DERMATOLOGY PARTNERS OF WNY, LLP
FINANCIAL POLICY

PATIENT NAME: _____ **DATE OF BIRTH:**_____

As a patient of Dermatology Partners of WNY, LLP, I acknowledge that I will assume full financial responsibility for services rendered to me, for any reason, including self-payment, if my health insurance carrier denies or does not cover my claim for these services at time of service.

INSURANCE

I understand that I am responsible to supply current or correct insurance information at time of service. If this information in not correct or not received within 30 days of services rendered, I acknowledge that I have been notified and will assume full responsibility for the service.

CO PAYS/DEDUCTIBLES

I understand that I am responsible to pay all co-payments and deductibles at the time of service. A co-pay or deductible **cannot** be waived at any time by the provider of service or Dermatology Partners of WNY, LLP.

OUTSIDE MEDICAL TESTING

I understand that all laboratory testing will be billed separately and is my responsibility if not covered by insurance.
ie: culture and pathology

APPOINTMENT CANCELLATION POLICY

I understand that there will be a charge for any appointment not changed or cancelled without 24 hours notice.

AGREEMENT TO PAY:

I have read and understand this financial policy and agree to be personally and fully responsible for payment.

X_____ _____
PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

NAME OF RESPONSIBLE PARTY (if not patient):_____

RELATIONSHIP_____ADDRESS:_____
(STREET) (CITY) (ZIP)

AUTHORIZATION FORM (**FOR MEDICARE ONLY**)

_____ _____
NAME OF BENEFICIARY HEALTH INSURANCE CLAIM NUMBER

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I request that payment of authorized Medicare benefits be made either to me or on my behalf to Dermatology Partners of Western New York, LLP for any services furnished me by that provider. I authorize any holder of medical information about me to release to the Health Care Financing administration and its agents any information needed to determine these benefits or the benefits payable for related services.

_____ _____
PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

Last Updated: 8/30/19

DERMATOLOGY PARTNERS OF WNY, LLP
HIPAA CONSENT

PATIENT NAME: _____ **DATE OF BIRTH:**_____
(LAST) (FIRST) (MI)

Primary Care Physician:_____

Additional providers to receive correspondence:_____

There are many instances where we may need to reach you to discuss information, as with appointment reminders or test results. In the event that we cannot reach you via telephone, test results may be sent by mail.

PREFERRED PHONE: (_____)_____ ☐ Cell ☐ Home

Permission to leave detailed medical message? ☐ **YES** ☐ **NO**

ALTERNATIVE PHONE: (_____)_____ ☐ Cell ☐ Home

Permission to leave detailed medical message? ☐ **YES** ☐ **NO**

By law, we may not contact individuals regarding your personal health information without your consent.

May we discuss your medical information with any others? ☐ **YES** ☐ **NO**

If **yes**, please list below:

NAME: _____**PHONE NUMBER:** (_____)_____

RELATIONSHIP TO PATIENT:_____

NAME: _____**PHONE NUMBER:** (_____)_____

RELATIONSHIP TO PATIENT:_____

X_____ _____
PATIENT/RESPONSIBLE PARTY SIGNATURE DATE

_____
RELATIONSHIP TO PATIENT

Last Updated: 8/30/19

Dermatology Partners of WNY, LLP
INTAKE FORM

DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:**_____
(LAST) (FIRST) (MI)

SEX: **M** **F** **Identifies as:** _____ Occupation:_____

Preferred Pharmacy and Location:_____

Past Medical History

Do you now have, or have you ever been diagnosed with the following conditions?

- □ Anxiety
- □ Arthritis
- □ Artificial joint (where on body?) _____
- □ Artificial heart valve, pacemaker, or defibrillator
- □ Asthma
- □ Atrial fibrillation
- □ Autism spectrum disorder
- □ Cancer (type?)_____
- □ COPD
- □ Coronary artery disease
- □ Covid
- □ Depression
- □ Diabetes
- □ Excessive scarring (Keloids)
- □ Kidney disease
- □ Hepatitis
- □ High blood pressure
- □ High cholesterol
- □ HIV/AIDS
- □ Hyperthyroid (high)
- □ Hypothyroid (low)
- □ Lupus
- □ Organ transplant (what organ?) _____
- □ Radiation or chemo treatment
- □ Seizures
- □ Stroke

Other medical problems not listed above: _____

_____

List any major surgeries:_____

Skin Disease History

Have you ever had skin cancer? ☐Yes ☐No ☐Not Sure

If yes, check what type(s):

☐Basal Cell ☐Squamous Cell ☐Melanoma ☐Not Sure ☐Other

Where on body?_____ When?_____

Do any of your blood relatives have melanoma? ☐Yes ☐No

Relationship:_____

Do you use sunscreen? ☐Yes ☐No Have you used a tanning bed? ☐Yes ☐No

(PLEASE SEE OPPOSITE SIDE)

DATE: _____

PATIENT NAME: _____ **DATE OF BIRTH:**_____
(LAST) (FIRST) (MI)

If None- ☐ **List any current medications (including aspirin and over the counter medications):**

If None- ☐ **List any medication allergies:**_____

Are you allergic to latex? ☐Yes ☐No

Did you get a flu shot during the most recent flu season, or do you plan to? ☐Yes ☐No ☐Not sure

(Over age 50) Have you had the shingles vaccine? ☐Yes ☐No ☐Not sure

(Over age 65) Have you had the pneumococcal vaccine? ☐Yes ☐No ☐Not sure

Do you have any problems with your immune system? ☐Yes ☐No

Have you ever had a bad reaction to local anesthesia? ☐Yes ☐No

Do you get a rapid heartbeat with epinephrine? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No

Do you smoke? ☐Yes ☐Quit ☐No ☐Child/not applicable

Females only

Are you pregnant or planning pregnancy? ☐Yes ☐No If pregnant, due date: _____

Are you breastfeeding? ☐Yes ☐No