MISSISSIPPI DERMATOLOGY ASSOCIATES

## PATIENT INFORMATION

| Patient's Name: First: | Middle Initial: | Last: | Preferred Name: |
|---|---|---|---|
| Mailing Address: | City: | State: | Zip: |
| Home Phone: ( ) | Work Phone: ( ) | Cell Phone: ( ) | OK to receive a text message reminder: Y / N<br>Preferred Phone Number: H / W / C |
| **Preferred Language:** □ English □ Spanish □ Other:____________ | | **Ethnicity:** □ Not Hispanic/Latino □ Hispanic/Latino | |
| **Race:** □ American Indian □ Asian □ African American □ White □ Other: ___________________ | | | **Gender:** □ M □ F |
| Email Address: | Birth Date: | Social Security Number: | Marital Status (circle one):<br>Single / Mar / Div / Sep / Wid |
| Occupation: | Employer: | Employer Address: | |
| Name of Parent or Spouse: | | Date of Birth | |
| Person Responsible for Account: | | Address (if different): | |
| Emergency Contact Name: | | Number: | |
| Other family members seen here: | | Referring Provider: | |

## PRIMARY INSURANCE INFORMATION Please give insurance card(s) to receptionist

| Policy Holder's Name: | Birth Date: | Address (if different): | Social Security Number: |
|---|---|---|---|
| Is this person a patient here:<br>□ Yes □ No | Insurance Company: | Policy Number: | |

## SECONDARY INSURANCE INFORMATION Please give insurance card(s) to receptionist

| Policy Holder's Name: | Birth Date: | Address (if different): | Social Security Number: |
|---|---|---|---|
| Is this person a patient here:<br>□ Yes □ No | Insurance Company: | Policy Number: | |

*I authorize the release of medical information necessary to process a claim on any insurance policy listed. I hereby assign to and authorize payment directly to this Clinic, of all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to the difference or the entire bill if necessary. In the event my account is given to an attorney for collection, I shall pay the reasonable attorney's fee, all court costs, and any expense incurred. Should a judgment be rendered against me, I agree to pay all costs of collection, including the reasonable attorney's fee, all court costs, and expenses incurred.*

______________________________ ______________________________

**SIGNATURE OF RESPONSIBLE PARTY** **DATE**

1006 Treetops Boulevard, Suite 101
Flowood, MS 39232

601-939-0005
Fax - 601-936-4949

MISSISSIPPI DERMATOLOGY ASSOCIATES

**AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION:**

I authorize the office of Mississippi Dermatology Associates to release any information regarding my account, insurance information, laboratory results, and medical reports to the following person(s):

______________________________________________ ____________________

Name of person (other than self) authorized to receive information — For security, please list the
Example: father, mother, spouse, child, etc. — authorized person's date of birth

*If the patient is a minor, the guardian must sign on behalf of the patient and is allowed to receive any information regarding the patient without any other authorization needed. This authorization may be revoked in writing by the patient or personal representative.*

May we leave a message on your home answering machine or cell phone? ☐ Yes ☐ No
May we leave a message for you at work? ☐ Yes ☐ No
May we send notices of information about the practice, such as appointment reminders, to your home? ☐ Yes ☐ No
May we use limited data for research, public health, and healthcare operation purposes, should this ever be requested? This data would only include the following identifiable information: admission, discharge, and service dates, date of death, age (including 90 or over), and five-digit zip code. We would not use name, social security number, address, phone number, etc. ☐ Yes ☐ No

______________________________________ ____________________

**SIGNATURE OF RESPONSIBLE PARTY** **DATE**

**AUTHORIZATION FOR SENDING SPECIMEN(S) TO OUTSIDE LABS:**

Many tests performed in our office require specimens to be sent to an outside (reference) lab for further assessment. These tests include certain biopsies and special blood tests. Your insurance may or may not pay for these tests. Your signature below reflects your understanding that if your insurance does not pay in full, you will be billed for the balance from our office and/or the outside (reference) lab(s) that performs these additional tests. Also by signing below you are authorizing Mississippi Dermatology Associates, PLLC. to release your medical and demographic information to these outside (reference) labs. This information will be used by these entities to file your insurance for the services they perform.

______________________________________ ____________________

**SIGNATURE OF RESPONSIBLE PARTY** **DATE**

**NOTICE TO PARENTS: Parent or Legal Guardian must accompany patient to their initial visit.**

Parents often find it difficult to accompany their minor children (under 18 years of age) to routine follow up appointments. This form has been created to give you the opportunity to authorize treatment for your minor child in your absence.

**Authorization for Treatment of a Minor**

I authorize providers at Mississippi Dermatology Associates to render treatment to my minor child without my presence in the office.

____________________ ________________________ ____________

PATIENT NAME SIGNATURE OF PARENT OR GUARDIAN DATE

MISSISSIPPI DERMATOLOGY ASSOCIATES

**Patient Name:** ____________________________________________________________

**PHARMACY:**________________ **CITY:**_________________ **LOCATION:**_________________

## Review of Systems:

| Problem | Y | N | Problem | Y | N | Problem | Y | N |
|---|---|---|---|---|---|---|---|---|
| Problems with Bleeding | | | Abdominal Pain | | | Allergy to Adhesive | | |
| Problems with Healing | | | Joint Aches | | | Allergy to Lidocaine | | |
| Problems with Scarring | | | Muscle Weakness | | | Allergy to Antibiotic Ointments | | |
| Rash | | | Headaches | | | Artificial Heart Valve | | |
| Immunosuppression | | | Seizures | | | Artificial Joints in the last two years | | |
| Hay Fever | | | Cough | | | Blood Thinners (Including Aspirin) | | |
| Chest Pain | | | Shortness of Breath | | | Defibrillator | | |
| Fever or Chills | | | Wheezing | | | MRSA | | |
| Night Sweats | | | Anxiety | | | Pacemaker | | |
| Unintentional Weight Loss | | | Depression | | | Premedication Prior to Procedures | | |
| Thyroid Problems | | | | | | Rapid Heartbeat with Epinephrine | | |
| Sore Throat | | | | | | Pregnant or Planning Pregnancy | | |
| Blurry Vision | | | | | | Allergy to Latex | | |

## Have you had in the past, or are you presently having a problem with:

| Condition | Y | N | Condition | Y | N | Condition | Y | N |
|---|---|---|---|---|---|---|---|---|
| Anxiety Disorder | | | Hearing Loss | | | Inflamed Pancreas | | |
| Arthritis | | | HIV/AIDS | | | Blood Clots in Lungs | | |
| Asthma | | | High Cholesterol | | | Bone Marrow Transplant | | |
| Atrial Fibrillation | | | Hyperthyroidism | | | Seizures | | |
| Enlarged Prostate (BPH) | | | Hypothyroidism | | | Chronic Headaches | | |
| COPD/Pulmonary Disease | | | Inflammatory Disease of Liver | | | Gallbladder Disease | | |
| Coronary Artery Disease | | | Leukemia | | | Heart Attack | | |
| Depression | | | Lymphoma | | | Anemia / Bleeding Disorder | | |
| Diabetes | | | Lung Cancer | | | Kidney Problems | | |
| High Blood Pressure | | | Breast Cancer | | | Pacemaker | | |
| End Stage Renal Disease | | | Colon Cancer | | | Sickle Cell Disease | | |
| Epilepsy | | | Prostate Cancer | | | Stroke | | |
| GERD/Reflux | | | Radiation Treatment | | | | | |

**Other medical problem not listed above:** ____________________________________________

**Have you had surgery in the last three years** ☐ Yes ☐ No

If yes, please list:____________________________________________________________

MISSISSIPPI DERMATOLOGY ASSOCIATES

**Skin Disease History:**

| Problem | Y | N | Problem | Y | N | Problem | Y | N |
|---|---|---|---|---|---|---|---|---|
| Acne | ☐ | ☐ | Actinic Keratosis | ☐ | ☐ | Basal Cell Carcinoma | ☐ | ☐ |
| Contact Dermatitis due to Poison Ivy | ☐ | ☐ | Dysplastic Nevus | ☐ | ☐ | Eczema | ☐ | ☐ |
| Malignant Melanoma | ☐ | ☐ | Psoriasis | ☐ | ☐ | Squamous Cell Carcinoma | ☐ | ☐ |

**Please list history of any other skin conditions**: ______________________________

Sunscreen Use ☐ Yes ☐ No If yes, what strength?________________________

Tanning Bed Use ☐ Yes ☐ No If yes, how often?____________________________

**Do you have a family history of:**

☐ Basal Cell ☐ Squamous Cell ☐ Melanoma ☐ None ☐ Unknown

Relationship: ______________________________________________________________

**Medication History:**

**Currently taking Aspirin daily?** ☐ Yes ☐ No **Blood thinner daily?** ☐ Yes ☐ No If yes, list: ________________

**Are you taking any other medications daily?** ☐ Yes ☐ No If yes, please list:

_____________________ _____________________ _____________________ _____________________

_____________________ _____________________ _____________________ _____________________

_____________________ _____________________ _____________________ _____________________

**Allergies:**

**Do you have allergies to any drugs, food, ointments, creams, make-up, Jewelry** ☐ Yes ☐ No

If yes, please list:______________________________________________________________________

**Social History:**

Alcohol Use ☐ Yes ☐ No☐ If yes, how much per day? ______________

Current Smoker ☐ Yes ☐ No If yes, how much per day?_______________

Former Smoker ☐ Yes ☐ No

**For patients 65 and older:**

Have you received a pneumonia vaccination? ☐ Yes ☐ No

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No

Which statement(s) best reflects your wishes on advanced care recommendations?

☐ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

☐ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

## Medical Appointment Cancellation / No Show Policy

Thank you for trusting your skin care to Mississippi Dermatology Associates, PLLC. When you schedule an appointment with one of our providers we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation / No Show Policy below:

- Effective April 1, 2022, any established patient who fails to show, cancel, or reschedule an appointment within **24 hours** of the scheduled appointment date/time will be considered a No Show and charged a **$30.00 fee**.
- A patient may be **dismissed** from Mississippi Dermatology Associates, PLLC practice after a **third** failure to show, cancel or reschedule within 24 hours of the appointment date/time.
- Any **new patient** who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

You may contact our clinic 24 hours a day, 7 days a week at (601) 939-0005. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. We send courtesy appointment reminders via phone call, text, and email for appointments. If you do not receive a reminder call or message, the Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

______________________________ ______________________________
Signature of Patient or Patient Representative **Patient Name**

______________________________ ______________ ______________
Description of Personal Representative Authority Date **Patient Date of Birth**

MISSISSIPPI DERMATOLOGY ASSOCIATES

**HIPAA** Consent for Purposes of Treatment, Payment, and Healthcare Operations:

I consent to the use or disclosure of protected health information by **Mississippi Dermatology Associates, PLLC** for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of **Mississippi Dermatology Associates, PLLC**. I understand that diagnosis or treatment of my by the provider may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. **Mississippi Dermatology Associates, PLLC** is not required to agree to the restrictions that I may request. However, if **Mississippi Dermatology Associates, PLLC** agrees to a restriction that I request, the restriction is binding on **Mississippi Dermatology Associates, PLLC** and the providers.

I have the right to revoke this consent, in writing, at any time, except to the extent that the provider or **Mississippi Dermatology Associates, PLLC** has taken action in reliance on this consent.

My "protected health information" means health information, including demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer, or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review **Mississippi Dermatology Associates, PLLC**'s Notice of Privacy Practices prior to signing this document. Ths **Mississippi Dermatology Associates, PLLC**'s Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills, or in the performance of healthcare operations of **Mississippi Dermatology Associates, PLLC**. The Notice of Privacy Practices also describes my rights and the **Mississippi Dermatology Associates, PLLC**'s duties with respect to my protected health information.

**Mississippi Dermatology Associates, PLLC** reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of the privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

_______________________________________ _______________________________________

Signature of Patient or Personal Representative Name of Patient or Personal Representative

_______________________________________ _______________________________________

Description of Personal Representative Authority Date

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**Office Use Only**

I attempted to obtain the patient's signature of acknowledgement on this HIPAA Consent for Purposes of Treatment, Payment and Healthcare Operations. This form shows acknowledgment of the Notice of Privacy Practices. I was unable to do so as documented below:

Date: ____________ Initials: ________ Reason:__________________________________

1006 Treetops Boulevard, Suite 101
Flowood, MS 39232

601-939-0005
Fax - 601-936-4949