Henning Dermatology Group

□ New Patient □ Name Change □ Address Change □ Insurance Change

***Please present ALL Insurance cards and Drivers License to the receptionist. If patient is a minor, and you are not the legal guardian, please speak with the receptionist immediately. Thank you.**

Patient Information: Please Complete All Fields Using Legal Names of the Parties Involved.

Name: (First)_____ (MI)_____ (Last)_____

Date of Birth: _____ Age: _____ Sex: □ Male □ Female Marital Status: Single Married Divorced Widow

Mailing Address:_____

City: _____ State: _____ Zip: _____ Social Security#:_____

Home Phone: _____ Cell: _____ Email:_____

Occupation: _____Employer: _____ Work Phone: _____

Pharmacy Name: _____ Town: _____Phone#:_____

Primary Doctor Name: _____ Town: _____Phone#:_____

Referring Physician _____Town: _____ Phone#:_____

New Patients: How did you hear about HDG? _____

Primary InsurancePlan:_____ID#_____

Primary Insurance Plan Holder's Name:_____ DOB:_____ Relationship:_____

Mailing address of Plan Holder if different from patient: _____

Home Phone of Plan Holder: _____ Cell phone of Plan holder:_____

Secondary Insurance Plan: _____ID#_____

Secondary Insurance Plan Holder's Name:_____ DOB:_____ Relationship to patient:_____

Patient Release: MUST BE SIGNED BY PATIENT OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I understand I am responsible for co-insurances, copayments and deductibles. If I am not insured or Henning Dermatology Group does not participate in my plan I am responsible for payment in full at the time of service

I certify that I hereby authorize Henning Dermatology Group, its providers and staff to provide my minor child in my absence with examinations and basic treatments following the initial visit for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

I agree to receive news and information about the practice via email, which may include offers and announcements for special events or offers from the practice and my physician._____ (initial)

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ Date: _____

Name of Legal Guardian if applicable: _____

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Emergency Contact

☐ Check here if emergency contact name and address is same as responsible person above and skip section below.

First Name:	Last Name:	Relationship to Patient:
Address:	City	State: Zip:
Mobile Phone:	Home Phone:	Email:

Favorite Pharmacy

Name	Phone:
Address:	City State: Zip:

Allergies

☐ No Allergies	☐ Latex	☐ Penicillin
☐ Other:		

Medications

Please list all medications you are taking below including vitamins, aspiring, supplements, herbals, over-the-counter.

Skin Conditions

Please select if you have any of the medical conditions below. If a condition is not listed, please write in the bottom.

☐ No Medical History	☐ Acne	☐ Actinic Keratosis/ AK's
☐ Basal Cell Carcinoma	☐ Dysplastic Nevus/ moles	☐ Eczema/ atopic dermatitis
☐ Keloids	☐ Malignant Melanoma	☐ Psoriasis
☐ Squamous Cell Skin Cancer		
☐ Other:		

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Medical Conditions

Please select if you have any of the medical conditions below. If a condition is not listed, please write in the bottom.

☐ No medical History	☐ Anxiety/ Depression	☐ Arthritis	☐ Asthma
☐ Blood Clotting Disorder	☐ Chron's disease	☐ Cancer_____	☐ Diabetes
☐ HIV positive	☐ Heart Attack	☐ Heart disease	☐ Heart failure
☐ Hepatitis B	☐ Hepatitis C	☐ High Blood Pressure	☐ Kidney Disease
☐ Liver Disease	☐ Lupus	☐ Mental Disorder_____	☐ Migraines
☐ Seasonal Allergy	☐ Seizure	☐ Stomach Ulcer	☐ Stroke
☐ Thyroid Disease	☐ Tuberculosis	☐ Ulcerative colitis	
Other:			

Family History

If yes, please include which relative.

☐ Atopic Dermatitis_____	☐ BCC _____	☐ SCC _____
☐ Psoriasis _____	☐ Malignant Melanoma _____	☐ Other _____

Obstetric History	☐ Not Applicable	☐ Pregnant Mother	☐ Currently Breastfeeding	
History of Exposure	☐ Excessive Sun exposure? ☐ Yes ☐ No	☐ tanning/ tanning bed use? ☐ Yes ☐ No	☐ Exposure to radiation? ☐ Yes ☐ No	☐ Sunscreen Use? ☐ Yes ☐ No

Smoking Status	☐ Non-Smoker	☐ Smoker	☐ Ex-Smoker	
Alcohol Use	☐ Social drinker	☐ Heavy drinker	☐ Non-drinker	
Marital status	☐ Married	☐ Single	☐ Divorced	☐ Widowed
Immunizations	Have your had your flu/ influenza vaccine this year? ☐ Yes ☐ No		If over age 65, have you had your pneumococcal vaccine? ☐ Yes ☐ No	
Advanced Directive	If over age 65, do you have an advanced care plan (advance directive)? ☐ Yes ☐ No			

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Patient Name: _____
Date of Birth: _____

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Henning Dermatology Group from discussing appointments, medications, test result or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. This becomes especially important if your spouse or adult children assist with making appointments for you or if you are an adult college student away at school and your parents assist with prescriptions and appointments.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only three individuals will be provided with information about you. Should you wish to update the names below, please ask the receptionist for a new HIPAA form.

*This **Release of Information** will remain in effect until terminated by me in writing.*

Release of Information

☐ I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

☐ Spouse: _____
☐ Child(ren): _____
☐ Other: _____

Messages

Please call ☐ my home ☐ my work ☐ my cell number: _____

If you are unable to reach me:

☐ You may leave a detailed message on my phone

☐ Please leave a message asking me to return your call

I acknowledge and understand the above HIPAA policies and understand I may request a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

Patient/Guardian Signature: _____ Date: _____
Witness Signature (Staff): _____ Date: _____

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Patient Name: _____Date of Birth: _____

Our goal is to provide you and your family with the very best care in a warm, supportive environment. We wish to provide you with information that helps us maintain this goal and through our Patient Policies. These policies manage expectations and assure understandings to develop a long-lasting relationship. We remain available for any questions you may have.

Appointment Cancellations and No Shows

- I understand a late cancellation or missing an appointment keeps other patients from being seen.
- I understand failure to give a 24-hour notice of cancellation for a medical appointment will result in a charge of $50.00; failure to provide a 48-hour notice for a surgical or cosmetic procedure may result in a charge of $100.00 or forfeit of my cosmetic deposit or one treatment in my laser package.
- These charges cannot be billed to my insurance company

Late Arrival for Appointments

- I understand Henning Dermatology Group (HDG) will do its best to accommodate me should I arrive late for an appointment. I understand arriving late means I have forfeited my appointment time and will need to wait to be worked back into the schedule if possible or be placed with another provider who may have availability. I also understand that there may be times when these accommodations are not available, and I will be asked to reschedule my visit.

Co-Payments, Deductibles and Co-Insurance and Balances

- Copayments are due and collected at check in on the day of the appointment. I understand I may be charged a $25.00 administrative billing fee for each co-payment that is not paid at the time of service.
- Insurance deductibles, including Medicare, will be verified prior to your visit. All unmet deductibles will be collected at the time of services.
- Medicare patients without a secondary insurance will be charged their 20% co-insurance at the time of the service.
- All balances are due in full within the 30 days of my first billing.
- Any balance left unpaid after 90 days without attempt at resolution will be considered for collections.
- Should my account be sent to collections, I understand I will be responsible for an additional 15% administrative collection fee plus any attorney/court fees associated with returned check fees plus a $25.00 administrative processing fee. Any returned check must be paid in full via credit card or cash within 15 days of notice or legal efforts to collect a balance will be instituted.

Referrals

- **It is my responsibility to know if my insurance plan requires a referral to see a specialist and it is my responsibility to obtain initial referral track usage, obtain additional referrals as needed, and verify Henning Dermatology Group has these referrals in their office prior to my visit.**

- I understand that should I fail to have a valid referral for my visit, HDG is not authorized to see me. I will either need to reschedule my appointment or pay in full at the time of services for my visit.
- If I decide to see the provider without my referral my insurance will not reimburse me, and I will be considered a self-pay patient for that visit and be responsible for the balance at the time of the service.
- I understand trying to contact the referring office to obtain or inquire about my referral at the time of my office visit with HDG will not allow enough time to maintain my scheduled appointment and doing so will forfeit my scheduled time at HDG.

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Insurance Policies

- I will confirm my insurance is current at each office visit. If there is a change to my insurance, I will provide valid insurance cards and/or a temporary print out at the time of my visit.
- If I am unable to produce this documentation I will either need to reschedule my appointment or pay in full at the time of service for my visit. I will be responsible for submitting my receipts to my insurance company should I wish to be reimbursed for my visit.
- My insurance carrier may consider certain routine services in dermatology to be surgical in nature and separate co-insurances, deductibles or co-payments may apply. Each insurance plan is different, and I understand it is my responsibility to understand my policy and what will be covered.
- I understand that signing below that I am responsible for notifying Henning Dermatology Group of any changes to my insurance or contact information. If insurance or referral information I present at the time of my visit is not correct, I will be responsible for all charges included.

Minor Patients

As a practice specializing in Pediatric and Adolescent Dermatology, we recognize the stress a family may encounter navigating the healthcare of the children under the best of circumstances. We also recognize this may be even more difficult in families where the parents are not tether. We are here to provide treatment and support to you and your children, not to be incombered in the legal issues and responsibilities of the family.

- I understand a legal guardian MUST ACCOMPANY my child under the age of 18 to their initial appointment.
- I understand a legal guardian MUST ACCOMPANY my child under the age of 18 to subsequent appointment's where an additional consent will be required.
- I understand as significant information is needed at the time of the initial visit and treatment plans are created, it is essential for a parent/legal guardian to be present at the initial visit. **Children without a legal guardian at their initial visit will be rescheduled. Forms/Notes from legal guardians with permission to treat is not acceptable.**
- I acknowledge that Grandparents, older siblings, step patents etc. are not considered legal guardians without a court document that must be presented at the time of service.
- I understand that unless documents are provided showing otherwise, both parents are assumed to make appointment and treatment decisions for their child. Disagreements on approach to treatment is between the parents to discuss.
- I understand Payment (Co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. We will collect payment due from the parent who brings the child to the office visit. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- I understand there may be times when I may allow my adolescent child to be unaccompanied for a follow up visit and all payments that are due at the time of the service will be handled by me either prior to the visit.

Insurance Inquiries

- From time to time I may receive a letter from my insurance company requesting information about my coverage.
- I understand that claims will not be paid without me providing this information.
- I will reply to all insurance inquires within 30 days of receipt or may be responsible for the entire balance.

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Cosmetic Deposits

A significant amount of time is reserved for our patient's cosmetic appointments, and therefore a deposit of $200.00 is required for all injectable and laser appointments, payable at the time of scheduling. Aesthetician services require 50% deposit to schedule an appointment. Your deposit will be charged immediately and will be noted as a credit on your account. The deposit will be applied to the total charges on the day of your treatment. Cancellations and/or rescheduled appointment's greater than a 48-hour notice will be refunded or applied to the new appointment in full. Changes made with less than 48 hours may forfeit the deposit in total.

Patient or Legal Guardian Signature: _____

Name of Legal Guardian (please print): _____

Relationship: _____

Date: _____