Cassis Dermatology & Aesthetics Center

DATE:_____ PATIENT ID _____

PATIENT INFORMATION

PLEASE PRINT

GENDER (please circle) Male Female

PATIENT _____
FIRST MIDDLE LAST

ADDRESS _____
STREET APT/UNIT CITY STATE ZIP

BIRTHDATE___/_____/_____

MARITAL STATUS S M D W O

SSN_____/_____/_____

HOME PHONE _____/_____-_____

WORK PHONE _____/_____-_____ EXT _____

CELL PHONE _____/_____-_____

RACE_____

ETHNICITY_____

LANGUAGE_____

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 PROVIDE 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

Patient: _____ Age: ____ Today's Date: ____/____/____

HT/WT _____ Primary Care Physician _____

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)

Lungs:	YES	NO
Bronchitis	❑	❑
Emphysema	❑	❑
Asthma	❑	❑
Chronic Cough	❑	❑
Morning Cough	❑	❑
Shortness of Breath	❑	❑
Wheezing	❑	❑

Cardiovascular:	YES	NO
High Blood Pressure	❑	❑
Chest Pain	❑	❑
Heart Attack	❑	❑
Heart Murmur	❑	❑
Irregular Heartbeat	❑	❑
Phlebitis	❑	❑
Inflammation of vein	❑	❑
Blood clots	❑	❑
Pacemaker	❑	❑

Other Systemic:	YES	NO
Diabetes	❑	❑
Excessive thirst/hunger	❑	❑
Amputation	❑	❑
Thyroid	❑	❑
Kidney	❑	❑
Dialysis	❑	❑
Bladder	❑	❑
Frequency/burning	❑	❑
Gastrointestinal		
Stomach absorptive disorder	❑	❑
Nausea, vomiting, diarrhea when taking antibiotics	❑	❑
Yeast infection when taking antibiotics	❑	❑
Arthritis/Joint Deformity	❑	❑
Arthralgia	❑	❑
Limited motion	❑	❑
Artificial joint	❑	❑
Convulsions, Epilepsy or Seizures	❑	❑
Fainting	❑	❑

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 _____ Initials

_____ Signed by Patient ____/____/____ Date

_____ Reviewed by ____/____/____ Date

Cassis
Dermatology & Aesthetics Center

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.

THIRD-PARY PROVIDERS

In order to ensure proper treatment of our patients, we utilize third-parties for pathology and lab-work. For pathology our practice uses Dermatopathology Alliance of Kentucky. For lab-work, our practice uses Quest Diagnostics and TEN Healthcare. It is not the responsibility of Cassis Dermatology, or any of its employees or agents, to ensure that your health insurance will cover services performed by either of these third-party providers. As such, if you wish for our practice to use a different third-party provider for pathology or lab-work, you must inform us prior to being seen by a Cassis Dermatology provider. Otherwise, services billed by the third-party provider will be paid for by your insurance or yourself personally, and you understand and agree that Cassis Dermatology or its employees/agents will not be held responsible or in anyway liable for disputes between yourself, the third-party providers, and your insurance regarding coverage or payment for services.

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.

Cassis
Dermatology & Aesthetics Center

X _____
Patient Name (Please Print)

X _____ Date _____
Signature of Patient or Responsible Party

X _____ Date _____
Signature of Co-Responsible Party

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 REFERAL 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 _____

GENERAL CONSENT FOR TREATMENT

By signing, I authorize Cassis Dermatology & Aesthetics Center and their staff to conduct any diagnostic examinations, tests, and procedures, including, but not limited to: biopsy, liquid nitrogen, kenalog injections, bloodwork, photo dynamic therapy, and other available treatment options and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

In giving my general consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating health care providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

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 a 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 _____

Cassis Dermatology & Aesthetics Center

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

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, LLC

Billing Agreement

Due to the recent increase in high deductibles 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 by Cassis Dermatology & Aesthetics Center.

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 you are in the arrears of 90 days (3 billing cycles/statements will be released to the patient) 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 to be 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:

LAST FOUR DIGITS ON CARD: _____ **CARD EXPIRATION:** _____

TYPE OF CARD: _____ **SECURITY CODE:** _____

(VISA, MC, DISCOVER, ETC.)

**** YOUR SIGNATURE INDICATES YOUR UNDERSTANDING AND COMPLIANCE WITH THIS POLICY.**

PATIENT NAME: _____ **DOB:** _____

(PLEASE PRINT)

CARDHOLDER NAME: _____ X _____

(PLEASE PRINT) CARDHOLDER SIGNATURE

Cassis Dermatology & Aesthetics Center

PATIENT AUTHORIZATION FOR A PERSONAL REPRESENTATIVE

Patient Name: _____

Social Security Number (last 4 digits): _____

Date of Birth: _____

Purpose of request: I authorize Cassis Dermatology to disclose or provide my protected health information (PHI) to the following individual who is authorized to act as my personal representative for the purposes of receiving all protected health information about myself. As my designated personal representative, he/she may exercise my right to inspect, copy, and request amendments to my protected health information. He/she may also consent or authorize the use or disclosure of my protected health information.

_____ (_____)_____

Name of Personal Representative Telephone

_____

Representative Address:

_____

City, State, Zip Code

- **Description of information to be disclosed:** I authorize Cassis Dermatology to disclose all of my protected health information to my designated Personal Representative.

- **Expirations or termination of authorization:** This authorization will remain in effect until terminated by you (the patient), your personal representative, or another individual(s) of legal entity authorized to do so by court order or law.

- **Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Manager. This can be done in-person or in writing by mailing your request to:

Cassis Dermatology & Aesthetics Center

9301 Dayflower Street, Suite 100

Prospect, Kentucky 40059

Re-disclosure: We have no control over the person(s) that you have listed as your personal representative. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of Cassis Dermatology.

_____ _____

Patient Signature **Date**