

DERMATOLOGY CLINIC OF N MS, PLLC

(662) 349-0200

Patient Information as of _____ (enter today's date)
(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name

MRN: _____ Last _____ First _____ Middle Initial _____

Mailing Address

Street & Apt # _____ City _____ State _____ Zip Code _____

Home Phone

Cell Phone

Email

Age:

Birthdate:

SS#:

Gender:

Race*:

Ethnicity*:

Preferred Language*:

*Optional. For government purposes only. The Dermatology Clinic of N MS, PLLC does not discriminate on the basis of sex, race, ethnicity, religion, or disability. For more information, please see our Non-discrimination policy.

RESPONSIBLE PARTY

(if patient is a minor)

Last _____

First _____

Middle Initial _____

Relationship to patient:

Birthdate:

SS#:

Gender:

PATIENT'S EMPLOYER

Occupation:

Industry:

Work phone number:

Extension:

N/A – Patient is a student or child.

N/A – Patient is retired.

Is it ok to call you at work? Yes No

RELEASE OF INFO RESTRICTIONS (Please include the person's NAME; not just the relationship)

Ok to release info to the following:

Ok to leave treatment info, lab results, prescription info on:

Home Answering Machine Cell Voice Mail Email None – Contact me only

Emergency contact (not in your household):

Home number: _____

Work number: _____

PRIMARY CARE PHYSICIAN Name:

Group Name:

Office Phone

PREFERRED PHARMACY

Pharmacy Number

Patient:

MRN:

PRIMARY HEALTH INSURANCE COMPANY:

Policy Number:	Group Number:
Insured: Name	DOB
Employer	SS#
Relationship to patient	Gender

SECONDARY HEALTH INSURANCE COMPANY:

Policy Number:	Group Number:
Insured: Name	DOB
Employer	SS#
Relationship to patient	Gender

AUTHORIZATION TO SUBMIT INSURANCE CLAIMS

I, _____, authorize Dermatology Clinic Of N MS, PLLC to bill my insurance company for services rendered. If necessary, copies of my medical record may be submitted with my claim.

Sign Here

Patient or Responsible Party

Date

NON DISCRIMINATION POLICY

I, _____, have reviewed the non-discrimination policy of Dermatology Clinic Of N MS, PLLC. I understand that Dermatology Clinic Of N MS, PLLC complies with applicable Federal civil rights laws and does not discriminate or treat differently on the basis of race, color, national origin, age, disability, or sex. I also understand my rights to necessary language interpretation.

Sign Here

Patient or Responsible Party

Date

HIPAA NOTICE

I, _____, have read or received a copy of the notice of privacy protection, which outlines how Dermatology Clinic Of N MS, PLLC protects your privacy and maintains HIPAA standards.

Sign Here

Patient or Responsible Party

Date

FINANCIAL POLICY

YOU COULD BE RESPONSIBLE FOR YOUR ENTIRE BILL!!!

If you have any questions about the following policy, please ask the receptionist or manager. We want to do our best to provide the most accurate information for you.

- **PAYMENT IS DUE AT TIME OF SERVICE:** Any co-pays, co-insurances, unmet deductibles, and fees for non-covered services are due at the time of service. With many insurance companies changing their regulations, patients are now subject to a higher financial burden. That means **YOU MAY HAVE TO PAY MORE MONEY OUT OF POCKET BEFORE YOUR INSURANCE COMPANY WILL PAY TOWARD YOUR MEDICAL EXPENSES.** We will try to make you aware of your benefits and financial responsibilities. All self-pay patients must also pay their bill in full at the time of service.
- **NON-COMPLIANCE WITH PAYMENT:** We are contractually required to collect the amount specified by your insurance company. Depending on the insurance company, we may be required to report if you refuse to pay your co-payment, co-insurance, or unmet deductible. If we are forced to report non-compliance to your insurance company, you could lose your insurance benefits.
- **MEDICAID PATIENTS:** Our office currently accepts Mississippi Medicaid and Mississippi United Health Care Community Plan. We do not accept TN Care of any kind, Magnolia, Ambetter, or any other Medicaid. If you have one of the plans we do not accept, we will not be able to treat you in our office as you must seek care from a provider contracted with your insurance company.
- **DIVORCE AGREEMENTS:** If you are bringing your child in for an appointment and your ex-spouse is obligated to you to pay for medical treatment through your divorce decree, we will try our best to accommodate your situation. **HOWEVER**, the parent bringing the child in for the appointment and signing this document is the one financially responsible to us. If your ex-spouse does not pay the bill, it will ultimately be your responsibility; not that of the ex-spouse.
- **OVER PAYMENTS AND BILLING:** If you overpay on your account, we will refund to you the amount you have overpaid after all services have been paid. We will bill you for any unforeseen amounts that were not collected at the time of service. Please be sure to inform us of any change in address, phone number, or employment. All balances are due in full within 14 days of the first billing date.
- **PAST DUE AND DELINQUENT ACCOUNTS:** We can notify credit bureaus, transfer your account to a collection agency, or take other collection actions against you if you do not pay your bill. You can also be terminated as a patient from our office. All attorney fees, court costs, and other expenses accumulated while collecting payment will be added to your outstanding balance. Checks that are returned will be subject to a \$40 returned check fee as well as Section 97-19-57 Mississippi Code of 1972. If a patient has written us a bad check, we will be unable to accept any more checks from the patient.
- **OUTSIDE LABS:** If you have a culture taken or a growth/mole/lesion/etc removed, we will send the specimen to an independent lab for examination by a pathologist. We want to send the specimen to a lab that is in your network, **BUT** in-network status changes often. If you are unsure which lab we should use, please contact your insurance company.
- **NO SHOW/SAME DAY CANCELLATIONS:** In the event that you need to cancel your appointment, we ask for 24 hour notice. If you have a same-day cancellation or no-show for your appointment, you will assess a \$25 fee.
- **BY SIGNING BELOW, I HAVE READ, UNDERSTAND, AND AGREE TO THIS POLICY.**

Patient or Responsible Party Signature

Date

Patient Name: _____

Patient Name: _____

DOB: _____

Height: _____ Weight: _____

MRN: _____

Do you now or have you ever had disease, condition of, or problem with the following:

(Please check YES or NO)

LUNGS

YES NO

Tuberculosis		
COPD/Emphysema		
Asthma		

CARDIOVASCULAR

CAD		
Valve replacement		
Defibrillator		
Pacemaker		
PVD		
HTN		
Stroke		
Atrial Fibrillation		
On blood thinners/aspirin		
Cholesterol/triglycerides		

SKIN

YES NO

Intentional tanning/tanning bed		
Skin Cancer		
Type if known _____		

FAMILY HISTORY

YES NO

Skin Cancer		
If yes, who? _____		
What type if known? _____		

OTHER SYSTEMIC

YES NO

Depression		
Suicide attempts		
Rheumatoid Arthritis		
Diabetes		
Insulin Dependent?		
Kidney failure w dialysis		
Other kidney		
Hepatitis		
HIV		
Thyroid Disease		
Bladder		
Prostate		
Stomach		
Inflammatory bowel		
Crohn's disease		
Ulcerative Colitis		
Cancer (not of skin)		

Type 1 or 2? _____

Problem: _____

A, B, or C? _____

Problem: _____

Cancer: _____

Problem: _____

Type: _____

Type: _____

Organ: _____

Organ: _____

Joint: _____

Joint: _____

SOCIAL HISTORY

What is/was your occupation? _____

Are you married? Yes No

SMOKING STATUS AND ALCOHOL USE

Are you a smoker? No, **never** smoker No, **former** smoker Yes, **current** smoker

If **current/former smoker**: smoking start date _____ & end date _____

Do you drink alcohol? Yes No

Men: How many times in a **year** do you drink more than five (5) drinks in a **day**? _____

Women: How many times in a **year** do you drink more than four (4) drinks in a **day**? _____

VACCINES

Have you had your flu shot? Yes No If yes, approx. date: _____

If over 65, have you had your pneumonia shot? Yes No If yes, approx. date: _____

FEMALES ONLY : (Please check if applicable)

<input type="checkbox"/> Currently pregnant	<input type="checkbox"/> Planning pregnancy soon	<input type="checkbox"/> Breastfeeding
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Excessive hair (face/body)	<input type="checkbox"/> On birth control; Type: _____

Patient Signature: _____

Date: _____