SILLS DERMATOLOGY

Dear Patient,

Welcome to Sills Dermatology. Enclosed is a packet of information that gives a basic overview of our practice. It is our mission to provide quality health care in a compassionate and confidential atmosphere. It is our hope that we meet and exceed your expectations.

In compliance with federal regulations known as HIPAA, (Health Information Portability and Accountability Act), we are enclosing our Notice of Privacy Practices. This notice explains how your health care information may be used and how you may obtain access to this information.

Please read the enclosed information and complete the requested forms. You will also find an authorization to release records to our practice and/or family members. Please complete this form and ask us any question as needed.

Sincerely,

Sills Dermatology

SILLS DERMATOLOGY

NEW PATIENT INFORMATION

NAME _____ DOB ____/____/____ SEX: M F
(Last) (First) (MI)

ADDRESS _____
(City) (State) (Zip)

HOME PHONE_____CELL_____EMAIL _____

SOCIAL SECURITY_____ RACE_____ETHNICITY Hispanic / Non-Hispanic

EMPLOYER/OCCUPATION:_____WORK PHONE _____

MARITAL STATUS_____ SPOUSE'S NAME _____

IF UNDER 18: GUARDIANS NAME _____ EMPLOYER _____

EMERGENCY CONTACT PERSON _____
(Name) (Relationship) (Phone)

INSURANCE INFORMATION

#1 PRIMARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID #_____POLICY/GROUP #_____POLICY HOLDER _____

Policy Holder Date of Birth _____ Policy Holder Social Security Number: _____

#2SECONDARY MEDICAL INSURANCE _____
(Name) (Mailing Address)

ID #_____POLICY/GROUP #_____POLICY HOLDER _____

Policy Holder Date of Birth _____ Policy Holder Social Security Number: _____

IS THIS A WORKMAN'S COMPENSATION (WORKPLACE) INJURY? YES_____NO _____

INSURANCE PATIENTS

As a courtesy to our patients with insurance coverage, we will take care of all the necessary paperwork associated with filing your insurance claim. I understand that health insurance is a contract agreement between the insurance company and myself. I understand that it is my responsibility to know the limits of my insurance coverage. Sills Dermatology will do our best to notify you, the patient, in advance of any non-covered services such as cosmetic procedures like skin tag removals, mole removals, and seborrheic keratosis treatment and require payment in full at the time of services for non-covered procedures. I also authorize my insurance benefits to be paid directly to SILLS DERMATOLOGY. I understand that I am financially responsible for non-covered services, including but not limited to services provided by a nurse practitioner, deductibles and coinsurances. In accordance with my insurance plan if necessary and appropriate, I hereby authorize Sills Dermatology to release any information required to process my services for insurance claims purposes. It is the responsibility of the insured to obtain the appropriate referral from your assigned primary care provider. If you do not have a current, valid referral on file you may be asked to reschedule your appointment or pay for the visit at the time of service.

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SELF -PAY or NON INSURED PATIENTS

We define a patient under the following circumstances: the patient is covered by an insurance plan that Sills Dermatology does not participate in; the patient does not have an insurance policy in effect at the time of service; the patient does not have a valid referral on file as required by their insurance plan and the insurance on file is not in effect. If you do not have insurance coverage you will be required to pay for services rendered at the time of services including but not limited to surgical procedures.

FOR MEDICARE PATIENTS ONLY: I AUTHORIZE ANY HOLDER OF MEDICAL OR OTHER INFORMATION ABOUT ME TO RELEASE TO THE SOCIAL SECURITY ADMINISTRATION, HEALTH FINANCING ADMINISTRATION, 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 TO THE PARTY WHO ACCEPTS ASSIGNMENT. REGULATIONS PERTAINING TO MEDICARE ASSIGNMENT OF BENEFITS APPLY.

NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act, I have certain rights to privacy regarding my protected health information. I understand that this information may be used during the course of my treatment that can include but are not limited to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in my treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations

I understand that, upon request, I have the right to receive a complete copy of our Notices of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand the practice has the right to change its Notice of Privacy Practices if necessary and that I may contact Sills Dermatology at any time to obtain a current copy. I understand that I may request in writing that Sills Dermatology restrict how my private information is used and/or disclosed to carry out treatment, payment and healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree to them then Sills Dermatology is bound to abide by such restrictions.

Financial Policy

1. We ask that you present your insurance card(s) at each visit. It is your responsibility to provide us the correct information to bill your insurance.
2. If you have a change of address, telephone numbers, or employer, please notify the receptionist.
3. We will collect your co-payment, charges from previous visits, and charges for non-covered services at the time of your visit. We accept cash, checks, and Visa, MasterCard, Discover, AMEX and debit cards and CareCredit.
4. Your account will be charged a fee for returned checks for non-sufficient funds.
5. By Federal Law and Managed Care Contract law, this office is required to collect co-payments at the time of service. If you do not pay your co-payment you will be charged a delinquent co-payment fee.
6. If your insurance denies our charges or does not pay us in a timely manner, you will be responsible for the charges.
7. If your account becomes delinquent we reserve the right to refer your account to a collection agency and report it to a credit bureau.
8. MEDICARE PATIENTS: We are participating providers with Medicare and will bill Medicare for all of your covered charges. We will also bill any secondary insurance you may have. If you do not have a secondary insurance, any remaining balance will be your responsibility. Each year you will be expected to pay the allowed amount of your charges until your Medicare deductible is met.

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9. HMO-PPO PATIENTS: If we participate with your plan, we will bill your insurance for you. If your plan requires you to choose a primary care physician, it is your responsibility to notify your plan. If your plan requires you to have an authorization to see a specialist you will need to obtain that from our office prior to seeing the specialist. No retroactive referrals will be given. If we do not participate with your plan, we will attempt to bill your insurance. Any amount remaining from your out-of-network benefits will be your responsibility to pay.
10. SELF-PAY PATIENTS: Patients with no insurance will be expected to pay at the time of service. If you are not able to pay in full, you will need to contact our billing department to discuss payment arrangements prior to being seen.
11. MEDICAID PATIENTS: We are contracted with traditional Medicaid and some Medicaid HMO plans. If we are contracted with your plan we will submit your claims. If we are not contracted with your plan we will not submit your claim and you will be considered self-pay and are liable for payment of all services provided. Services may be a covered Medicaid service and other providers may render the service at no cost to you. In the future if you choose to utilize your Medicaid plan you agree to transfer care to a Medicaid provider. Patients that miss an appointment will be discharged from the practice.
12. When an appointment is scheduled that time is specifically allocated for you. When an appointment is not canceled in advance we consider this a "no show". We understand there may be times when you are unable to keep an appointment, but we ask the courtesy of a phone call to cancel your appointment at least twenty-four (24) hours ahead. If two appointments are missed without cancellation, you may be charged a fee of $50.00 as a deposit before you will be able to reschedule. Failing to miss this third (3rd) appointment will result in forfeiture of your deposit.

Any balance 60 days past due may be turned over to a third party collection agency. If this occurs I will be responsible financially for all cost associated including, but not limited to, the agency fees, litigation expenses, court cost and or attorney fees.

All returned checks will be assessed a $25.00 fee in addition to the amount of the check

Two (2) consecutive appointments missed will result in a $50.00 deposit the next time I schedule an appointment.

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. It is very important that you understand the provisions in your policy. We cannot guarantee payment of all claims. If your insurance company pays only a portion of the bill or rejects your claim, this becomes your financial obligation.

Remember, whether you do or do not have insurance, you are ultimately financially responsible for payment of your charges. If you have any questions regarding our financial policy, please contact our billing department at 800-221-7146.

By signing below you are attesting that you have read and have a full understanding of the above policies of SILLS DERMATOLOGY.

Printed Name:_____ Date of Birth: _____

Signature/Legal Guardian:_____ Date: _____

SILLS DERMATOLOGY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PATIENT NAME:_____ **DOB:** _____

With my consent, SILLS DERMATOLOGY may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. SILLS DERMATOLOGY reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to SILLS DERMATOLOGY ,1003 Windover Rd, Jonesboro, AR 72401

With my consent, SILLS DERMATOLOGY may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, SILLS DERMATOLOGY may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as lab results, reminders of care, and patient statements as long as they are addressed to me.

With my consent, SILLS DERMATOLOGY may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders, lab results, and patient statements.

I have the right to request restriction on how SILLS DERMATOLOGY uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to SILLS DERMATOLGY use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Sills Dermatology may decline to provide treatment to me.

_____ _____

Print Name of Patient or Legal Guardian Signature and Date of Patient or Legal Guardian

SILLS DERMATOLOGY

AUTHORIZATION TO RELEASE MEDICAL RECORDS

PATIENTS NAME_____ DATE OF BIRTH_____

Please print name, address and phone number from whom records are being requested.

FROM:_____ PHONE: _____

For the following reason(s): _____

Designate instructions by checking one of the following:

_____Entire medical record **including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Entire medical record **excluding** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted diseases and HIV/AIDS.

_____ Record care from_____to_____**including** information related to the treatment of substance abuse or dependency, mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____ Record care from_____to_____**excluding** information related to the treatment of substance abuse or dependency mental health treatment and information relating to testing or treatment of sexually transmitted disease and HIV/AIDS.

_____Other as stated: _____

CONDITIONS:

- The patient agrees to authorize the above-named individuals/organizations to access his/her confidential healthcare information only for purposes listed above
- The patient has the right to a copy of the confidential healthcare information for which this authorization is being sought
- The practice may not condition treatment or payment on whether the patient signs this authorization
- The patient authorizes the information to be disclosed by fax transmission, if necessary
- The patient is voluntarily signing this authorization
- The patient reserves the right to refuse to sign this authorization
- The patient reserves the right to revoke this authorization at any time in writing
- The patient has the right to receive a copy of the signed authorization

I authorize records to be released as indicated above. I understand that this release is in effect for one year from date of signature, but I may revoke my consent at any time by providing written revocation to the facility releasing the information.

SIGNATURE:
Patient/Legal Representative: _____ Date: _____

SILLS DERMATOLOGY

Authorization to Release Information to Family and Friends

Due to federal privacy laws, we are unable to release certain personal health information without your consent. If you wish for information to be released, this form must be completed, signed and returned. In your absence, you must designate personal representative(s) for any personal health information to be released. The written authorization does not mean that we will automatically send information to these individual(s); it simply means that we will release information to them if they request. Such information includes, but is not limited to: individual identifiable health information and medical records regarding any past, present or future medical or mental health condition, including all information relating to the diagnosis and treatment of HIV/AIDS, sexually transmitted diseases, mental illness, and drug or alcohol abuse.

PATIENT NAME:_____ DOB: _____

Release information to the following representative(s):

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

Name:_____Relationship:_____Phone: _____

REASON FOR DISCLOSURE: _____

CONDITIONS:

- The patient agrees to authorize the above-named individuals/organizations to access his/her confidential healthcare information only for purposes listed above
- The patient understands there is a potential that the information disclosed may be re-disclosed by the recipient and no longer protected by HIPAA regulations
- The practice may not condition treatment or payment on whether the patient signs this authorization
- The patient authorizes the information to be disclosed by fax transmission, if necessary
- The patient is voluntarily signing this authorization
- The patient reserves the right to refuse to sign this authorization
- The patient reserves the right to revoke this authorization at any time in writing
- The patient has the right to receive a copy of the signed authorization

I hereby authorize Sills Dermatology to provide the above-named individual(s) with all medical data, billing, and other information they may request. I understand that this release is in effect for two years following my death or I may revoke my consent at any time by providing written revocation to the facility releasing the information.

Signature of Patient_____ Date_____

SILLS DERMATOLOGY

Referring Provider: _____ MRN: _____

For Sills Dermatology Staff Use Only

Name: _____ **Date of Birth**: _____/_____/_____

Weight: _____ lbs.

Height: _____ ft. _____ in.

Reason for Visit:_____

Please circle all that **CURRENTLY** apply:

Problems with Bleeding
Problems with Healing
Problems with Scarring
Rash
Allergies/Hay Fever
Fever/Chills
Night Sweats
Unintentional Weight Loss
Sore Throat
Blurry Vision
Abdominal Pain
Joint Aches
Muscle Weakness
Itching
Numbness/Tingling
Cough
Anxiety/Depression

Past Medical History: (please circle all that apply)

Arthritis
Asthma
Atrial fibrillation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Seizures
Stroke
Heart Valve Replacement

Other_____

Past Surgical History: (please circle all that apply)

Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (R/L)
Joint Replacement, Hip (R/L)
Joint Replacement within last 2 years
Kidney Transplant
Basal Cell Carcinoma Surgery
Squamous Cell Carcinoma
Melanoma Surgery
Spleen Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

Other_____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Abnormal/Dysplastic Moles
Psoriasis
Squamous Cell Skin Cancer
Other_____

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Do you wear Sunscreen? YES NO
If yes, what SPF? _____

Do you tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO
If yes, which relative(s)?
_____

Current Medications: ☐ Check if you brought a list

_____
_____
_____
_____
_____

Allergies: ☐ Check if you brought a list ☐ Latex Allergy?

_____
_____
_____

Social History: (please circle all that apply)

Tobacco	Smokeless Tobacco	Alcohol Use
Never Smoked	YES	YES
Quit: Former Smoker	NO	NO
Smokes less than daily	VAPOR or "Vaping"	If yes, how many drinks?
Smokes Daily		_____drinks per
		▪ DAY
		▪ WEEK
		▪ MONTH
		▪ YEAR

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
A few times a day
Once a day
A few times a week
A few times a month
Never

Occupation: _____

Pharmacy: Name: _____

Street (if known): _____ City/State: _____

Have you had a **flu vaccination**? No Yes If so, when? _____

Have you had a **pneumonia vaccine?** No Yes If so, when? _____