

Patient Information: Please print clearly

Last: _____ First: _____ MI: _____ Male
 Female

Preferred Name: _____ Prefix: _____ Suffix: _____ DOB: ___ / ___ / _____

SS #: _____ - _____ - _____ Marital Status: Single Married Divorced Widowed Legally Separated

Race: Caucasian African American Asian Other: _____

Language: English Other: _____ Ethnicity: Hispanic or Latino Not Hispanic or Latino

Billing or Mailing Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: (_____) _____ - _____ Secondary Phone: (_____) _____ - _____
 Home Cell Home Cell

Email: _____

Emergency Contact: _____ Relationship: _____ Phone: (_____) _____ - _____

Employment status: Employed Not Employed Retired Student Disabled

Employer: _____ Occupation: _____

How did you hear about us? _____

Guarantor Information: Complete only if the patient is a minor or has an appointed Power of Attorney.

Legal Name: _____ DOB: ___ / ___ / _____ Male
 Female

SS #: _____ - _____ - _____ Relationship: _____ Phone: (_____) _____ - _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Sharing of Medical Information

I give the physician and office staff of DMSI permission to discuss my medical condition with the following individuals, if none please select none:
*(You must add your spouse or your emergency contact if you wish for us to be able to talk with them.)
(Ask our Receptionist for additional space for Sharing of Medical Information.)*

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

None

Communication

I would like Voicemails to be left on the phone number I provided: Yes No

If Yes I specifically authorize Voicemails to be left for: Appointments Results Medication Issues

Primary Insurance

Name of Insurance: _____

Name of Policy Owner: _____ Policy Owner's DOB: ___ / ___ / _____

Policy Owner's Employer: _____ Relationship to Patient: Self Spouse Parent

Secondary Insurance

Name of Insurance: _____

Name of Policy Owner: _____ Policy Owner's DOB: ___ / ___ / _____

Policy Owner's Employer: _____ Relationship to Patient: Self Spouse Parent

**Dermatology & Mohs Surgery Institute
Medical History**

Patient Name: _____ **DOB:** ____ / ____ / _____

Medical History: Please check all that apply		
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Hyperthyroidism
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hypothyroidism
<input type="checkbox"/> Asthma	<input type="checkbox"/> End Stage Renal Disease	<input type="checkbox"/> Leukemia
<input type="checkbox"/> Atrial Fibrillation (Irregular heartbeat)	<input type="checkbox"/> Gastro Esophageal Reflux Disease (GERD)	<input type="checkbox"/> Lung Cancer
<input type="checkbox"/> Benign Prostatic Hypertrophy (BPH)	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Lymphoma
<input type="checkbox"/> Bone Marrow Transplantation	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Breast Cancer	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Radiation Treatment
<input type="checkbox"/> Colon Cancer	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Seizures
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/> High Cholesterol (Hyper Cholesterolemia)	<input type="checkbox"/> Stroke
<input type="checkbox"/> Coronary Artery Disease		<input type="checkbox"/> Other: _____
		<input type="checkbox"/> None

Surgical History: Please check all that apply		
<input type="checkbox"/> Appendix Removed (Appendectomy)	<input type="checkbox"/> Gallbladder Removed (Cholecystectomy)	<input type="checkbox"/> Prostate: Prostate Removal (Prostatectomy)
<input type="checkbox"/> Bladder Removed (Cystectomy)	<input type="checkbox"/> Heart: Biological Valve Replacement	<input type="checkbox"/> Prostate: Prostate Biopsy
<input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral)	<input type="checkbox"/> Heart: Coronary Artery Bypass Surgery	<input type="checkbox"/> Prostate: Prostate Cancer
<input type="checkbox"/> Breast Lumpectomy (Right, Left, Both)	<input type="checkbox"/> Heart: Heart Transplant	<input type="checkbox"/> Prostate: TURP
<input type="checkbox"/> Breast Mastectomy (Right, Left, Both)	<input type="checkbox"/> Heart: Mechanical Valve Replacement	<input type="checkbox"/> Rectum: APR
<input type="checkbox"/> Breast Reduction	<input type="checkbox"/> Heart: PTCA	<input type="checkbox"/> Rectum: Low Anterior Resection
<input type="checkbox"/> Breast Implants	<input type="checkbox"/> Hysterectomy: Fibroids	<input type="checkbox"/> Skin: BCC
<input type="checkbox"/> Colectomy: (Colon Cancer Resection)	<input type="checkbox"/> Hysterectomy: Uterine Cancer	<input type="checkbox"/> Skin: Melanoma
<input type="checkbox"/> Colectomy: Diverticulitis	<input type="checkbox"/> Joint Replacement, Hip (Right, Left, Both)	<input type="checkbox"/> Skin: Skin Biopsy
<input type="checkbox"/> Colectomy: IBD – Inflammatory Bowel Disease	<input type="checkbox"/> Liver: Liver Removal (Hepatectomy)	<input type="checkbox"/> Skin: SCC
<input type="checkbox"/> Colon: Colostomy	<input type="checkbox"/> Liver: Liver Transplant	<input type="checkbox"/> Spleen: Spleen Removal (Splenectomy)
<input type="checkbox"/> Coronary Artery Bypass	<input type="checkbox"/> Liver: Shunt	<input type="checkbox"/> Testicles: Testicle Removal (Orchiectomy)
<input type="checkbox"/> Joint Replacement, Knee (Right, Left, Both)	<input type="checkbox"/> Ovaries: Ovary Removal (Oophorectomy)	<input type="checkbox"/> Uterus: Uterus Removal (Hysterectomy)
<input type="checkbox"/> Kidney: Kidney Biopsy	<input type="checkbox"/> Ovaries: Endometriosis	<input type="checkbox"/> Uterus: Fibroids
<input type="checkbox"/> Kidney: Kidney Stone Removal	<input type="checkbox"/> Ovaries: Ovarian Cancer	<input type="checkbox"/> Uterus: Uterine Cancer
<input type="checkbox"/> Kidney: Kidney Transplant	<input type="checkbox"/> Ovaries: Ovarian Cyst	<input type="checkbox"/> Uterus: Cervical Cancer
<input type="checkbox"/> Kidney: Nephrectomy	<input type="checkbox"/> Ovaries: Tubal Ligation	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Liver: Hepatectomy	<input type="checkbox"/> Pancreas: Pancreas Removal (Pancreatectomy)	<input type="checkbox"/> None

Skin Disease History: Please check all that apply			
<input type="checkbox"/> Acne	<input type="checkbox"/> Dry Skin	<input type="checkbox"/> Melanoma	<input type="checkbox"/> Squamous Cell Carcinoma
<input type="checkbox"/> Actinic Keratosis	<input type="checkbox"/> Eczema	<input type="checkbox"/> Poison Ivy	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Basal Cell Carcinoma	<input type="checkbox"/> Flaking or Itchy Scalp	<input type="checkbox"/> Precancerous Moles	<input type="checkbox"/> None
<input type="checkbox"/> Blistering Sunburns	<input type="checkbox"/> Hay Fever/ Allergies	<input type="checkbox"/> Psoriasis	

**Both sides of this page must be completed. Bring this form with you into the exam room.
Do not return this form to the front desk.**

Patient Name: _____ DOB: ____ / ____ / _____

Medications: Please list Medication Name

_____ **None**

Allergies: Please list all allergies

_____ **No Known Allergies**

Social History: Please check one

Tobacco Use: Never Quit Less than daily Daily
Alcohol Use: : Never Yes: How much and how often _____

Family History

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Review of Systems

Are you Pregnant? Yes, Due Date _____ No Not Applicable
Are you planning to become pregnant? Yes No Not Applicable
Do you have problems with: Bleeding Healing Scarring
Artificial Heart Valve within the past 2 years? Yes, When _____ No
Artificial Joints within the past 2 years? Yes, When _____ No
Pacemaker? Yes No
Blood Thinners or Aspirin? Yes No

Referring Physician: Please give as much information as possible

First Name Last Name Doctor Nurse Practitioner
 Physician Assistant Other: _____

Phone Number Fax Number Location

Primary Care Physician: Please give as much information as possible

First Name Last Name Doctor Nurse Practitioner
 Physician Assistant Other: _____

Phone Number Fax Number Location

Pharmacy: Please give as much information as possible

Name Location Phone Number

**Both sides of this page must be completed. Bring this form with you into the exam room.
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To better serve you, our patient, we would like to invite you to access our Patient Portal.

If you have any questions after a biopsy or surgery, please contact our office directly at 309-451-3376.

Our patient portal allows you to:

- View finalized biopsy results
- Input past medical history/medications/allergies/social history/family history/preferred pharmacy
- View finalized visit notes and patient handouts

To log in, you will receive an email (that you provided us with) with your username and a link to create a password. The email link will expire in 72 hours. If the link has expired, you can use the 'forgot password' link on the login page. **If you did not provide us with an email, please inform the front desk and they can manually generate a username and password for you.**

You can access the portal 2 ways:

- a. Visit **www.dermatologymohsinstitute.com** and select the button for the patient portal

OR

- b. Go directly to **dermandmohs.ema.md** (do NOT put www. first!!)

NOTE: The portal works best in the Mozilla Firefox browser but can still be viewed in other browsers. You can download the Firefox browser for free at www.mozilla.org.

If you have any questions and/or concerns, please contact our office directly at 309-451-3376.

Thank you for trusting us with your skin care needs!



Patient Financial Policy

Thank you for choosing us for your healthcare needs. As your healthcare provider, we are committed to providing you with the best possible care. Please read our financial policy and, if you have any questions, please ask one of our associates for assistance or call our billing office at (844) 733-1400.

You will be asked to show the front office staff your current insurance card at each visit. Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

PATIENTS WITH INSURANCE POLICIES

For Insurance companies that we participate with:

We are pleased to bill your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at time of service. In addition, you will be responsible for any amount the insurance plan deems not covered, up to the entire amount.

If we do not hear from your insurance company:

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues.

*For insurance companies that we **DO NOT** participate with:*

If your insurance has an out-of-network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. PhyNet reserves the right to collect any unmet deductible or coinsurance at the time of service. It is ultimately the patient's responsibility to verify if we are in your network and what the out-of-pocket costs in using an out-of-network provider will be.

SELF PAY PATIENTS

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required prior to the service. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express. A returned check fee of \$35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card.

COPAYMENTS

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are not prepared to pay your co-pay, your appointment will be rescheduled.

COINSURANCE

Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example, you may have an 80/20 plan, meaning the insurance will consider and pay on 80% of the charges and the remaining 20% is your responsibility. It is very important to review your coverage to determine your level of coinsurance.

NO SHOW FEES

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a \$50 fee for an office visit and a \$150 fee for a missed surgical/cosmetic appointment.

PAST DUE ACCOUNTS

In the event a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fees associated with collecting the outstanding balance.

DISABILITY AND OTHER SPECIAL FORMS

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time-consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete these forms at the following rates:

- FMLA - \$25
- Disability/Physician Attestation - \$25
- Miscellaneous Forms - \$25
- Medical Records - \$35

Payment of the form filing fee is due at the time of request and a medical release form must be signed.

We will gladly discuss your proposed treatment and will do our best to answer any questions relative to your insurance. You must realize that: A) your insurance is a contract between you, your employer, and the insurance company. B) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As your medical provider, our relationship and concern is with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, **all charges are your responsibility from the date services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature: _____

Date: _____

Patient Name: _____



PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dermatology & MOHS Surgery Institute to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Dermatology & MOHS Surgery Institute 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. Dermatology & MOHS Surgery Institute 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 Dermatology & MOHS Surgery Institute management.

With my consent, Dermatology & MOHS Surgery Institute 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, Dermatology & MOHS Surgery Institute may communicate with me via SMS/Text or iMessage 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, Dermatology & MOHS Surgery Institute may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

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- With my consent, I hereby give Dermatology & MOHS Surgery Institute permission to discuss/ share my PHI pertaining to my treatment and/or diagnosis with [Relationship to patient:] Contact Phone # Please initial:
I choose not to give consent to Dermatology & MOHS Surgery Institute to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Dermatology & MOHS Surgery Institute.

By signing this form, I am consenting to Dermatology & MOHS Surgery Institute use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Dermatology & MOHS Surgery Institute Notice of Privacy Polices.

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, Dermatology & MOHS Surgery Institute may decline to provide treatment to me.

Results notification will be primarily through the patient portal for benign or normal pathology/lab results. Benign or normal reports will be uploaded to your portal once reviewed by your provider and you will receive an email informing you when your report(s) have been uploaded. We will call you at your provided phone number(s) for any abnormal results or those that require further explanation. If you wish to opt out of portal notifications, you must do so in writing.

Signature of Patient or Legal Guardian Name of Legal Guardian (if applicable)
Patient's Name Patient DOB Date Signed