PATIENT INTAKE FORM

(to be completed by patient)

The information in your medical record is confidential and 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:** _____ **MI:** _____ **Preferred Name:** _____ **Suffix (Jr, Sr):** _____

Social Security #: _____ **Date of Birth:** _____ **Age:** _____ **Birth Sex*:** □ Male □ Female

*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.

Marital Status:
□ Married
□ Single
□ Partnered
□ Widowed

Preferred language:
□ English
□ Spanish
□ American Sign Language
□ Other _____

Ethnic group:
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Choose not to specify

Race: (✓ all that apply)
□ African American/Black
□ Asian
□ Caucasian/White
□ Native American/Alaskan Native
□ Pacific Islander
□ Other

Gender identity:
□ Male
□ Female
□ Transgender Male
□ Transgender Female
□ Genderqueer (neither exclusively Male or female)
□ Other
□ Choose not to specify

Sexual Orientation:
□ Lesbian, gay or homosexual
□ Straight or heterosexual
□ Bisexual
□ Something else
□ Don't know
□ Choose not to specify

Preferred Contact Method:
□ Home Phone
□ Cell Phone
□ Work Phone
□ Email

Emergency or Alternate contact: _____ **Phone #:** _____

Patient Home phone: _____ **Cell phone:** _____ **Work phone:** _____ **Ok to leave a detailed message?** □ Yes □ No

Email: _____ **Ok to opt in to email notifications?** □ Yes □ No

Street Address: _____ **City:** _____ **State:** _____ **Zip code:** _____

Employment Status:
□ Employed □ Retired
□ Student Full Time □ Unemployed
□ Student Part Time □ Other

Employer: _____ **Occupation:** _____

Insurance & Guarantor Information Self Pay ☐

Insurance Holder Name: _____ **Date of Birth:** _____ **Phone #:** _____

Guarantor (If other than patient): _____ **Date of Birth:** _____ **Social Security #:** _____

Guarantor Street Address: _____ **City:** _____ **State:** _____ **Zip Code:** _____

Guarantor Phone #: _____ **Relationship to patient:** _____

(over)

PATIENT INTAKE FORM (Cont'd)

Primary Care Provider: **Phone #:** **City:**

_____

Referring Provider (if applicable): **Preferred Pharmacy:** **Location (Street & City):**

_____ _____ _____

How did you hear about us?
□ Provider Recommendation (name) _____
□ Web search
□ Facebook □ Instagram □ Other _____
□ Current Patient/Friend (name) _____
□ Billboard
□ Insurance
□ Other _____

Preferred Lab (for skin/tissue processing):

_____

Current Medical Conditions: □ Heart Failure □ Diabetes □ Coronary Artery Disease (heart stents) □ COPD

_____

Surgeries: _____

Skin Disease History: □ Eczema □ Psoriasis □ Abnormal Moles □ Skin Cancer (type & location) _____

□ Other:_____

Do you use sunscreen? □ Daily □ Most Days □ Only if I will be out in the sun □ Rarely □ Never

Medications □No Current Medications	Dose	How Often	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies □ No Known Allergies	Reaction	Allergy	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you smoke? □ Never □ Formerly □ Occasionally □ Everyday **Have you had a flu vaccine this year?** □ Yes □ No

Do you drink alcohol? □ Never □ Formerly □ Occasionally □ Everyday **Have you had a pneumonia vaccine?** □ Yes □ No

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

Name:_____Relationship: _____ Phone #: _____

Significant family medical history (Mother, Father, Brother, Sister): □ Melanoma □ Non-Melanoma Skin Cancer □ Cancer
□ Psoriasis □ Eczema □ Autoimmune Disease (thyroid, RA, lupus) ***Please explain positives below*** □ Adopted

_____

Current Height:_____ **Weight:** _____

Currently Pregnant or planning a pregnancy? □ Yes □ No □ N/A **Currently Breastfeeding?** □ Yes □ No □ N/A

Any problems with local anesthesia or suture material in the past? □ Yes □ No _____

Reason for today's visit? _____

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.

No Surprises Act of 2022: In accordance with the No Surprises Act of 2022, I understand that it is my responsibility to see participating providers within my plan. Should my plan not be participating with Randall Dermatology, PC or a provider of Randall Dermatology, PC and I receive medical services, I understand that I will be billed the Out of Network patient responsibility or non-participating balances as they pertain to 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. I request that payment of authorized Medicare benefits be made either to me or on my behalf Randall Dermatology, PC for any services furnished to me by their providers. 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. 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.

Credit Card on File Authorization: Randall Dermatology offers a Credit Card on File program as a convenient method of paying for the portion of your services that are patient responsibility such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure. This policy has been implemented to simplify and enhance your patient experience, and to simplify our business operations.

Randall Dermatology's Financial Policy

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.

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 Date

Rev. 3/17/21