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)

*****WE WILL NOT RELEASE INFORMATION TO ANY PRIVATE INDIVIDUAL NOT LISTED IN THIS SECTION*****

Ok to release info to the following:

Ok to leave treatment info, lab results, prescription info on: □ Home Answering Machine □ Cell Voice Mail

□ Email - Email address: □ None – Contact me only

PRIMARY CARE PHYSICIAN **Name:**

Primary Care Office Phone

PREFERRED PHARMACY **Pharmacy Number**

EMERGENCY CONTACT

NOT IN YOUR HOUSEHOLD!!! Emergency contacts are only contacted if we MUST reach you about your treatment and cannot reach you. The person added here will not be able to get information about your treatment unless they are also listed in the "Release of Info" section above.

Emergency Contact Name

Emergency Contact Phone Number **Relationship to patient**

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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#

AUTHORIZATION TO SUBMIT INSURANCE CLAIMS

I, _, authorize zBaptist Hospital/desoto to bill my insurance company for services rendered. If necessary, copies of my medical record may be submitted with my claim.

Sign Here ______________________________ ______________________

or Responsible Party Date

NON DISCRIMINATION POLICY

I, _,have reviewed the non-discrimination policy of zBaptist Hospital/desoto. I understand that zBaptist Hospital/desoto 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 ______________________________ ______________________

or Responsible Party Date

HIPAA NOTICE

I, _, have read or received a copy of the notice of privacy protection, which outlines how zBaptist Hospital/desoto protects your privacy and maintains HIPAA standards.

Sign Here ______________________________ ______________________

or Responsible Party Date

TEXT AND EMAIL POLICY

Your healthcare is important to us. To keep you informed, our office will send text message and email reminders about upcoming appointments as well as notifications regarding your prescriptions or updates to your medical record. No HIPAA related information is transmitted via text/email. You may get an email or text asking you to review your experience at our office. We will not sell or give your information to a 3rd party for marketing purposes.

*****Please note, we do not call with appointment reminders. We only use the text/email system.*****

Sign Here ______________________________ ______________________

or Responsible Party Date

☐ I do not want to receive emails. ☐ I do not want to receive text messages.

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 MECIAL 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 Date

MEDICATION LIST

Do you currently take any medications (including topical/rub-on medications) either prescribed or over the counter: ◻ YES (list below) ◻ NO

NAME OF MEDICATION	DOSEAGE	DOCTOR WHO PRESCRIBED

Do you have any allergies: ◻ YES (list in table below) ◻ NO – No known drug allergies

ALLERGEN	REACTION

Patient Name: DOB: Height: __________ Weight: _________

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			Type 1 or 2? _________
Insulin Dependent?			
Kidney failure w dialysis			
Other kidney			Problem: _____________
Hepatitis			A, B, or C? ___________
HIV			
Thyroid Disease			
Bladder			Problem: _____________
Prostate			Cancer: ______________
Stomach			Problem: _____________
Inflammatory bowel			
Crohn's disease			
Ulcerative Colitis			
Cancer (not of skin)			Type: ______________ Type: ______________

	YES	NO	
Organ Transplant			Organ: ______________ Organ: ______________

	YES	NO	
Joint Replacement			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)

☐ Currently pregnant ☐ Planning pregnancy soon ☐ Breastfeeding

☐ Irregular periods ☐ Excessive hair (face/body) ☐ On birth control; Type:_______________

Patient Signature: ____ Date: _____________________

AGENDA FORM

Patient Name: MRN: DOB:

Today's Date: ______________________________

What brings you to the dermatologist today?

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