LAST

BIRTH DATE OF POLICYHOLDER ____/____/____ RELATIONSHIP TO PATIENT _____

EMERGENCY CONTACT INFORMATION

NAME _____

RELATIONSHIP TO PATIENT _____

HOME PHONE ____/____-____

CELL PHONE ____/____-____

WORK PHONE ____/____-____ ext ____

BEST NUMBER BTWN 9AM & 4PM (Please circle one) Home Work Cell

Dermatology Medical History

Referred by: _____

Patient: _____ Age: _____

Today's Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? YES NO Any bad reaction? YES NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

	YES	NO		YES	NO
Lungs:			Other Systemic:		
Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst/hunger	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Amputation	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>
Morning Cough	<input type="checkbox"/>	<input type="checkbox"/>	Kidney	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Dialysis	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Bladder	<input type="checkbox"/>	<input type="checkbox"/>
			Frequency/burning	<input type="checkbox"/>	<input type="checkbox"/>
Cardiovascular:	YES	NO	Gastrointestinal		
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stomach absorptive disorder	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Nausea, vomiting, diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	when taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infection when		
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	taking antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Inflammation of vein	<input type="checkbox"/>	<input type="checkbox"/>	Arthralgia	<input type="checkbox"/>	<input type="checkbox"/>
Blood clots	<input type="checkbox"/>	<input type="checkbox"/>	Limited motion	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Artificial joint	<input type="checkbox"/>	<input type="checkbox"/>
			Convulsions, Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
			Fainting	<input type="checkbox"/>	<input type="checkbox"/>

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin: Have you ever had skin cancer? YES NO
 Has anyone in your family had skin cancer? YES NO If yes, TYPE: _____
 Do you have a history of any specific skin diseases? YES NO If yes, _____
 Do you have problems with healing YES NO
 Do you develop keloids (scars) after surgery YES NO
 Do you bleed easily? YES NO
 Do you develop skin rashes in reaction to Medications Food Environment Bandages Topical Neosporin
 Other _____

Social History:

Do you drink alcohol? YES NO If YES _____ drinks per day
 Do you use IV drugs? YES NO If YES, what? _____ How often? _____
 Do you smoke? YES NO If YES, how much: _____
 Have you had or have you been exposed to HIV (AIDS)? YES NO HEPATITIS? If YES, TYPE: A B C

Please answer the following questions:

(Women) Are you pregnant? YES NO Due Date: ___/___/___

What is your occupation? _____ Hobbies? _____

Completed by: Patient _____ / /
 Medical Assistant _____ Signed by Patient _____ Date
 Initials _____

Cassis Dermatology & Aesthetics Center

NOTICE OF PRIVACY PRACTICES

I acknowledge Cassis Dermatology & Aesthetics Center (the Practice) has provided me a copy of its Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed by this consent, as well as other rights I have regarding my protected health information.

Signature

Date

Printed Name of Patient or Personal Representative
(If different than patient only)

Relationship to Patient

CONSENT FOR USE OR DISCLOSURE OF PATIENT INFORMATION

I hereby consent to Cassis Dermatology & Aesthetics Center using or disclosing my protected health information for the purpose of providing treatment to me, obtaining payment for health care services rendered to me, or to carry out the Practice's health care operations. I also consent to the Practice using or disclosing my protected health information for treatment activities provided by another health care provider, as well as the payment activities conducted by another health care provider or entity. I further consent to the disclosure of my protected health information in order for another provider or health care entity to conduct health care operations including quality assessment and reviewing the competence of health care professionals.

Signature

Date

Printed Name (if different than patient only)

Relationship to Patient

SPECIFIC INFORMATION RELEASE (if applicable)

I specifically authorize release of the following information for the purposes of treatment, payment, and health care operations:
(Initial any you agree to release)

____ Chemical Dependency/Substance Abuse

____ Sexually Transmitted Diseases

Signature

Date

Printed Name (if different than patient only)

Relationship to Patient

**Patient Authorization for Photography and Use of Health Information for
Cassis Dermatology & Aesthetics Center**

By signing this authorization, I agree to allow the medical staff at Cassis Dermatology & Aesthetics Center to photograph my skin to include specific lesions for medical or cosmetic purposes. I understand that I am giving consent to obtain information from me including my name, age, and sex. The photographs will be taken utilizing a camera and will be removed from the camera disk as soon as possible and will be stored on password protected computers including those within the offices of Cassis Dermatology & Aesthetics Center, personal computers of faculty member and possibly on an off-site computer server. My name and other identifying protected health information (PHI) will be removed from the electronic storage sites, with the exception of the date the photograph was taken, the physician's name who took the photograph and potentially my initials. I further understand that the photographs taken will be placed in my medical record and may be used for the purpose of continuing medical education and/or graduate medical education now and at future dates.

I understand that the photographs may be used for print, visual, or electronic media and may also be published, republished either separately or in connection with each other in professional journals or medical books or as poster exhibits, or used for any other purpose in the interest of medical education, knowledge, or research by Cassis Dermatology & Aesthetics Center and their agents; provided, however, that it is specifically understood that in any publication or use, I shall not be identified by name. However, the use of other PHI such as my age, sex and race and other details of my medical history may also be used as part of the publication

I understand that I do not have to sign the authorization, but in not doing so photographs will not be taken. I also understand that there will be no consequence to my care by refusing to sign this consent.

A copy of this consent will become part of my medical record, further I acknowledge that I have received a copy of this consent form or have revoked my right to receive a copy of this document.

Signature of Patient or Legal Guardian

Relationship to Patient

Print Name of Patient or Legal Guardian

Date

Cassis Dermatology & Aesthetics Center

INSURANCE AND BILLING AUTHORIZATION

I understand I am personally responsible to Cassis Dermatology & Aesthetics Center (The Practice) for any charges incurred for services performed regardless of insurance coverage. I accept full FINANCIAL RESPONSIBILITY for the patient's account in accordance with the regular rates and terms of The Practice's policy.

I understand most health insurance carriers require The Practice to file a claim for my services, but that I am responsible for any and all amounts not covered and not paid by my insurance carrier. These amounts may include co-payments, deductibles, and fees not covered by my health insurance. IF MY INSURANCE CARRIER REQUIRES A REFERRAL FOR MY OFFICE VISIT, I UNDERSTAND IT IS MY RESPONSIBILITY TO OBTAIN THIS AND PRESENT THIS REFERRAL AT THE TIME OF MY VISIT (IF NOT BEFORE). Failure to obtain a referral, if required, does not release me from my responsibility to The Practice. SERVICES PROVIDED WITHOUT A REFERRAL, IF A REFERRAL IS REQUIRED, REMAIN MY RESPONSIBILITY.

I understand that if I am not covered under a current insurance policy or if I do not present a current insurance card at the time of service, that I will be responsible for payment in full at the time services are rendered.

Most aesthetic services are not covered by health insurance. Biopsy and removal of skin lesions may not be covered by my health insurance. I am responsible for payment of any aesthetic services or treatments or any medical conditions not covered by my insurance.

I hereby authorize The Practice to submit a claim to my Insurance Carrier or it's intermediaries related to services rendered by any physician or medical provider employed by Cassis Dermatology & Aesthetics Center, and direct my insurance carrier or it's intermediaries to issue payment directly to The Practice and/or provider who accepts assignment.

CONSENT TO WIRELESS TELEPHONE CALLS:

If at any time I provide a wireless telephone number at which I may be contacted, I consent to receive calls or text messages, including but not restricted to communications regarding billing and payment for items and services, unless I notify the practice to the contrary in writing. In this section, calls and text messages include but are not restricted to pre-recorded messages, artificial voice messages, automatic telephone dialing services or other computer assisted technology, or by electronic mail, text messaging or by any other form of electronic communication from the practice, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

CONSENT TO EMAIL USAGE:

If at any time I provide my email address at which I may be contacted, unless I notify the practice to the contrary in writing, I consent to receiving communications regarding billing and payment for items and services at the email address from the practice, affiliates, contractors, servicers, clinical providers, attorneys or its agents including collection agencies.

Signature

Date

NO SHOW FOR APPOINTMENTS AND COLLECTION FEES

I understand when The Practice provides an appointment time; I remain responsible for payment for services. If I fail to notify The Practice with 24-hour notice, I remain responsible for payment for my appointment. Failure to notify The Practice may result in a \$25 no show fee. I understand my health insurance will not cover this fee, and I will remain personally responsible for payment of this fee. Repeated failure to show for appointments may result in my dismissal from The Practice.

If Cassis Dermatology & Aesthetics Center refers my account to a collection agency, I agree to pay all fees, collection fees and legal fees, associated with my delinquent account. I understand I will be responsible for any collection fees, including any legal expenses incurred in settling my delinquent account. I understand a delinquent account may be reason for termination from The Practice.

Signature

Date

CONSENT FOR CARE AND TREATMENT OF DEPENDENT

PERMISSION FOR TREATMENT is hereby grant to any physician or medical provider employed by The Practice to render such medical and surgical treatment as deemed necessary for

Dependent's Name

Signature of Parent or Guardian

Relationship to Patient



FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to the quality treatment of each and every patient. Please understand that payment for your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

All patients must complete our Patient Registration process prior to seeing the physician.

WE ACCEPT CASH, CHECKS, VISA & MASTERCARD & AMERICAN EXPRESS.
In the event of a returned check, for any the following reasons: non-sufficient funds, stop payment or closed account, a fee of \$30.00 will be charged to your account.

INSURANCE CARD

We will not bill your insurance company unless you provide a current insurance card.

PARTICIPATING PROVIDER (CONTRACTED)

We accept assignment of insurance benefits on many insurance plans. During the Patient Registration process you will be told whether or not we accept assignment of your insurance benefits. We will file all charges to your insurance company. Because we are a participating provider with your insurance carrier, you be responsible to pay any co-pay amounts each visit. You will also be responsible for any deductible/coinsurance amounts, as stated in your policy, and you will receive a statement in the mail, from our office, for these amounts. If you participate in a High Deductible Insurance Plan, you will be asked to pay at the time of service. We will file the claim on your behalf with your carrier. Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be due **in full at the time of service.**

NON-PARTICIPATING PROVIDER (NON-CONTRACTED)

Because we are not contracted with your insurance carrier, you will be responsible to pay your total charges. We will file all charges to your insurance company. You will be responsible for any charges not covered by your insurance carrier, as stated in your policy. We will allow 45 days to receive payment from the insurance carrier; if not received, the entire balance will be billed to you. You will receive a statement in the mail from our office for these amounts. Any charges considered cosmetic, non-covered or not medically necessary will be your responsibility and will be due **in full at the time of service.** We will not follow-up with your insurance carrier on any unpaid claim. It is your responsibility to work directly with your insurance carrier on any disputed or unpaid claims.

RATES

Our practice is committed to providing the best treatment for our patients at a rate considered usual and customary for our area.

MINOR PATIENTS

Minor patients must be accompanied by a parent or legal guardian each visit. The parent/legal guardian accompanying the minor to the first visit will be considered guarantor on the account; therefore, accepting full financial responsibility for all services rendered on the minor's behalf and charged to their account.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

X _____
Patient Name (Please Print)

X _____
Signature of Patient or Responsible Party

Date _____

X _____
Signature of Co-Responsible Party

Date _____

**CASSIS DERMATOLOGY
& AESTHETICS CENTER, LLC**
Billing Agreement

Patient Name _____ DOB _____

Due to the recent increase in high deductible plans, it is now the policy of Cassis Dermatology & Aesthetics Center, LLC to require either a credit card or Flexible Health Spending Account card to be kept on file for all patients. All visits will first be charged to your designated insurance carrier/provider for services rendered by Cassis Dermatology & Aesthetics Center.

Any remaining balances, such as deductibles or co-pays, will then be charged to the credit card or Flexing Health Spending account card kept on file. Our office has obtained Cyber Security Insurance Protection to alleviate any worries you may have of a cyber-attack. Also, our office has obtained back-up security which is provided by NAS Insurance Agency. Further, a third-party information technology provider, Louisville Geek, will be providing security checks.

It is YOUR responsibility to notify us of any change to your insurance so that we can determine if there is any change in your benefits.

You, the Patient, by signing this agreement, agree to allow Cassis Dermatology & Aesthetics Center, LLC to utilize your credit card or Flexible Health Spending Account to pay any and all fees and costs due to Cassis Dermatology & Aesthetics Center, LLC at any time that you are in arrears of 90 days (3 billing cycles) on costs, but only after your primary insurance carrier has been billed. You further agree to allow Cassis Dermatology & Aesthetics Center, LLC to scan the credit card or Flexible Health Spending Account card kept on file.

All account numbers and charges made by Cassis Dermatology & Aesthetics Center, LLC are generally confidential and are protected from disclosure except as provided by law.

HAVE REVIEWED, UNDERSTAND, AND GIVE MY PERMISSION TO CHARGE MY CREDIT CARD/FLEXIBLE HEALTH SPENDING ACCOUNT CARD ACCORDINGLY:

Cardholder: _____ Date: _____

Last Four Digits on Card: _____ Security Code: _____

Type of Card: _____ Card Expiration Date: _____
(Visa, MC, Discover etc.)

***Your signature indicates your understanding and compliance with this policy.**

PATIENT NAME (PRINT)

X _____
PATIENT SIGNATURE

GUARDIAN NAME (PRINT)
(If patient is under 18 years of age)

X _____
GUARDIAN SIGNATURE
(If patient is under 18 years of age)