# MEDICAL HISTORY FORM

Patient Name:_____ Birth Date:_____ Today's Date:_____

**Race:** ☐ American Indian ☐ Asian ☐ Black ☐ Hispanic ☐ White ☐ Other_____

**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic or Latino **Language:**_____

……

**Reason for today's visit:**_____

**Please mark any of the following you have had in the past or currently have**:

☐ Artificial Heart Valve
☐ High Cholesterol
☐ High Blood Pressure
☐ Heart Attack
☐ Angina/Chest Pain
☐ Congestive Heart Failure
☐ Heart Murmur
☐ Mitral Valve Prolapse
☐ Kidney Disease_____
☐ Kidney Stones
☐ Kidney Transplant
☐ Stomach Ulcers
☐ Ulcerative Colitis
☐ Colon Disease _____
☐ Alcohol Use
☐ Tobacco Use
☐ IV Drug Use
☐ HIV Positive
☐ Xray Therapy

☐ Diabetes
☐ Cancer _____
☐ Asthma
☐ Chronic Bronchitis
☐ Emphysema
☐ Other Lung Disease
☐ Exposure to TB
☐ Thyroid Disease
☐ Fainting
☐ Headaches
☐ Stroke
☐ Seizures/Epilepsy
☐ Head Injury
☐ Narcolepsy
☐ Gout
☐ Hiatal Hernia
☐ Liver Disease_____
☐ Hepatitis A / B / C
☐ Allergies

☐ Autoimmune Disease
☐ Lupus
☐ Raynaud's
☐ Arthritis
☐ Back Problems
☐ Muscle Weakness
☐ Osteoarthritis
☐ Osteoporosis
☐ Joint Replacement
☐ Lyme Disease
☐ Eye Condition _____
☐ Anemia
☐ Reaction to Local Anesthetic ☐ Abnormal Skin Healing
☐ Reactions to Substances applied to the Skin
☐ Pre-medication requirements ☐ Abnormal Bleeding
☐ Currently Pregnant / Breast Feeding
☐ **Cosmetic Surgery:**_____
☐ **Botox / Filler:**_____
☐ **Other Cosmetic Services:**_____

☐ ADHD
☐ Anxiety / Depression
☐ Bipolar
☐ Psychiatric Illness
☐ Dysplastic Nevus
☐ Skin Cancer _____
☐ Scleroderma
☐ Sarcoidosis
☐ Sjogrens
☐ Blood Transfusions
☐ Taking Blood Thinners
☐ Bleeding/Clotting Disorder

**Please list any operations and serious illnesses not listed above:**_____

_____

**Family history of skin cancer?** Yes_____ No_____ Type:_____ Relation:_____

**Medication or substance allergy:**_____

**Current medications:** 1. _____2. _____ 3. _____
*List attached* ☐

**Name of family physician or pediatrician:**_____

**Pharmacy Name:**_____ **Pharmacy Location:**_____ Mail away ***RX***: ☐ Yes ☐ No

*What preventative skin care are you using?* ……

**Signature of patient and/or guardian**:_____ Date:_____

Signature of assistant:_____Date:_____ Reviewed by:_____

# Acknowledgement of Notice of Privacy Practices (HIPAA)

Dr. Wendy L. McFalda, Dr. Brian Kopitzki, Dr. Brett Bender, Dr. Michelle Dawson and associates, in an effort to comply with HIPAA, has a Notice of Privacy Practices available to all patients in the reception area and with the receptionist.

**Patient Consent for Use and Disclosure of Protected Health Information**

With my consent, Dr. Wendy L. McFalda, Dr. Brian Kopitzki, Dr. Brett Bender, Dr. Michelle Dawson and associates, may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to the Clarkston Dermatology & Vein Center's 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 the consent. Dr. Wendy L. McFalda, Dr. Brian Kopitzki, Dr. Brett Bender, Dr. Michelle Dawson and associates, reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by forwarding a written request to:

Wendy L. McFalda, D.O.
5701 Bow Pointe Dr., Suite 215
Clarkston, MI 48346

With my consent, Dr. Wendy L. McFalda, Dr. Brian Kopitzki, Dr. Brett Bender, Dr. Michelle Dawson, associates and staff, send a text message, email or may call my home or other designated location and/or leave a message in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items or any call pertaining to my clinical care.

With my consent, Dr. Wendy L. McFalda, Dr. Brian Kopitzki, Dr. Brett Bender, Dr. Michelle Dawson, associates and staff, 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.

With my consent, Dr. Wendy L. McFalda, Dr. Brian Kopitzki, Dr. Brett Bender, Dr. Michelle Dawson, associates and staff, may e-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. I have the right to request that Dr. Wendy L. McFalda restrict how it uses or discloses my Protected Health Information to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dr. Wendy L. McFalda, and Dr. Brian Kopitzki, Dr. Brett Bender, Dr. Michelle Dawson and associates, use and disclosure any of my Protected Health Information to carry out TPO.

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, Dr. Wendy L. McFalda, and Dr. Brian Kopitzki, Dr. Brett Bender Dr. Michelle Dawson, and associates, may decline to provide treatment to me.

I have read the above authorizations, acknowledgements, and policies. I understand them and agree to this as outlined.

**Signature of Patient or Guardian**_____

Patient's Name (print) _____

Guardian's Name (print) _____

Relationship to Patient _____

Date_____ Witness_____

# PATIENT INFORMATION

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change ☐ Yearly Update

**Name** _____

**Date of Birth:** ____/____/____ **Sex:** ☐ Male ☐ Female **Social Security Number:** ____/_____/_____

**Mailing Address:** _____
*City* *State* *Zip*

**Please check preferred daytime phone #** ☐ Home Phone: ( )_____

☐ Cell Phone: ( )_____ ☐ Work Phone: ( )_____

**Are you currently working:** ☐ Yes ☐ No **Employer:** _____ **Occupation:** _____

**How did you learn about our office:** ☐ Google ☐ Flyer ☐ Radio ☐ Internet Website _____

☐ Physician Referral _____ ☐ Friend _____ ☐ Other _____

……

**INSURANCE CARRIER INFORMATION:** Please complete *responsible party* if you are **not** the policy holder

Primary Insurance Carrier: _____

Secondary Insurance Carrier: _____

**RESPONSIBLE PARTY -** ☐ PARENT ☐ SPOUSE ☐ GUARDIAN ☐ DOMESTIC PARTNER

***(Payment Policy -** The Adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.)*

**Name:** _____**Date of Birth:** ____/____/____

*Address same as home address: ☐*

**Address:**_____
City State Zip

**Home Phone:** ( )_____ **Work Phone:** ( )_____

**Employer:** _____

***Emergency Contact Name / Phone #:***_____

**Do you give our office permission to discuss your medical information with family Members?** ☐ Yes ☐ No

Name: _____ Relationship: _____ Phone: ( )_____

……

**PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE**

I, the patient listed above, authorize and agree to the terms stated in the Authorization and Agreement for Medical Treatment Policy, provided by Clarkston Dermatology & Vein Center. I acknowledge all patient responsibilities and have reviewed these terms. Only services that are considered medically necessary will be billed to my current health insurance. It is my responsibility to keep this office informed of any changes to my health insurance coverage, and to obtain a referral for all medical services, if applicable. I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Date: ____/____/____ Signature: _____

# Patient Financial Responsibilities

We are committed to meeting your healthcare needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost effective manner, we ask that you adhere to the following guidelines. The following is a statement of our financial policy, which we request you read and sign prior to your treatment. Due to the ongoing changes in healthcare, Clarkston Dermatology ("the office") may make periodic updates or modifications to our financial policy. In the event there are changes to the financial policy, we will require each patient to have an updated, signed copy in their chart.

1. I agree to furnish the office with a copy of my current health insurance card(s) I also agree to provide an explanation of benefits and/or claim form(s) from my insurance company, when applicable.
2. I authorize the release of medical information necessary to process my insurance claim and I assign insurance benefits to the office for services provided to me.
3. I understand that co-pays are due at the time of service, as required by my insurance company. If the co-pay, or quote is not paid at the time of service, I will be assessed a $25 late fee. Co-payments, co-insurance, and deductibles are a contract responsibility between me and my insurance plan. Unfortunately, the office is unable to negotiate or reduce these amounts. We accept cash, check, debit and credit cards (Visa, MasterCard, American Express, Discover, and Care Credit). If you are not able to pay in full at the time of service, payment arrangements can be made prior to seeing the doctor.
4. I agree that I will be responsible for balances applied to my account that are not covered by my health insurance plan.
5. HMO patients are responsible for obtaining the required referral/note prior to their office visit. Failure to provide a referral/note when necessary may result in your appointment being canceled or rescheduled, or payment will be expected prior to seeing the physician.
6. I understand that the office will bill my health insurance company and will refund any overpayment on my account to the appropriate party (i.e., insurance company, patient). The office will submit claims to my insurance company as a service. My insurance carrier will not be billed unless I provide the necessary documentation. The office will only accept assignment of benefits for insurance plans which they participate with. *Please check with your carrier for coverage limitations, it is very important that you understand the provisions of your policy. If the correct insurance information is not provided to us in a timely manner, the entire balance will become the patients' responsibility.
7. I understand that the office will consider any patient who is uninsured, or who is electing not to utilize their insurance benefits, as self-pay. *With our self-pay patients, we still follow insurance guidelines for our billing and coding to ensure we are consistent in our billing practices. Charges for these services must be paid in full at the time of service.
8. Responsibility for payment for services rendered to the child(ren) of divorced or separated parents rests with the parent who seeks treatment. Any court ordered judgment must be between the individuals involved without including our facility. The office will not send duplicate statements.
9. I will receive a statement/explanation of benefits (EOB) from my insurance carrier, as well as from the office, outlining my financial responsibility. If the balance remains unpaid after statement(s) from the office, I understand I will receive a final notice before my account becomes delinquent. *We reserve the right to refer delinquent accounts to a collection agency that reports to credit bureaus. Each account turned over to a collection agency will assess a fee equal to 25% of the unpaid balance on the account.
10. I understand that my account will be charged $35 when a check I presented for payment is returned and marked "non-sufficient funds" (NSF). Returned checks over $500 will be assessed a fee of 5% of the amount of the check.
11. I understand that allows 30 days for the processing of my claim by the insurance company. In the event the office does not receive reimbursement within 45 days, they will contact my insurance company regarding the claim; I will be notified if they do not receive a response.
12. I will notify an Insurance Specialist at the practice if I am aware of a payment delay by my insurance company. It is my understanding the Insurance Specialists at the practice will provide me with assistance in resolving the claim.
13. For your safety we have hand selected the following facilities based on the expertise of their dermatopathologist for the reading of your skin specimens; Pinkus, Botsford, St. Joes and Miraca. Be advised that any laboratory charges are completely separate from our office charges. For skin cultures our office only sends specimens to quest diagnostics.
14. I understand if I fail to show up for my appointments without canceling with a call to the office 24 hours in advance;
    - I will be charged a $35 fee for a medical visit.

15. I understand if I fail to show up for my appointments without canceling with a call to the office 48 hours in advance,
    - I will be charged a $250 fee for a surgical or Mohs Surgery visit.
    - I will be charged a $250 fee (or forfeiture of deposit) for Active FX / Cellfina / Coolsculpting / Filler /Genius / Pico/ PRP/ UltraShape / Ylift
    - I will be charged a $100 fee for any other cosmetic service appointment
16. If I plan to pay privately for services, I understand that it is the policy of Clarkston Dermatology to collect payment in full at the time of service. If I am unable to make payment in full at the time of service, my appointment will be rescheduled to a more convenient time, or payment arrangements can be established.
17. Form Fees: Forms and letters requested by our patients will be assessed a fee as listed below. This list is not meant to be all inclusive but is merely representative of the items that may incur a charge. This fee covers our administrative expenses related to physician/staff time, photocopying, mailing, etc.
    a. Work Excuses - $15 each
    b. Disability forms - $20 each
    c. Letters of Medical Necessity - $30 each
    d. Family Medical Leave Act Forms - $15 one page, $25 two pages, $35 three pages, $50 4+ pages
    e. Medical Records -1-35 pages = $0.75 per page; more than 35 pages = $.20 plus postage
18. Indeterminate coverage procedures or procedures in which a predetermination is not possible will be reviewed prior to surgery. The patient will be required to sign an appropriate ABN.
19. Due to the specialized nature of our practice we provide some cosmetic services that are not covered by insurance carriers. It is fraud to bill for services that are cosmetic in nature. Clarkston Dermatology will not support or reimburse for services considered cosmetic preoperatively and subsequently submitted by the patient to their insurance carrier. Any undetermined coverage will be discussed prior to the procedure by your provider or his/her representative. Clarification received in writing prior to the procedure is possible. The cosmetic price quote is considered a contract of what services are cosmetic. The staff will review these additional fees and all patients will be required to sign a waiver prior to receiving these additional services. These services must be paid for in full at the time of service.

## Consent for Examination and Treatment

I understand that medical treatment may be necessary for the patient by Dr. Wendy L. McFalda, Dr. Brian A. Kopitzki, Dr. Brett B. Bender, Dr. Michelle Dawson and their assistants and/or associates. I understand the examination procedures will be explained to me and I shall consent to the partial or complete examination. I understand that the examination results will be provided to me with recommendations. The responsibility for any follow-up examination to check abnormalities found and treated, lies with me and not Dr. Wendy L. McFalda, Dr. Brian A. Kopitzki, Dr. Brett B. Bender, Dr. Michelle Dawson and their assistants and/or associates. No guarantee or assurance has been given by anyone as to the results that may be obtained by such treatments. I hereby release my examiner from all responsibility in connection with the examination. For patients less than 18 years old, a parent or legal guardian must accompany them to the initial visit, and must sign our parental consent form, giving Dr. McFalda, Dr. Brian A. Kopitzki, Dr. Brett B. Bender, Dr. Michelle Dawson and their assistants and/or associates permission for continuing ongoing medical treatment if a parent or legal guardian will not be present. The adult accompanying a minor will be held responsible for the payment of any services that are rendered.

*I have read, understand, and agree to the insurance assignment and Financial Policies & Consent for Examination and Treatment stated above. I also agree that I have had the opportunity to discuss any questions or concerns regarding the above with the Insurance Specialists or Provider at the practice.*

**Your signature below acknowledges that you have read and have a full understanding of Clarkston Dermatology's Patient Financial Responsibilities and Consent for Examination and Treatment.**

Signature:_____ Date:_____

Print Patient Name:_____ Patient Date of Birth: _____

## How would you like to be reminded of your appointments and notifications?

*Select all that apply. Please clearly print email information.*
*You will be reminded 48 hours in advance.*

☐ **EMAIL:** _____@_____
The email address provided will be used for patient education newsletters, recare and special appointment reminders.

☐ **TEXT ONLY:** (  ) _____---_____

☐ **HOME PHONE:** (  ) _____---_____
***Please note if you use your mobile phone in place of a land-line our system will recognize this and will automatically send a text message.

Please check all you grant permission for:
☐ **Test results** ☐ **Prescription details** ☐ **Insurance Information** ☐ **Reschedule appointment**
☐ **Post care question & Answer** ☐ ***All the above***

Would you like to receive email information about in-office Special Offers & Events: ☐ Yes ☐ No
(Terms of Clarkston Dermatology "E-MAIL USAGE" are available upon request.)

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## MISSED APPOINTMENT AND CANCELLATION POLICY

As a courtesy to our patients, the office staff confirms appointments up to 48 hours in advance. In today's hectic world unplanned circumstances arise for all of us. We recognize this fact, but we respectfully request that you cancel your scheduled appointment with a minimum of 24 hours for regular office visits, and 48 hours for surgical and cosmetic visits. It allows us to schedule more efficiently and reduce wait times.

*I understand if I do not cancel by the deadline, I will be assessed a:*

- $35 fee for a missed office visit appointment
- $250 fee for a surgical or Mohs surgery missed appointment
- $250 fee for an Active FX / Cellfina / Coolsculpting / Filler / Infini / Spectra / UltraShape / Ylift missed appointment, or forfeiture of deposit
- $100 fee for any other cosmetic service appointment

These fees are not covered by insurance carriers or Medicare and will be your responsibility to pay at the time of your next visit. Our aim here is to open otherwise unused appointments and keep a timely schedule for our patients, not to collect missed appointment fees. Please note, more than 3 appointments missed within a 12 month period may be cause for dismissal from the practice. Your cooperation and consideration are appreciated as we institute this policy.

**I have read and agree with the above missed appointment and cancellation policy:**

| _____ | _____ | _____ |
|---|---|---|
| **Signature** | **Patient Name (Print)** | **Date of Birth** |

| _____ | _____ | _____ |
|---|---|---|
| **Date** | **Guardian's Name** | **Relationship to patient** |