TRUE DERMATOLOGY
Skin Cancer Surgery & Cosmetic Specialists

615 1st Street North, Alabaster
1320 Woodfin Lane, Clanton
Phone: (205) 624-2100
Fax: (205) 624-2104
www.truedermatology.com

WELCOME TO TRUE DERMATOLOGY. PLEASE FILL OUT ALL PERTINENT SECTIONS AND SIGN WHERE INDICATED.

			TODAY'S DATE: / /	
Last Name:			Home Phone#: Check Preferred Contact Number	
First Name:	M. I.		Work Phone#: Ext:	
Street Address:	Apt#		Cell Phone#:	
Street Address 2:			Date of Birth:	
Zip Code:			Social Security #:	
City:	State:	Sex (M/F):	Marital Status: Single Married Other	
Employed: Employed Full-time student Part-time student			E-Mail Address:	
EMERGENCY CONTACT				
Name:			In addition to the emergency contact listed, I give permission for my medical information to be released to the following individuals as well:	
Phone #:			Name:	
Do you give our office permission to discuss your medical information with the person listed above? Y E S N O			Name:	
REFERRING DOCTOR			**PRIMARY CARE PHYSICIAN (If different than referring doctor)**	
Last Name:	First Name:		Last Name:	First Name:
Address:	Phone#:		Address:	Phone#:
City:	State:	Zip:	City:	State: Zip:
PRIMARY INSURANCE INFORMATION				
Insurance Carrier:			Group Name or Number:	
Subscriber ID#:			Copay:	Deductible Amount:
Your relationship to the insured person: **___Self __Husband Wife __Child __Other**				
PRIMARY INSURED PARTY: If the insured party is different from the patient, you must complete all information in the section below.				
First Name:	Last Name:		M. I.	Sex: ( )Male ( )Female
Address:	City:	State:	Zip:	Phone#::
Date-of-Birth:			Insured's Social Security Number:	
SECONDARY INSURANCE INFORMATION				
Insurance Carrier:			Group Name or Number:	
Subscriber ID#:			Copay:	Deductible Amount:
Your relationship to the insured person: **___Self __Husband Wife __Child __Other**				
SECONDARY INSURED PARTY: If the insured party is different from the patient, you must complete all information in the section below.				
First Name:	Last Name:		M. I.	Sex: ( )Male ( )Female
Address:	City:	State:	Zip:	Phone#::
Date-of-Birth:			Insured's Social Security Number:	

PATIENT'S NAME (LAST, FIRST):_____

REASON FOR TODAY'S VISIT:_____ DATE:_____

Past Medical History: (please circle all that apply)

Anxiety	Depression	Thyroid Problems
Arthritis	Diabetes	Leukemia
Asthma	End Stage Renal Disease	Lung Cancer
Atrial fibrillation	GERD	Lymphoma
Bone Marrow Transplantation	Hearing Loss	Prostate Cancer
Breast Cancer	Hepatitis	Radiation Treatment
Colon Cancer	High Blood Pressure	Seizures
COPD	HIV/AIDS	Stroke
Coronary Artery Disease	High Cholesterol	NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed	Joint Replacement within last 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy: IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	NONE

Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

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

PATIENT'S NAME (LAST, FIRST):

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:	Alcohol Use:
Currently Smokes	None
Has smoked in the past	Less than 1 drink per day
Never smoked	1-2 drinks per day
Former Smoker	3 or more drinks per day

Family Medical History: (Only first degree relatives)

_____
_____
_____
_____

Cosmetic Dermatology:

Are you interested in discussing any treatments to address fine lines and wrinkles, facial volume loss or any other cosmetic concerns?

Yes ____ No ____

Preferred Language: _____

Race: _____ **Ethnic Group:** _____

Preferred Pharmacy Name: _____

Phone#: _____

City or Zip Code: _____

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TRUE DERMATOLOGY FINANCIAL POLICIES - PLEASE SIGN WHERE INDICATED BELOW

Thank you for choosing True Dermatology, LLC. for your skin care needs. In order to minimize any misunderstanding or confusion between our patients and this practice, we have adopted the following financial policies.

GENERAL
Your insurance policy is a contract between you and your insurance company only. If you fail to notify our practice of any insurance change(s), you are fully responsible for any amount not paid by your insurance company. Each health plan varies with regard to deductibles, co-payments and co-insurance. Terms are contracted between the insurance company and the patient at the time you accept the insurance. It is your responsibility to be aware of your deductibles, co-payments and co-insurance, and it will be your obligation to remit all appropriate payments as outlined in your insurance policy. These policy requirements do not allow our practice to absorb any co-payments, co-insurance or deductibles.

COMMERCIAL INSURANCE
If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a current/valid driver's license. *All co-payments are **due on the day of visit***. If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provide all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. *You will be responsible for all deductibles, co-insurance, co-payments and any services denied by your insurance carrier as not medically necessary and/or not covered.*

MEDICARE
Our physician is a participating Medicare provider and accepts Medicare assignment as of 8/1/16, which is the allowable charge**,** approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy, we will submit any remaining balance to that particular carrier. *You will be responsible for all deductibles, co-insurance, co-payments and any services denied by your insurance carrier as not medically necessary and/or not covered.*

LABORATORY
Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken (biopsy or culture) during your visit. You may receive a second bill from the institution processing and analyzing that specimen.

SELF-PAY PATIENTS
For patients with no insurance, the guarantor is responsible for the charges incurred prior to any service(s) being rendered.

COSMETIC PATIENTS
Cosmetic procedures are elective and will not be submitted to your insurance company. Payment in full is due prior to any service(s) being rendered.

MINOR PATIENTS
For all services rendered to minor patients, we will hold the parent or guardian accompanying the minor responsible for expenses incurred during the visit. A parent or guardian must accompany minor patients at all visits.

PAYMENTS
Payments can be made by cash, check, debit card, VISA, American Express, Discover or MasterCard. Patient balances are due immediately upon receipt of statement. There will be an additional minimum $15.00 re-billing charge on any outstanding balance if payment is not received within thirty (30) days unless previous arrangements have been made in advance with our Billing Department.

COLLECTIONS
In the event that any action is brought to collection, I agree to pay any reasonable collection costs and/or attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services rendered at True Dermatology, LLC.

BENEFITS ASSIGNMENT
I hereby authorize the assignment of benefits (payments) directly to True Dermatology, LLC./Raj Patel, M.D. for all my insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-payments, deductibles and non-covered services are due in full at the time of service.

RELEASE OF RECORDS
I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

I have read the Financial Policies, Benefit Assignment and Release of Records statement and fully understand all of the information above. I understand that there is no guarantee or assurance as to the results that may be obtained from any treatment. I understand the terms and conditions outlined herein as confirmed by my signature below.

Printed Name *(First, Middle, Last)*: _____

Signature: _____ Date: ____/____/____

Relationship to Patient: _____

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PLEASE SIGN WHERE INDICATED BELOW.

Please read the following statement carefully and sign below

All of the information that I have provided on this form is true and complete. The signature below will also be used as a "signature on file" for insurance purposes including any medical information necessary to process relevant claims. I hereby assign my insurance benefits to be paid directly to True Dermatology, LLC. I am aware it is my responsibility to obtain a referral if one is required by my insurance. I authorize the release of medical information necessary to process claims to insurance companies or their agencies (including Medicare) for the purpose of filing and payment of medical claims. I certify that the insurance information I have provided above is accurate and that the coverage I have listed above is currently active and not expired. I give my permission for photographs to be taken for diagnostic purposes and to enhance medical records, and I agree that these photographs may be used for medical, scientific, educational or marketing purposes provided that they do not include any information or content that could reveal my identity. (Please cross out the previous sentence if not desired.) I hereby authorize Raj Patel M.D., and the staff at True Dermatology, LLC. to administer any treatment or to administer such anesthetics and to perform such procedures as may be deemed necessary or advisable for my diagnosis and treatment. I have read the True Dermatology, LLC. Financial Policy Statement along with the credit card policy and agree that I am ultimately responsible for all non-covered services.

Printed Name (First, Middle, Last): _____

Signature: _____ Date: ____/____/____

For Medicare Patients: I hereby authorize payment of medical benefits to True Dermatology, LLC.

Printed Name (First, Middle, Last): _____

Signature: _____ Date: ____/____/____

TRUE DERMATOLOGY ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge that this Medical Practice has given you a copy of its Notice of Privacy Practices. This notice explains how your health information will be handled. HIPAA, the new Federal law concerning medical privacy, requires this notice.

I have received a copy of the Notice of Privacy Practices. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Printed Name *(First, Middle, Last)*: _____

Signature: _____ Date: ____/____/____

Relationship to Patient: _____

You may discuss my medical condition with: _____

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- ☐ **The patient refused to sign.**
- ☐ **Due to an emergency situation it was not possible to obtain an acknowledgement.**
- ☐ **We weren't able to communicate with the patient.**
- ☐ **Other (Please provide specific details)**

_____

_____

Staff Signature _____ Date_____