SKIN WELLNESS
P H Y S I C I A N S

# PATIENT REGISTRATION

Name ______________________________________________________________Today's Date______________
Last First M.I.

Mailing Address ________________________________________________________________ Age __________
Street Address Apartment Number

_______________________________________________________________________________________
City State Zip code

Second/Northern Address _____________________________________________________________________

_______________________________________________________________________________________
City State Zip Code

Home Phone (_____) _______________ Work Phone (_____) ________________ Cell Phone (_____) ______________

E-Mail ___________________________________________________________________________________

Date of Birth ____/____/____ SS # ____________________________ Marital Status_____________ Gender __________

Employer____________________________________ Retired _____ Full Time Student _____ Part Time Student _____

Spouse's Name: ________________________________Employer _____________________ Work # ______________

Person to notify in case of emergency _______________________________________ Phone ____________________

Do you have a cosmetic or antiaging concern (i.e. fine lines, loss of volume, texture)? ☐Y ☐N
Have you had a cosmetic or antiaging treatment in the past? (i.e. Botox, fillers, laser rejuvenation) ☐Y ☐N
Would you be interested in hearing about the cosmetic/antiaging treatments we offer in our practice? ☐Y ☐N

May we leave a message on your home/cell answering machine? ☐Y ☐N
May we leave a message for you at work to call us? ☐Y ☐N
May we discuss your medical condition with another person? ☐Y ☐N

If yes, whom ____________________________________________________ Relationship ______________________

How did you hear about our practice? Please be specific (Referring Provider, search engine, magazine, newspaper)

_______________________________________________________________________________________
***************************************************************************************************
Policy Holder (if different from patient or responsible party) ___________________________________________
Policy Holder's Date of Birth _____/_____/______SS# ___________________________________________________
Employer of Policy Holder ____________________________________________ Work Phone (______) ____________
Patient's Relationship to Policy Holder ______________________________________________________________
***************************************************************************************************

**If patient is a minor, please enter responsible party information.** (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name ________________________________________________________ SS# __________________________________
Last First M.I.
Address __________________________________________________________________________________________
Street City State Zip
Home Phone (_____) ______________ Work Phone (_____) _______________ Cell Phone (____) ___________________

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SKIN WELLNESS
PHYSICIANS

**Assignment of Benefits**

I hereby assign and authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/or all commercial payors to make payments on behalf directly to Skin Wellness Physicians. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this authorization to be used in place of the original.

________________________________________ ____________________

Responsible Party Signature Date

**Medicare Authorization**

I request that payment for authorized Medicare benefits be made on my behalf to Skin Wellness Physicians (SWP) for any services furnished to me by providers of SWP. I authorize SWP to release to the CMS and its agents any information needed to determine these benefits payable for related services.

**Medicare is not always the Primary Insurance. Federal regulations REQUIRE that we obtain information to determine if another insurer may be primary to Medicare;**

| Yes | No | |
|---|---|---|
| | | Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job? |
| | | Are you covered by an HMO/PPO which makes Medicare secondary? |
| | | Is this illness/injury covered by the VA (Veterans Administration)? |
| | | Is this illness/injury covered by the Federal Black Lung or End Stage Renal Disease Program? |
| | | Is this illness/injury due to an automobile accident? |
| | | Is this illness/injury due to work related causes? |

________________________________________ ____________________

Signature as it appears on Medicare Card Date

SKIN WELLNESS
PHYSICIANS

# FINANCIAL POLICY

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. To achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer.

**Medicare & Contracted Insurance Plans**

If you are on traditional Medicare or are a member of a health plan we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co- payment, coinsurance and/or deductible, or any non-covered services at the time services are rendered.

**Secondary/Supplemental Insurance Plans**

We will file your secondary claims as a courtesy. If your secondary insurance has not paid us within 30 days, the balance will become your responsibility.

**Non-Contracted Insurance Plans**

If we do not participate with your insurance carrier, we will give you a form to attach to your claim for direct filing with your insurance carrier. Payment in full is required at the time of service.

**Medicaid**

We are not contracted with any Medicaid plan. Medicaid patients seeking services are responsible for payment in full at the time of service.

**Minors**

A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. We can submit the charges to an absent parent’s insurance only with a signed permission from the policy holder. The parent presenting the child for care is responsible for payment at the time of service. Any patient over the age of 18 will be financially responsible for all charges incurred.

**Cosmetic Services**

Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures.

**(*Continued on back*)**

SKIN WELLNESS
PHYSICIANS

**Cancellations & No-Show Appointments**
Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment. Office appointments, cosmetic and/or Procedure/Surgery appointments which are cancelled with less than one business day notice, may be subject to a **$50.00** cancellation fee.
Patients who do not show up for an appointment without a call to cancel will be considered a **NO SHOW**. Patients who No-Show two (2) or more times in a 6-month period, may be dismissed from the practice thus they will be denied any future appointments. Patients may also be subject to **a $50.00 No Show fee.**
The Cancellation and No-Show fees are the sole responsibility of the patient and must be paid in full before the patient's next appointment. We understand that special unavoidable circumstances may cause you to cancel within 24 hours. If you reschedule within 24 hours, fees in this instance may be put towards your service or waived but only with management approval.

**Medical Records**
Medical records requests and/or completion of documents (e.g. disability, life insurance, cancer policy, etc.) are subject to fees determined by state law and contractual agreements. Medical records requests require time to be processed and cannot be provided the same day requested.

**Collection Fees**
You agree to reimburse fees of any collection agency, which may be based on a percentage at a maximum of 25% of the debt, and all costs and expenses, including reasonable attorney's fees, which we may incur in such collection efforts.

**Returned Check Fee**
A $25.00 fee will be added to your account balance in addition to the amount of the check which has been returned for insufficient funds. This total must be paid by cash or credit card within 7 days.

**Pathology Fees**
Depending upon specific factors, your provider may send a specimen to an outside lab for slide processing and interpretation. In those cases, patients or their insurance company will receive a bill from an outside lab.

**Benign Lesions**
Patients are financially responsible for the removal or treatment of all benign skin lesions unless they have met certain clinical criteria, including, but not limited to change in quality or character, increase in size, pain, or bleeding. Billing insurance for such circumstances may represent fraud.

**My signature below indicates that I have read, understand and will comply with the information contained within this financial policy. A copy of this policy is available upon request.**

____________________________________________ ______________________

**(Signature of Patient or Guardian)** **(Date)**

SKIN WELLNESS
PHYSICIANS

# Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

________________________________________ ________________

Signature of Patient (or Legal Representative) Date

# Patient Communication Consent Form

## Email/Text Message Account Alerts

Skin Wellness Physicians has the advantage of communicating appointment reminders via email/text message with our patients.

I authorize Skin Wellness Physicians to send email/text message appointment reminders to me on my provided cell phone number. I understand that I may reply with various commands to receive account information. By accepting these terms, I agree to receive text messages from the practice. Text charges from your cell phone provider may apply.

**My signature below indicates that I represent and warrant that I am the person legally responsible for use of the account, and that I agree to the terms and conditions for the use of the text messaging services. I understand that I may opt out of text message communication at any time.**

________________________________________ ________________

Signature of Patient (or Legal Representative) Date

# SKIN WELLNESS
PHYSICIANS

Phone: 239-732-0044 Fax: 239-732-0094

For the purpose of patient care, I hereby request and authorize the following organization or individual to release my medical records to ______________________________________________as specified in this release.

(name of organization or individual authorized to release or obtain PHI)

## AUTHORIZATION TO RELEASE/OBTAIN HEALTHCARE INFORMATION

Patient's Name: ______________________ Date of Birth: ______________________

Previous Name: ______________________ Social Security #: ______________________

I request and authorize ____________________________________________________________

(name of organization or individual authorized to release or obtain information)

to release healthcare information of the patient named above to:

Name: **Skin Wellness Physicians**

Address: 1300 Goodlette Rd. N. Ste. 101

Naples, FL 34102

Phone: (239) 732-0044 Fax: (239) 732-0094

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: ____________________

______________________________________________________________________

______________________________________________________________________

☐ All healthcare information

☐ Other: ______________________________________________________________

Patient/Representative Signature: ______________________________ Date Signed: ____________________

Relationship to Patient: ______________________________ Witness: ____________________

I understand that my authorization will remain effective from the date of my signature for 365 days after, and that the information will be handled confidentially in compliance with all applicable federal laws.

I understand that I may see the information that is to be sent, and that I may revoke the authorization at any time by written, dated communication. I have read and understand the nature of this release.

Patient Name: ____________________________________________ Date of Birth: ____________________

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**Reason(s) for visit:**

______________________________________________________________________________

______________________________________________________________________________

**Referred By:**

______________________________________________________________________________

**Primary Care Doctor**:

______________________________________________________________________________

## PAST MEDICAL HISTORY: (Please CIRCLE if you have/had any of the following)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Depression
Diabetes

End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
HIV/AIDS
High Blood Pressure
High Cholesterol
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer

Radiation Treatment
Seizures
Stroke
Thyroid Problems:
Hypo Hyper
NONE OF THE ABOVE

Other:___________________________________________________________________________

______________________________________________________________________________

## PAST SURGICAL HISTORY: (Please CIRCLE all that apply)

Appendix removed
Bladder removed
Mastectomy: Right Left Both
Lumpectomy: Right Left Both
Breast Biopsy: Right Left Both
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Mechanical Valve Replacement
Hysterectomy: Fibroids Uterine Cancer
Organ Transplant:
NONE OF THE ABOVE

Joint Replacement:
Knee: Right Left Both
Hip: Right Left Both
Shoulder: Right Left Both
Kidney Biopsy: Right Left Both
Ovaries Removed: Endometriosis Cyst Ovarian Cancer
Prostate Removed
Gallbladder Removed
Spleen Removed
Coronary Artery Bypass
Biological Valve Replacement

What Organ_________________________________

# SKIN WELLNESS
PHYSICIANS

**SKIN DISEASE HISTORY:** (Please CIRCLE all that apply)

| | | | |
|---|---|---|---|
| Acne | Actinic Keratosis | Asthma | Basal Cell Skin Cancer |
| Blistering Sunburns | Dry Skin | Eczema | Flaking or Itchy Scalp |
| Hay Fever/Allergies | Melanoma | Poison Ivy | Precancerous Moles |
| Psoriasis | Squamous Cell Skin Cancer | | NONE OF THE ABOVE |

Other:

_______________________________________________________________________________

Do you wear Sunscreen? Yes No If yes, what SPF? _________________

Do you tan in a tanning salon? Yes No

**FAMILY HISTORY OF SKIN DISEASE:** (Please indicate which Family Member)

Melanoma: ________________________________________________

Psoriasis: ________________________________________________

Skin Cancer: ________________________________________________

Eczema: ________________________________________________

Keloids: ________________________________________________

Other: ______________ ________________________________________________

Other:

_______________________________________________________________________________

_______________________________________________________________________________

_______________________________________________________________________________

**Name of Person Completing this form:**

_______________________________________________________________________________

Print Name Relationship to patient Date

_______________________________________________________________________________

Signature

Patient Name Date

**REVIEW OF SYSTEMS:** (Please CIRCLE if you are experiencing any of the following)

Itch
Irregular menses
Problems with bleeding
Problems with healing
Problems with scarring (hypertrophic/keloid)
Rash
Unintentional Weight Loss
Hay Fever
Joint Aches
Muscle Weakness
Wheezing
Night Sweats
Anxiety
Chest Pain
Fever or Chills
Thyroid Problems
NONE OF THE ABOVE

Sore Throat
Blurry Vision
Abdominal Pain
Neck Stiffness
Headaches
Shortness of Breath
Depression
Cough

**OTHER:** (Please CIRCLE all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotic ointments
Allergy to betadine
Allergy to latex
Artificial heart valve
Artificial joints
Blood thinners
Defibrillator
History of MRSA

Premedication prior to procedures
Rapid heartbeat with epinephrine
Immunosuppression
Referred from another dermatologist
History of melanoma
History of poorly-differentiated Squamous Cell Carcinoma
Currently taking prednisone
NONE OF THE ABOVE

HIV/AIDS
Hepatitis
History of Leukemia
History of Lymphoma
West Africa: Travel or Contact
Ebola Risk: Fever >=100.4 d F/ 38.0 d C
Ebola Risk: Resided or Traveled to Country with widespread Ebola transmission in the last 21 days
Ebola Risk: Contact with an Ebola Patient Pacemaker without proper protective equipment in the last 21 days
Pregnancy or planning a pregnancy
Pain during intercourse
Urinary Incontinence
Vaginal Dryness
History of Merkel Cell Carcinoma
History of organ transplant

**MEDICATIONS:** (Please enter current medications; both prescribed and over the counter)

**No Medications:**
**Medication List Attached:**
**No Changes Since Last Visit:**

| Name: | Dose: | Frequency |
|---|---|---|
| | | |
| | | |
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**MEDICATION ALLERGIES:** (Please enter all medication allergies)

**No known Drug Allergies:**

| Name: | Type of Reaction: |
|---|---|
| | |
| | |
| | |
| | |
| | |

Pharmacy: ______________________________________________ Phone:____________________________________

Patient Signature Date

Patient Name Date

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*****NOTICE*****
**We are now required to have you answer the questions below.**
**Failure to complete this information will result in a delay of your appointment.**
**We apologize for any redundancies.**

1. Alcohol Use (patients 18 years and older):
   - None
   - 1 drink or less per day
   - 1-2 drinks per day
   - 3 or more drinks per day

   How many times in the past year have you had 5 (for men) or 4 (for women) or more drinks in a day? ___________

2. Check the one that best fits (patients 12 years and older)
   - Never Smoked
   - Ex-smoker
   - Current Smoker (cigarettes, cigars or pipes)

3. Influenza Vaccine (patients 6 months and older): Check the one that best fits
   - Received a flu vaccine this season
     - January – March
     - October - December
   - Did not receive a flu vaccine this season

4. Pneumonia Vaccine (patients 65 years and older): Check the one that best fits
   - Received a pneumococcal vaccine (Pneumovax)
   - Did not receive a pneumococcal vaccine

5. Over the past 2 weeks, how often have you been bothered by any of the following problems. (PHQ-2) (0 = Not at all, 1 = Several Days, 2 = More than half the days, 3 = Nearly every day) (patients 12 years and older)

| | **Circle the one that best fits** | | | |
|---|---|---|---|---|
| Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |

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6. Fall Risk Screening (patients 65 years and older): Circle all that apply
   - Have you fallen within the past year? Yes or No
     - If so, did the fall result in an injury? Yes or No
   - Have you had 2 or more falls within the past year? Yes or No

7. Please answer the following (patients 18 years and older)
   - Have you been tested for Hepatitis C? Yes or No
   - Do you have a history of Hepatitis C? Yes or No
   - Were you born between 1945 – 1965? Yes or No
   - Do you have a history of blood transfusions prior to 1992? Yes or No
   - Are you receiving maintenance hemodialysis? Yes or No
   - Do you have a history of injection drug use? (recreational or prescribed) Yes or No
   - Are you a current intravenous drug user? (recreational or prescribed) Yes or No

_______________________________________________________________

Print Name Relationship to patient Date

_______________________________________________________________

Signature