SEEBERGER DERMATOLOGY

Patient Information

Please present picture ID and Insurance card

Name: _____
Last First M.I. (Preferred Name)

Address: _____
Street City State Zip

Date of Birth:_____/_____/_____ Age: _____ Gender: M F Marital Status: S M D W

Ethnicity:_____SSN: _____Primary Contact Number: ☐ Home ☐ Cell ☐ Work

Home: (____)_____Cell: (____)_____Work: (_____)_____ Ext: _____

Email:_____Pharmacy & Location: _____

Employer:_____ Occupation: _____

In case of emergency, notify:_____Phone: _____
Relationship

Who is your family doctor? _____Phone: _____

Seeberger Dermatology LLC may treat my child in my absence. _____
Parent Signature

Insurance Subscriber (☐ Check if same as above)

Name: _____
Last First M.I. SS#

Address: _____
Street City State Zip

Work Phone: (_____)_____Ext._____Home Phone: (_____)_____

Cell Phone: (_____)_____Date of birth:_____/____/____Relationship to patient: _____

Insurance Information (Please present card at time of check-in.)

Primary Insurance name:_____Secondary Insurance name: _____

Policy Holder:_____Policy Holder: _____

Contract #: _____ Contract #: _____

Group #: _____ Group #: _____

Relationship to patient:_____Relationship to patient: _____

Medicare Authorization

I request that payment of authorized Medicare benefits be made either to me or on my behalf to this provider for any services furnished me by this physician. I authorize any medical information about me to be released to the Health Care Financing Administration and its agents as needed to determine benefits for related medical services. I authorize Medicare to furnish the above-named doctor any information regarding my medical claims under Title XVII of the Social Security Act.

Commercial Insurance

I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits, otherwise payable to me, to the doctor indicated on the claim. I understand I am financially responsible for any balance not covered by insurance. I give consent for Seeberger Dermatology LLC to communicate with my referring physician.

Patient or Guardian Signature:_____Date:_/_/_____

What are your concerns today and when did the problem(s) begin? _____

Which Pharmacy do you currently use? _____ Phone Number _____

Medical History

Select any of the following medical conditions that you currently have**.**

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other: _____

_____

Past Surgical History

Select any organs that you have had previous surgeries.

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast Biopsy
- ☐ Breast Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Mastectomy (Right, Left, Bilateral)
- ☐ Colon (Colectomy): Colon Cancer Resection
- ☐ Colon (Colectomy): Diverticulitis
- ☐ Colon (Colectomy): Inflammatory Bowel Disease
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Coronary Artery Bypass Surgery
- ☐ Heart Transplant
- ☐ Heart: Mechanical Valve Replacement
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Right, Left, Bilateral)
- ☐ Joint Replacement: Knee (Right, Left, Bilateral)
- ☐ Kidney Biopsy
- ☐ Kidney Stone Removal
- ☐ Kidney Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver Transplant
- ☐ Liver Shunt
- ☐ Ovaries (Oophorectomy): Endometriosis
- ☐ Ovaries (Oophorectomy): Ovarian Cancer
- ☐ Ovaries (Oophorectomy): Ovarian Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate (Prostatectomy) Prostate Biopsy
- ☐ Prostate (Prostatectomy): Prostate Cancer
- ☐ Prostate (Prostatectomy): TURP
- ☐ Rectum: APR
- ☐ Rectum: Low Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin Biopsy
- ☐ Squamous Cell Carcinoma
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Uterus (Hysterectomy): Fibroids
- ☐ Uterus (Hysterectomy): Uterine Cancer
- ☐ Uterus (Hysterectomy): Cervical Cancer
- ☐ NONE
- ☐ OTHER

_____

_____

Medical History Continued

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ 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
- ☐ Other: _____

Do you use Sunscreen? ☐ Yes ☐ No If Yes, what SPF? _____Do you Tan indoor or outdoor? ☐ Yes ☐ No

Do you have a family history of Skin Cancer? ☐ Yes ☐ No If yes which relative(s)? _____

Do you have a family history of Melanoma? ☐ Yes ☐ No If yes which relative(s)? _____

List all current medications you take or apply regularly: _____

Do you need to take antibiotics before any surgeries or dental procedures? ☐ Yes ☐ No

If yes, what_____

List all allergies and reactions if known: _____

☐ I want my skin checked for skin cancer (Full Body Exam)

☐ I want my skin checked for skin cancer (Full Body Exam), and I will call at a later date to make an appointment. ☐ No, I do not want my skin checked for skin cancer. (Decline a Full Body Exam)

Social History

Smoking Status (please choose one):

- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Start Smoking:

- mm/dd/yyyy -

_____

Quit Smoking:

- mm/dd/yyyy -

_____

Number of Packs Per Day: _____

Total Years Smoking: _____

Alcohol Intake (Please Choose one)

- ☐ None
- ☐ 1 or less per day
- ☐ 1-2 per day
- ☐ 3 or more per day

Driving Status:

- ☐ Drives in the Daytime
- ☐ Drives at Night

Social History Continued

How often do you exercise?	**What is your caffeine use?**
☐ Unspecified ☐ Several times a day ☐ Once a day ☐ A few times a week ☐ A few times a month ☐ Never ☐ Other _____	☐ Unspecified ☐ Several times a day ☐ Once a day ☐ A few times a week ☐ A few times a month ☐ Never ☐ Other _____

Cosmetic Concerns

What are you skin care or cosmetic concerns? Please circle all that apply

Facial Concerns

Brown spots	White heads	Black heads	Sun damage
Spider veins	Yellow/stained teeth	Redness	Loss of elasticity
Loss of facial volume	Wrinkles/lines	Enlarged pores	Sensitivity
Oily skin	Excess hair	Non-matching makeup	Uneven skin texture
Dry skin	Thin lips	Scars	Other:

Body Concerns

Scars	Excessive sweating	Appearance of chest	Fragile/brittle nails
Sagging skin	Excess fat	Dry body skin	Cellulite
Stretch marks	Body acne	Sun damage	Spider veins
Thinning hair	Other:	Other:	Other:

Medical History Review of Systems

Please circle **ALL** conditions that apply, please check **NO** if none of the conditions apply

System Review	Circle all that apply (Presently)	No	Comments/Other
Constitutional	Fevers, chills, night sweats		
Skin	Color changes, infections, masses, open sores, hair changes, rash, itching, eczema		
Ears, Nose, Throat	Loss of hearing, trouble swallowing, nosebleeds, hoarseness, earache, nasal polyps, ear ringing		
Eyes	Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma		
Respiratory	Shortness of breath, asthma, difficulty breathing, emphysema, bronchitis, tuberculosis		
Cardiovascular	Heart attack, irregular heartbeat, heart murmur, chest pain, high blood pressure		
Gastrointestinal	Ulcer, hepatitis, weight changes, bowel changes, weight gain, weight loss, liver problems, intestinal disorders, reflux		
Genitourinary	Painful urination, difficulty urinating, blood in urine, renal disease/failure, frequent urination, kidney problems		
Musculoskeletal	Arthritis, weakness, back pain, joint pain, cramps, stiffness, osteoporosis		
Neurologic	Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines, myasthenia gravis		
Psychological	Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness		
Endocrinology	Intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue, diabetic		
Hematologic	Blood clots, anemia, bleeding problems, hepatitis, blood transfusions, platelet disorder		
Immunologic/Allergic	Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes		
Other Medical Problems	Such as: Cancers, infectious disease, HIV, autoimmune disease, etc.		

Have you had an annual flu shot? Yes:_____Date:_____No: _____

Are you pregnant or nursing?_____Yes_____No If Yes how far along: _____

Are you planning on getting pregnant?_____Yes_____No Is your menstrual cycle regular?_____Yes_____No

Have you ever taken Accutane?_____If yes, for how long? _____

I consent to being tested for hepatitis / HIV (AIDS) if an office staff member is directly exposed to potentially contagious material (i.e., needle stick). **Initials:_____Date: _____**

Patient or Guardian Signature:_____Date: _____

The Health Care Provider signature below indicates this entire form was reviewed to include:
allergies · past medical history · family history · social history surgical history · medications · review of systems

Provider Signature:_____Date:_____
(Doctor, nurse practitioner, physician assistant)

FINANCIAL POLICY AND AGREEMENT FOR SEEBERGER DERMATOLOGY LLC

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Your clear understanding of our practice financial policy is important to our professional relationship. The following information outlines your responsibility related to payment and appointment reservation for professional services. In order to keep healthcare costs to an absolute minimum, we have adopted the following policies.

Insurance: At each visit we must verify your current insurance. If we are unable to verify insurance coverage, you will be responsible for the total visit amount at the time of service. Please contact your insurance company directly with any questions you may have regarding your benefits and coverage.

Co-payment: A copayment is a dollar amount set by your insurance company which you are responsible for at each visit. Some insurance plans may also have a coinsurance, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. All co-payments must be paid at the time of service. We accept cash, check, Visa, MasterCard, American Express, Discover, and third-party payment services (i.e. Cherry).

Deductible: An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay. Payment will be due at time of service if your deductible has not been met.

Co-Insurance: Is the percentage of responsibility that you must pay after your deductible is met and is applied to your maximum out of pocket balance. Most insurance plans state, once your maximum out of pocket balance is met, your insurance plan will pay 100% of your medical expense.

Credit Card on File: For any prearranged payment plans or payment plans, Seeberger Dermatology LLC will keep credit cards on file (CCOF). We do not keep any credit card information on file in the office or on any of our computers. We use a secure, encrypted gateway that is compliant with applicable law. We must have a signed authorization on file to charge your credit card. This program expedites the checkout process and enables us to process refunds on your account efficiently.

Non-Payment: All balances over $100 and not on a payment plan and 270 days past due, will be referred to an external collection agency with a 30% collection fee added. This will need to be paid in full along with the past due balance to schedule future appointments with Pinnacle Dermatology, SC. The collection vendor may report your delinquency to a credit bureau and may file litigation in efforts to collect the total balance due. Any litigation fees will be applied to the collection balance. For balances greater than $500 and 90 days past due, patient must settle the outstanding balance through one of the following before an appointment can be scheduled: payment in full including patient financing options through Cherry or resolve the balance greater than $500 and accept a payment plan for the remaining balance only if patient does not qualify for patient financing solutions.

Returned Checks: Seeberger Dermatology LLC ***may*** charge a $25 fee for any returned checks.

Self-pay: Patients who do not have insurance coverage are considered self-pay. Payment in full for services provided are due at the time of service for self-pay patients. *SRT exception per SRT policy.

Missed Appointments: If you are unable to keep your appointment, please notify our office at least 24 hours in advance. Failure to provide 24 hour notice will result in a no-show charge and will be collected to the extent permitted by law or applicable payor contracts. The no-show fee is $50 for a Monday-Friday regular medical visit, $100 for Saturday appointments and $250 for a surgery-related appointment (regardless of day scheduled). In addition, the no-show fee is $99 for a cosmetic consultation and $250 for a cosmetic procedure. Patients with repeat cancellations or missed appointments may be discharged from our practice at our discretion.

Dismissal from Practice: Please note that noncompliance with treatment plans (including medications and/or lab work), non-payment of charges owed (to the extent permitted by law or applicable payor contracts) and abusive/inappropriate behavior towards staff and/or other patients may result in dismissal of your care from our practice.

Cosmetic Services (services that are not medically necessary): Patients are responsible for all cosmetic procedure fees at the time of service. We do not bill insurance companies for cosmetic procedures. The cost of any procedure will be a separate fee from an office visit or consultation fee.

Laboratory and Pathology Fees: It may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. Seeberger Dermatology LLC uses pathologists who perform the slide preparation and interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider. You may receive an additional bill for lab services that are not paid by your insurance. Depending on specific factors, your provider may send the

specimen to an outside lab for slide processing and interpretation. In those instances, you or your insurance will receive a bill from the outside lab. If you have identified as "self-pay," you shall be responsible for all fees related to processing and interpreting you specimen (including, but not limited to, special staining).

Referrals and Preauthorization: If your insurance company requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain one. If the referral is not sent to us prior to your scheduled appointment, you may be asked to reschedule the visit until we have a valid referral on file. It is also your responsibility to obtain preauthorization for services if required by your insurance company and to ensure that your PCP is listed correctly with your insurance company. If we do not receive documentation of preauthorization or the PCP is not correct at the time of service, you will be responsible to pay for the cost of services rendered if your insurer denies the claim.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is required for subsequent visits. All co-pays or monies due are expected to be paid at the time of each service.

Determining Guarantor: The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if they are over the age of 18 (although this may vary from state to state). The guarantor for a minor child is the parent that presents the child for care at the time of the initial visit.

I have read and understand the Financial Policy and agree to its terms.

Signature of patient or legal representative:_____

Printed name of patient or legal representative:_____

Relationship to patient:_____

Date:_____

Patient HIPAA Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
• Protected health information may be disclosed or used for treatment, payment or health care operations.
• The Practice has a Notice of Privacy Practices the patient has the opportunity to review this Notice.
• The Practice reserves the right to change the Notice of Privacy Practices
• The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
• The patient may revoke this Authorization in writing at any time and all future disclosures will then cease.
• The practice may condition receipt of treatment upon the execution of this Authorization.

Signature below is only acknowledgment that you have received this Notice of our Privacy Practices.

Patient or Guardian Signature:_____ **Date:** _____

Consent for Verbal Release of Information

Preferred Number		**Type** (please circle)	**Leave Detailed Message** (please circle)	**Leave Detail Lab/Test Result** (please circle)
Primary Phone #:		Home/Work/Cell	Yes/No	Yes/No
Secondary Phone #:		Home/Work/Cell	Yes/No	Yes/No

Please note the voice mail message must have an identifying message to confirm these are your numbers for example, "You have reached John Doe". If the message does not identify your name, we will be unable to leave a detailed message even if you opted us to do so.
I hereby give permission to Seeberger Dermatology LLC to notify me by telephone, text, and/or email for the following:

- ☐ Appointment Reminders
- ☐ A message to call the office for test results (actual results will not be left)
- ☐ Benign results, a message will be left, stating no further treatment would be needed and to keep any advised follow up as recommended by the provider.

I authorize Seeberger Dermatology LLC to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history, or any other such related information to myself and those listed below.

Name	**Phone Number**	**Relationship**

Assisted living/Long term care facility residents:

Power of Attorney Name _____ Relationship to Patient _____

Telephone Number _____ Date of POA Received _____

*Please note the POA is only valid if we have the paperwork scanned into the patient's medical record
Please list any facility personnel we can speak with on your behalf regarding your medical information:

Name _____ Telephone Number _____ Relationship _____

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through all Seeberger Dermatology LLC locations and providers. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the Seeberger Dermatology LLC. I also understand that I will not be able to revoke this consent in cases where the provider has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the provider's office.

Signature: _____ Date: _____

Printed Name: _____ Relationship to Patient: _____