PATIENT INTAKE FORM (to be completed by patient)

The information in your medical record is confidential and is protected under Indiana Public Law 104-191. Your written consent will be requested for release of information except in the case of a court order.

Last Name:______________________ First Name:______________________ Middle Initial: ______

Legal Sex* (check one) ☐ Female ☐ Male Preferred Name: ______________________

While Randall Dermatology recognizes a number of genders/sexes, many insurance companies and legal entities unfortunately do not. Please be aware that the name and sex you have listed on your insurance must be used on documents pertaining to insurance, billing and correspondence. If your preferred name and pronouns are different from these please let us know.

Address: ____

City:______________________ State:______________________ Zip Code:______________________

Home Phone:______________________ Cell Phone:______________________ Work Phone:______________________

E-mail address:______________________________

By providing my email address, I authorize your office to contact me via the email address(es) provided.

Preferred Contact Method (check one) ☐ Primary Phone ☐ Cell Phone ☐ Home Email ☐ Work Email

Date of Birth _____/_____/_____ Age __________ Social Security #:______________________

1) Employment Status	**2) Racial Group(s)** (check all that apply)	**3) Ethnicity**	**5) Preferred Language** (Choose one)	**6)Do you have one of the following?**
☐ Employed full time ☐ Employed part time ☐ Student full time ☐ Student part time ☐ Retired ☐ Unemployed ☐ Other __________	☐ African American/Black ☐ Asian ☐ Caucasian/White ☐ Native American/Alaskan Native/Inuit ☐ Pacific Islander ☐ Other __________	☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Chose not to specify **4) Country of Birth** ☐ USA ☐ Other __________	☐ English ☐ Spanish ☐ American Sign Language ☐ I choose not to specify ☐ Other __________	☐ CAD ☐ COPD ☐ Diabetes ☐ HF
7) Martial Status (Choose one) ☐ Married ☐ Partnered ☐ Single ☐ Divorced ☐ Other __________	**8) What is your gender?** ☐ Female ☐ Male ☐ Genderqueer or not Exclusively male or female	**9) Do you identify as transgender or transsexual?** ☐ Yes ☐ No ☐ Other	**10) Do you think of yourself as:** ☐ Lesbian, gay or Homosexual ☐ Straight or heterosexual ☐ Bisexual ☐ Something else ☐ Don't know	
11) Smoking Status ☐ Never been a smoker ☐ Former Smoker ☐ Current sometimes smoker ☐ Current every day smoker	**12) Alcohol Use** ☐ Never drink ☐ Former drinker ☐ Current Social drinker ☐ Current drink every day	**13) Have you had a Flu Vaccine this year?** ☐ Yes ☐ No	**14) Have you had a Pneumonia Vaccine?** ☐ Yes ☐ No ***These questions are included to comply with required Federal Health guidelines. This information is for demographic purposes only and will not affect your care.**	

Current medications, including frequency and dosage if known. **If there are no current medications, check here:** ☐

Medication	Frequency	Dosage	Reason
__________	__________	__________	__________
__________	__________	__________	__________
__________	__________	__________	__________

Please list your preferred pharmacy:

Name: ______________________ Phone: ______________________

List any known allergies you have had to any medications. **If there are no know medications allergies, check here** ☐

1)______________________ 3)______________________ 5)______________________

2)______________________ 4)______________________ 6)______________________

Patient Intake Form Continued.....

Reason for TODAY'S visit ______________________________

Have you used any prescription creams or topical preparations within the last month? If yes please list them.

____

Have you used any home remedy or over-the counter preparations used within the last two months? Please list them.

____

Have you taken the following within the last year? Cortisone (circle one) Yes/No Oral Contraceptives (circle one) Yes/No

Please list all past surgeries ______________________________

Have you had any problems in the past with anesthetics? Yes / NO If yes please comment ______________________________

____

Please list any medical conditions of family members (father, mother, brothers, sisters) may have/had ______________________________

____

Please list Primary Care Doctor:

Physician Name: ______________________________

Phone number: ______________________________

If referred by Physician please provide:

Physician Name: ______________________________

Phone number: ______________________________ Fax number: ______________________________

Office address : ______________________________

Guarantor Information – If other than patient

Guarantor Name ______________________________ DOB ______________

Sex (circle one) Male Female Social Security # ______________________________

Home Address ______________________________

City ______________________________ State ______________ Zip ______________

Home Phone ______________________________ Cell Phone ______________________________

Work Phone ______________________________ Relationship to Patient ______________________________

Employer ______________________________

Insurance Information

Primary Insurance Company ______________________________

Policy # ______________________________ Group # ______________________________

Group Name ______________________________

Name of Insured ______________________________ DOB ______________

Last 4 digits of Social Security # ______________ Employer ______________________________

Important! Does your insurance Carrier require a special pathology laboratory to be used (circle) Yes No

If yes – Laboratory Name ______________________________

Important! The PATIENT is responsible for Lab costs if "Laboratory Name" is not completed accurately!

Secondary Insurance Company ______________________________

Policy # ______________________________ Group # ______________________________

Group Name ______________________________

Name of Insured ______________________________ DOB ______________

Last 4 digits of Social Security # ______________ Employer ______________________________

Important! Does your insurance Carrier require a special pathology laboratory to be used (circle) Yes No

If yes – Laboratory Name ______________________________

Important! The PATIENT is responsible for Lab costs if "Laboratory Name" is not completed accurately!

Randall Dermatology's Financial Policy

Thank you for allowing Randall Dermatology to be your healthcare provider. Randall Dermatology is committed to the success of your medical treatment and care. Our practice will work with you to help fulfill your payment responsibility. We will file your primary and secondary medical claims for you. It is important that you provide us with current and accurate insurance information at the time of your appointment. We will scan a copy of your insurance cards at the time of your visit. If you fail to provide insurance information, you will be considered **Self Pay** and will be required to make payment at the time of service. It is important for you to understand that you have the contract with your insurance carrier to expedite the reimbursement process. **As the patient, you are responsible for any unpaid balance not contractually covered by your insurance.** You have final responsibility for payment for services provided.

Privacy Policy: As required by law, Randall Dermatology maintains a privacy policy dedicated to the protection of our patient's medical information.

Medicare: Randall Dermatology is a participating Medicare provider, accepting assignment for Medicare Part B (Physician Services) claims. The patient is financially responsible for their co-insurance, deductibles and any services rendered that are not covered by Medicare.

Medicaid: Randall Dermatology accepts Medicaid patients. Medicaid patients must submit a **valid** identification card at every visit. The patient is responsible for any spend down amount for services provided on dates that are not eligible for coverage. The patient is responsible for any services rendered that are not covered by Medicaid.

Managed Care Plans: In order to see a specialist, some insurance plans require a referral from the Primary Care Physician (PCP) or pre-certification before treatment can be rendered. It is the patient's responsibility to ensure we have this referral or pre-certification **prior** to the visit. If we do not receive the necessary referral or pre-certification, the patient will be responsible for payment, or will need to reschedule their appointment. **All co-pays are due at the time of service.**

Commercial Plans: Randall Dermatology has established fees that are usual and customary this healthcare service area. Every insurance carrier has their own usual and customary fee schedule; however, the patient is responsible for payment regardless of the insurance carrier's arbitrary determination of rates. **All co-pays are due at the time of service.**

Non-Covered Services: Some services we provide may be deemed not medically necessary by your insurance carrier or not a covered benefit by your specific policy, therefore, not paid by your insurance. Many cosmetic procedures we provide are not covered by insurance. The patient is responsible for payment at the time of service for all services not covered by insurance.

Laboratory Services: Some services, such as biopsies or surgery require specimens be sent to a laboratory for processing. The patient may receive a separate bill from this laboratory. **If you or your insurance requires the use of a specific lab for specimens, this needs to be clearly communicated to our staff prior to services being provided.**

Self-Pay: Patient who do not have insurance coverage are considered to be self-pay. Self-pay patients will be extended a 25% discount of gross charges. This must be paid in full at the completion of services being rendered.

Payment Arrangements: Randall Dermatology may consider payment arrangements for those patients who need assistance in meeting their account obligation. Randall Dermatology reserves the right to set the terms and conditions for any payment arrangement.

Credit Cards: Randall Dermatology accepts Visa, MasterCard, Discover, and American Express. Other forms of payment accepted are debit cards, checks, and cash. If a patient has an approved payment arrangement, monthly credit card debits are offered as an option for payment.

Returned Check Policy: Randall Dermatology will charge a thirty-five-dollar ($35.00) fee for each check returned by our bank for non-sufficient funds or other reasons.

Missed Appointment Fees: Randall Dermatology may charge a fee for missed office visit appointments when the patients fails to give appropriate notification. A cancellation notice must be received twenty-four (24) hours in advance of the scheduled appointment. A twenty-five-dollar ($25.00) charge may be applied for failure to meet this requirement. Extenuating circumstances will be reviewed by Business office Manager.

Collection Agencies: Should it become necessary for Randall Dermatology to send a patients account to a collection agency, the patient will be responsible for any and all fess associated with the collection effort of the account, to include reasonable attorney fees, court costs, collection charges and interest.

Business Office Contact: Randall Dermatology's business office can be reached at (765) 463-6722. The fax number is (765) 463-0905. Please do not hesitate to contact the business office whenever you have a question.

Initials: ______________

PATIENT ACKNOWLEDGEMENT and AUTHORIZATIONS:

Authorization for Treatment: With your signature below, Randall Dermatology is hereby authorized to conduct examination, perform procedures as medically required and administer treatment and medication as deemed necessary or advisable.

Authorization for Release of Information: With your signature below, Randall Dermatology, (and/or laboratory provider) is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's workers compensation carrier, other third-party payers, the Social Security Administration under Title XVIII (18) of the Social Security Act, Professional Review Organizations or other intermediaries responsible for payments for services rendered. The release of information consent may be revoked at any time by giving written notice. If release of information is refused, the patient will be held responsible for payment of all charges for services rendered.

Authorization for Assignment of Benefits: In consideration for medical services provided, with your signature below, Randall Dermatology (and/or laboratory provider) is given all rights, title and interest to the medical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefit including Medicare Part B. The patient will be fully responsible for payment of any and all charges not covered by insurance.

Good Faith Estimate Service Cost:

Beginning July 1, 2020, you have the right to request a good faith estimate of your service cost.

Patient Initials: ________________________

I have read the Financial Policy and Authorizations. 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.

____ ____________________

Patient Signature of Responsible Party **Date Signed**

For Internal Office Use Only:

Patient's Printed Name: ________________________________

Account #: ______________________DOB: __________________

Randall Dermatology, PC

CONSENT FOR LIMITED RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: ____

Email: ______________________ Last 4 SSN: __________ DOB: __________

Please check one of the following:

___ Restricted: Randall Dermatology, PC cannot speak to anyone regarding my appointments, prescriptions, or biopsy results.

___ Limited: Randall Dermatology, PC may speak to the person(s) I have listed below in regards to my appointments, prescriptions, or biopsy results, and may leave any messages regarding my care.

Randall Dermatology, PC may release limited information as indicated above to the following person(s):

______________________________ ______________________

Name/Relationship Phone number

______________________________ ______________________

Name/Relationship Phone number

______________________________ ______________________

Signature of patient/Legal Guardian date