

**MEDICAL HISTORY**

**NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

**DERMATOLOGY HISTORY**

Personal: Basal Cell Carcinoma	YES	NO
Squamous Cell Carcinoma	YES	NO
Malignant Melanoma	YES	NO
Unknown Type of Skin Cancer	YES	NO
Actinic Keratosis (Pre-Cancers)	YES	NO
Dysplastic Nevi (Atypical Moles)	YES	NO
Other _____	YES	NO
Family: Basal Cell Carcinoma	YES	NO
Squamous Cell Carcinoma	YES	NO
Malignant Melanoma	YES	NO
Unknown Type of Skin Cancer	YES	NO
Actinic Keratosis (Pre-Cancers)	YES	NO
Dysplastic Nevi (Atypical Moles)	YES	NO
Other _____	YES	NO

**PAST MEDICAL HISTORY**

Diabetes Mellitus	YES	NO
GERD (Gastro Esophageal Reflux Disease)	YES	NO
Hyperlipidemia	YES	NO
Hypertension	YES	NO
Hyperthyroidism	YES	NO
Hypothyroidism	YES	NO
Internal Malignancy (Type _____ )	YES	NO
Liver Disease (Type _____ )	YES	NO
Mitral Valve Prolapse	YES	NO
Communicable Disease: Hepatitis B	YES	NO
Hepatitis C	YES	NO
HIV	YES	NO
Syphilis	YES	NO
Tuberculosis	YES	NO
Other _____	YES	NO

**PAST SURGICAL HISTORY**

Pacemaker	YES	NO
Defibrillator	YES	NO
Artificial Heart Valve	YES	NO
Joint Replacement: Hip	YES	NO
Knee	YES	NO
Other _____	YES	NO

**ALLERGIES (TO MEDICATIONS)**      YES      NO

\_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS**      YES      NO

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Smoking	YES	NO
Alcohol	YES	NO

**MISCELLANEOUS**

Pregnant	YES	NO
Breastfeeding	YES	NO

**BIOPSY & CRYOSURGERY CONSENT FORM**

\_\_\_\_\_  
**Patient Name**

\_\_\_\_\_  
**Date**

**While under the care of Dr. Gregory M. Houck or Alison Lees ARNP, I consent to biopsy or cryosurgical procedures as recommended by the doctor or nurse practitioner.**

**(Please note: In addition, we will obtain verbal consent prior to performing any of the above procedures.)**

1. I understand that all surgical and therapeutic procedures involve some risks to some degree. These risks may include but are not limited to the potential for infection, allergic reaction, pain, scarring, keloid, swelling, erythema, peeling, hypopigmentation, hyperpigmentation, blister or crust formation, injury to blood vessels and/or bleeding, bruising, hematoma, injury to nerves and/or numbness, incomplete removal of lesion(s), recurrence of lesion(s) and/or symptoms, and the need for further treatment and/or surgery.
  
2. I am aware that in the practice of medicine, other unexpected risks or complications not discussed may occur. I further acknowledge that no guarantees or promises have been made to me concerning the results of any procedures. Although the benefits are judged to outweigh the risks, should any complications occur, any one of them could be permanent. I hereby voluntarily give my authorization and consent to Dr. Gregory M. Houck or Alison Lees ARNP to perform the proposed procedures described above.
  
3. I consent to the administration of local anesthetics as may be considered necessary or advisable by the provider responsible for this service. I hereby consent to the administration of anesthesia by Dr. Gregory M. Houck, Alison Lees ARNP or his medical assistants. I consent to the administration of the following local anesthetics:

1% Lidocaine with Epinephrine

Other \_\_\_\_\_

4. I hereby authorize and consent to the disposal of tissue necessarily removed as a part of the procedure for diagnostic purposes.
  
5. I have been given the opportunity to ask questions about my condition, alternative forms of treatment, risks of non treatment, the procedure to be used, and the risks and hazards involved. I believe I have sufficient information to give this informed consent.
  
6. **I UNDERSTAND THAT AN INDEPENDENT LABORATORY MAY BILL ME. LABORATORY BILLING IS NOT PART OF ESTERO DERMATOLOGY & SKIN SURGERY CENTER BILLING – PLEASE CONTACT THE LABORATORY DIRECTLY IF YOU RECEIVE A BILL.**

I certify I have read and fully understand the contents of this form, that the disclosure referred to above were made to me, and that all blanks and statements requiring insertion or completion were filled in before I signed my name below.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

If patient is a minor or unable to give consent:

Signature of person authorized to consent for patient:

\_\_\_\_\_

Relationship to patient:

\_\_\_\_\_



# Estero Dermatology & Skin Surgery Center

## REFERRAL INFORMATION PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Referred By: \_\_\_\_\_ Primary Care Physician \_\_\_\_\_

Pharmacy of Choice: \_\_\_\_\_ Phone ( ) \_\_\_\_\_

In Case of Emergency, Who Should Be Notified? \_\_\_\_\_ Phone ( ) \_\_\_\_\_

### RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### PAYMENT POLICY:

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered including applicable co-payments and deductibles. We accept payment in the form of cash, check or credit card. Our office will file claims with the appropriate insurance company. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. In the event your account must be turned over to collections, a \$10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

### MEDICARE PAYMENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

*I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.*

Signature As It Appears On Medicare Card \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

If you have a supplemental policy and it is a MEDIGAP (Supplemental Insurance) policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

*I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.*

Signature As It Appears On Medigap Card \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

**Thank you for choosing this office to assist in caring for your skin.**

**FINANCIAL POLICY**

Thank you for choosing Estero Dermatology & Skin Surgery Center as your healthcare provider. We are committed to making your treatment here a success. Along with providing you with quality service, Estero Dermatology would also like to assist you with your billing needs.

**Any change in home address, phone number, insurance information, or a change of primary doctor must be given to us prior to your appointment. Charges incurred if this information is not given will be patient responsibility.**

Our billing office will make every effort to maximize your insurance reimbursement and expedite payment of your claim. Please read the insurance categories below and initial the insurance category that pertains to you.

\_\_\_\_\_1. SELF PAY: Payment is due at the time services are rendered, unless prior arrangements have been made. Estero Dermatology will accept cash, checks, Visa, MasterCard, American Express, and Discover.

\_\_\_\_\_2. MEDICARE ONLY: As a participating provider, we will bill Medicare for you. However, you will still be responsible for the 20% that Medicare does not cover. Not all services are covered by Medicare.

\_\_\_\_\_3. MEDICARE / SUPPLEMENTAL INSURANCES: Estero Dermatology will file to your secondary insurance. However, claims denied, rejected or partially paid by your supplemental carrier will be your responsibility in 30 days.

\_\_\_\_\_4. HMO PLANS: Estero Dermatology will file to your insurance company. All co-pays must be satisfied each and every visit. You are responsible for making sure proper referral information and authorization had been obtained from your primary care physician in advance of your appointment.

\_\_\_\_\_5. PPO PLANS: Estero Dermatology will file to your insurance carrier. All co-pays, co-insurance, and deductibles will be your responsibility.

**Usual and Customary Policy:** Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. If you are covered by an insurance plan with which we do not have a contract, you are responsible for payment regardless of the insurance company's arbitrary determination of rates.

**Minor Patient Policy:** The adult accompanying a minor patient or the parents or guardians of the minor are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan or payment by cash or check at the time of service has been verified.

**Interest and Re-billing Fee:** Should your account balance require the assistance of an outside collection agency, it is understood that the balance may accrue a monthly interest fee and you will be responsible for any costs incurred in collection of said balance should that become necessary.

**I have read this Financial Policy and understand the billing procedures of Estero Dermatology & Skin Surgery Center. I agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.**

\*\* You will also be billed by the laboratory for any procedures involving pathological evaluation.

\_\_\_\_\_  
Signature of Patient or Responsible Party

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

