Dermatology Outreach, LLC
107 B Cambridge Place
Bridgeport, WV 26330

Cancellations/No Show Policy

We understand that there are times when you must miss an appointment due to emergencies or obligations to work or family. However, when you do not call to cancel an appointment, you may prevent another patient from getting much needed treatment. Conversely, the situation may arise when another patient fails to cancel their appointment, and we are unable to schedule you for a visit due to what seems like a "full" schedule.

Therefore, if an appointment is not cancelled at least 24 hours in advance, you will be charged a $25.00 fee, which will not be covered by insurance. Future appointments will not be scheduled until this fee is paid in full.

Be aware that you may cancel your appointment when you receive your call reminder by simply listening to the prompts. We will discuss any extenuating circumstances on an individual basis.

Signing below simply states that you have been notified of the cancellation/no show policy.

Printed Name: _____

Signature: _____

Date: _____/_____/_____

Patient Name: _____ MR#: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

FOR DERMATOLOGY OUTREACH, LLC

I understand that under the HIPAA (Health Insurance Portability and Account and Ability Act of 1996), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and provider certifications.

By signing below, I acknowledge that I understand the privacy practices of Dermatology Outreach, LLC.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

Assessment of Benefits/Authorization for Treatment

I hereby authorize treatment and authorize the provider of medical services to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to Dermatology Outreach, LLC on my behalf. I understand that I am financially responsible for all charges not covered by my insurance. Returned checks are subject to a $25 fee in addition to the original check amount.

PATIENT/GUARANTOR SIGNATURE: _____ DATE: _____

Skin Disease History

Acne	Y	N	Flaking or itchy scalp	Y	N
Actinic Keratosis	Y	N	Hay Fever/Allergies	Y	N
Asthma	Y	N	Melanoma	Y	N
Basal Cell Skin Cancer	Y	N	Poison Ivy	Y	N
Blistering Sunburns	Y	N	Precancerous Moles	Y	N
Dry Skin	Y	N	Psoriasis	Y	N
Eczema	Y	N	Squamous Cell Skin Cancer	Y	N

Other: _____

Do you wear sunscreen? Y N

If yes, what SPF? _____

Do you tan in a tanning bed? Y N

Family History

Do you have a family history of melanoma? Y N

If so, which relative? _____

Past Medical History

Anxiety	Y	N	Hearing Loss	Y	N
Arthritis	Y	N	Hepatitis	Y	N
Asthma	Y	N	High Blood Pressure	Y	N
Irregular Heartbeat	Y	N	HIV/AIDS	Y	N

Enlarged Prostate	Y	N	High Cholesterol	Y	N
Thyroid Disorder	Y	N	Breast Cancer	Y	N
Colon Cancer	Y	N	Leukemia	Y	N
Lung Cancer	Y	N	Lymphoma	Y	N
Chronic Lung Disease	Y	N	Heart Disease	Y	N
Depression	Y	N	Prostate Cancer	Y	N
Diabetes	Y	N	Radiation Treatment	Y	N
Kidney Disease/Failure	Y	N	Seizures	Y	N
Gastric Reflux(GERD)	Y	N	Stroke	Y	N

Past Surgeries

Have you ever had surgery on the following organs?

Appendix	Y	N	Joint Replacement	Y	N
Bladder	Y	N	Kidney	Y	N
Breast: Mastectomy	Y	N	Breast: Lumpectomy	Y	N
Breast Implants	Y	N	Ovaries	Y	N
Colon	Y	N	Prostate	Y	N
Gall Bladder removed	Y	N	Skin Biopsy	Y	N
Skin: Basal Cell	Y	N	Skin: Squamous Cell	Y	N
Skin: Melanoma	Y	N	Heart (bypass surgery)	Y	N
Heart Valve Replaced	Y	N	Heart Angioplasty	Y	N
Spleen	Y	N	Testicles	Y	N
Uterus (Hysterectomy)	Y	N			

Other: _____

Social History

Alcohol Use	Y	N	Less than 1 drink/day	Y	N
2-3 drinks/day	Y	N	Occasional drink	Y	N
Drug Use	Y	N	IV Drug Use	Y	N
Smoker	Y	N	Former Smoker	Y	N
Never Smoked	Y	N			

Review of Systems

Problems with bleeding	Y	N	Acne Problems	Y	N
Problems with healing	Y	N	New/Changing lesion	Y	N
Problems with scarring	Y	N	Dry Skin	Y	N
Rash	Y	N	Unintentional weight loss	Y	N
Immunosuppression	Y	N	Thyroid problem	Y	N
Hay fever	Y	N	Sore throat	Y	N
Blurry Vision	Y	N	Abdominal Pain	Y	N
Bloody Stool	Y	N	Bloody Urine	Y	N
Joint Aches	Y	N	Muscle Weakness	Y	N
Neck Stiffness	Y	N	Headaches	Y	N
Seizures	Y	N	Cough	Y	N
Shortness of Breath	Y	N	Wheezing	Y	N
Chest Pain	Y	N	Fever or chills	Y	N
Anxiety	Y	N	Depression	Y	N

Other: _____

Alerts

Allergy to adhesives	Y	N
Allergy to lidocaine	Y	N
Allergy to topical antibiotic	Y	N
Artificial heart valve	Y	N
Artificial joints in past 2 years	Y	N
Blood thinners	Y	N
Defibrillator	Y	N
Pacemaker	Y	N
MRSA	Y	N
Rapid heart rate with epinephrine	Y	N
Premedication prior to procedures	Y	N
Pregnancy or planning a pregnancy	Y	N

Patient Information Today's Date: ___/___/___

Patient's Last Name _____First Name _____ M.I. _____

Mailing Address _____ City _____State _____ Zip _____

Home Phone ( )_____ Cell ( )_____ Work ( ) _____

Email Address _____

Date of Birth ____/____/____ Age _____ Social Security # _____-_____-_____

Sex: M F Marital Status _____ If married – Spouse's Name _____

If Child – Name of Mother and Father or Legal Guardian _____

Primary Care Physician _____ Phone Number ( )_____

If referred, referring provider's name _____

Preferred Pharmacy _____ City

_____ **Parent/Responsible Party (if different from above)**

Last Name _____First Name _____

Street Address _____ City _____State _____ Zip _____

Home Phone ( )_____ Cell ( )_____ Work ( ) _____

Date of Birth ____/____/____ Sex: M F Marital Status _____ Spouse's Name _____

Insurance Information

Primary Ins Name _____

Name of Subscriber _____

Date of Birth _____/_____/_____

Insured's ID# _____

Group# _____

Employer Name _____

Employer Address _____

Relationship to Insured _____

Secondary Ins Name _____

Name of Subscriber _____

Date of Birth _____/_____/_____

Insured's ID# _____

Group# _____

Employer Name _____

Employer Address _____

Relationship to Insured _____