Today's Date: _____ *Rev. 004/2023*

YARDLEY DERMATOLOGY ASSOCIATES
PATIENT MEDICAL INFORMATION FORM

Name: _____ DATE OF BIRTH: _____ Age: _____

Reason for today's visit (include location on the body, duration of problem, description of symptoms (painful, itching, bleeding, etc.), and treatments used in the past): _____

_____

Were you referred by a doctor to have specific skin problem(s) evaluated? ☐ Yes ☐ No

Doctor Name: _____

Doctor Address: _____

MEDS/ALL

Medication Allergies: _____

Medications & Supplements: _____

_____

PMH

Present or Past Medical Problems/Major Surgical Procedures (for ex, diabetes, high blood pressure, breast cancer, etc.): _____

_____

Past or Present History of:

Artificial Joint	☐ *Yes*	☐ *No*	*Radiation/X-Ray Treatment*	☐ *Yes*	☐ *No*
Artificial Heart Valve	☐ *Yes*	☐ *No*	*Bone Marrow or Organ Transplant/ Immunosuppression*	☐ *Yes*	☐ *No*
Pacemaker	☐ *Yes*	☐ *No*			
Bleeding Condition	☐ *Yes*	☐ *No*			
Hepatitis/HIV	☐ *Yes*	☐ *No*	Pregnant or Planning Soon?	☐ *Yes*	☐ *No*
Heart Valve Infection	☐ *Yes*	☐ *No*			

ROS

Are you experiencing symptoms or problems related to:

Fever/Unintentional Weight Loss	☐ *Yes*	☐ *No*	*Stomach/Intestines*	☐ *Yes*	☐ *No*
Eyes Ears/Nose	☐ *Yes*	☐ *No*	*Kidney/Bladder*	☐ *Yes*	☐ *No*
Heart	☐ *Yes*	☐ *No*	*Muscles/Bones/Joints*	☐ *Yes*	☐ *No*
Lungs	☐ *Yes*	☐ *No*	*Neurological/Seizures/Headaches*	☐ *Yes*	☐ *No*
Hormones	☐ *Yes*	☐ *No*	*Emotional/Psychiatric Illness*	☐ *Yes*	☐ *No*

SKIN CA

Personal History of Skin Cancer (type, location, & date): _____

Do You Have a History of:

Blistering Sunburn	☐ *Yes*	☐ *No*	*Numerous or Irregular Moles*	☐ *Yes*	☐ *No*
Tanning Bed Use	☐ *Yes*	☐ *No*			

FH

Family History of:

Melanoma	☐ *Yes*	☐ *No*	*Relationship:*	☐ *Parent*	☐ *Sibling*	☐ *Child*
Allergies/Hay Fever/Asthma/Eczema	☐ *Yes*	☐ *No*	*Relationship:*	☐ *Parent*	☐ *Sibling*	☐ *Child*
Psoriasis	☐ *Yes*	☐ *No*	*Relationship:*	☐ *Parent*	☐ *Sibling*	☐ *Child*

SH

Occupation: _____

Do You Have a History of:

Smoking/Tobacco Use	☐ *Yes*	☐ *No*	*Drug Abuse*	☐ *Yes*	☐ *No*
Alcohol Abuse	☐ *Yes*	☐ *No*			

YARDLEY DERMATOLOGY ASSOCIATES
PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

PATIENT DEMOGRAPHICS

Name: _____ Date of Birth: _____ Sex: ☐ M ☐ F

Address: _____City: _____State:____Zip: _____

Cell Phone #: _____ Home Phone #: _____

E-mail: _____ Preferred Contact: ☐ Cell Phone ☐ Home Phone

Marital Status: ☐ Single ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow(er)

Employer/School: _____ Occupation: _____

Emergency Contact: _____Relationship: _____ Phone #: _____

PATIENT COMMUNICATION CONSENT

I authorize Yardley Dermatology Associates to:

- Leave detailed voicemail messages Cell Phone: ☐ Yes ☐ No Home Phone: ☐ Yes ☐ No
- Leave detailed message with individuals answering the phone ☐ Yes ☐ No
- Contact me via email ☐ Yes ☐ No

I authorize Yardley Dermatology Associates to discuss my medical information with the following individual(s):

Emergency Contact listed above: ☐ Yes ☐ No

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

INSURANCE SUBSCRIBER INFORMATION

PRIMARY INSURANCE POLICY HOLDER: ☐ Self ☐ Spouse/Partner ☐ Parent/Legal Guardian

If ANY information below is the same as in PATIENT DEMOGRAPHICS, please write "Same."

Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____City: _____State:____Zip: _____

Phone #: _____ Employer: _____

SECONDARY INSURANCE POLICY HOLDER (IF APPLICABLE): ☐ Self ☐ Spouse/Partner ☐ Parent/Legal Guardian

Name: _____ DOB: _____ Sex: ☐ M ☐ F

Address: _____City: _____State:____Zip: _____

Phone #: _____ Employer: _____

MEDICAL CONTACT INFORMATION

Primary Care Physician: _____ Phone #: _____

Preferred Pharmacy: _____ Phone #: _____

YARDLEY DERMATOLOGY ASSOCIATES
FINANCIAL POLICY

NAME: _____ DATE OF BIRTH: _____ DATE: _____

Thank you for choosing Yardley Dermatology Associates as your health care provider. We are committed to providing you with the best possible health care. The following information is provided to ensure you are aware of and understand our financial policy.

Please ask if you have any questions about our fees and policies and your responsibilities. It is your responsibility to notify our office of any patient information changes (e.g. address, name change, insurance policy, etc).

PLEASE READ CAREFULLY!

COPAYS, CO-INSURANCE, & DEDUCTIBLES
The patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of your appointment. We accept cash, checks, Visa, Mastercard, American Express, and Discover. If you have an insurance deductible or co-insurance, any and all office visit and/or procedure charges will apply towards your deductible, and you will be billed accordingly. If a patient is a minor (18 years of age and below) and is using a parent's insurance benefit, the parent or guardian must sign below. The parent or guardian assumes responsibility for any payment due at the time of service.

If you are unable to pay for necessary medical care, you may be eligible for financial assistance or a payment plan. It is your responsibility to inform us of your financial need **prior** to your visit. Please ask to discuss arrangements with our billing department.

MEDICAL PROCEDURES
Any medical procedures (e.g. liquid nitrogen "freezing" treatment or biopsies) performed in our office are considered separate, billable charges in addition to your office visit charge. If you are scheduled for a cosmetic appointment and have medical services during that appointment, your insurance will be billed for these medical services, and you will be responsible for any copay, co-insurance, or deductibles.

COSMETIC FEES & PAYMENT
Certain procedures and services provided during your medical visit are not covered by most insurance companies. These are considered cosmetic procedures. It is your responsibility to understand that you may have cosmetic fees in addition to your medical visit. These fees are due at the time of service.

INSURANCE CLAIMS
As a courtesy to you, we will submit medical claims to your insurance company. Any balance after processing of the claim by your carrier is your responsibility. Your insurance policy is a contract between you and your insurance company. You are responsible for verifying if providers are in network with your insurance company. In order to properly bill your insurance company we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. It is your responsibility to know your insurance benefits as it may not cover all the services provided to you. **If your insurance requires referrals to specialists, it is your responsibility to obtain that referral PRIOR to your appointment. Failure to obtain a valid referral by your appointment time will require your appointment to be rescheduled.** Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered including, but not limited to, those charges above the usual and customary

allowance. If we are out of network and your insurance pays you directly, you are responsible for payment in full and agree to forward the payment to us immediately.

SELF-PAY ACCOUNTS
Self-pay accounts are patients without insurance coverage or patients covered by insurance plans in which the office does not participate. It is always the patient's responsibility to know if our office is participating with their plan. If there is a discrepancy with our information, the patient will be considered self-pay unless otherwise proven. Self-pay accounts are payable at the time of service.

CANCELLATION OF APPOINTMENTS
Yardley Dermatology Associates requires a 24-hour notice for appointment cancellations so that we can offer the appointment to another patient who needs to be seen. There is a fee of $50 for medical appointments that are missed and/or are not previously cancelled. There is a fee of $100 for cosmetic appointments that are missed and/or are not previously cancelled. This fee must be paid before rescheduling the missed appointment.

RETURNED CHECKS
The charge for returned checks is $30 payable in cash or by credit card. This will be applied to your account in addition to the insufficient funds amount.

OUTSTANDING BALANCE POLICY
A medical practice, like any business, depends on timely payments. It is our policy that all accounts remain current. In the event that a patient balance remains outstanding, and no resolution can be made, your account may be sent to a collection agency and/or you may be discharged from the practice.

ASSIGNMENT OF BENEFITS
I hereby assign all medical and surgical benefits to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance, and any other health/medical plan to issue payment directly to Yardley Dermatology Associates. I understand that I am responsible for any amount not covered by insurance.

LABORATORY FEES
Most laboratory charges, such as blood work, cultures, and pathology tests, ordered through our office are billed directly to your insurance by the laboratory processing the test. In the case of biopsies performed in our office, Yardley Dermatology utilizes our in-house lab to process the specimens. We then send the slides to a separate lab where a pathologist reads the slide and makes a diagnosis. These two steps are billed independently from each other. If you receive a statement from the pathologist laboratory, we request that you contact them directly to resolve any billing questions.

I HAVE READ EACH SECTION OF THIS FINANCIAL POLICY AND UNDERSTAND THE ABOVE INFORMATION AND AGREE TO COMPLY WITH THESE FINANCIAL POLICIES.

_____ _____
Signature of Patient or Legal Guardian *Date*

_____ _____
Patient Name (If different from above) *Date*

ARE YOU INTERESTED IN A FREE SKIN CARE CONSULTATION?
Please check here if you would like to schedule a complimentary consultation with one of our **Aestheticians** to discuss skincare products and available treatments.

☐ YES ☐ NO

YARDLEY DERMATOLOGY ASSOCIATES
PATIENT CONSENT FORM

Patient Name (print): _____ DATE OF BIRTH:_____

Legal Guardian Name (print): _____

AUTHORIZATIONS

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to YARDLEY DERMATOLOGY ASSOCIATES. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patient and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa™, or Mastercard™. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered service, and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

Patient or Legal Guardian Signature: _____ Date: _____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent YARDLEY DERMATOLOGY ASSOCIATES may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to YARDLEY DERMATOLOGY ASSOCIATES' Notice of Privacy Practices for a more complete description of such uses and disclosures. I have received and reviewed the Notice of Privacy Practices prior to signing this consent. YARDLEY DERMATOLOGY ASSOCIATES reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to YARDLEY DERMATOLOGY ASSOCIATES Privacy Officer at 903 Floral Vale Blvd. Yardley, PA 19067. With my consent YARDLEY DERMATOLOGY ASSOCIATES may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO such as appointment reminders, insurance items, and any call pertaining to my clinical care including laboratory results among others. With my consent YARDLEY DERMATOLOGY ASSOCIATES may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent YARDLEY DERMATOLOGY ASSOCIATES may e-mail my home or other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements. I have the right to request that YARDLEY DERMATOLOGY ASSOCIATES restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form I am consenting to YARDLEY DERMATOLOGY ASSOCIATES' use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent YARDLEY DERMATOLOGY ASSOCIATES may decline to provide treatment to me.

Patient or Legal Guardian Signature: _____ Date: _____

MEDICARE HEALTH INSURANCE FORM (*COMPLETE IF YOU HAVE MEDICARE)*

I request that payment of authorized Medicare benefits be made either to me or on my behalf to YARDLEY DERMATOLOGY ASSOCIATES for any services furnished to me by YARDLEY DERMATOLOGY ASSOCIATES. I authorize any holder of medical information about me to release to the Center for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related service.

Patient or Legal Guardian Signature: _____ Date: _____

Date:_____

MIPS 2023 PATIENT QUESTIONNAIRE

Patient Name:_____ **Date of Birth**:_____

Primary Care Physician:_____ ☐ **I do not have a PCP**

Referring Physician:_____ ☐ **I do not have a referring physician**

ALL PATIENTS COMPLETE THE FOLLOWING

Please describe your Nicotine habits:

☐ Never a Nicotine User
☐ Former Nicotine User
☐ Current Everyday Nicotine User
☐ Current Occasional Nicotine User

PATIENTS AGES 65 AND OVER ONLY!

COMPLETE THE FOLLOWING

Do you have a health care proxy*?
**Proxy (medical power of attorney) – A person named to make medical decisions on your behalf if you are no longer able to do so.*

☐ Yes If YES, Please provide details below

Name:_____

Phone Number:_____

☐ No
☐ Decline

Do you have a living will*?
**Living will – A written statement of a person's desires regarding their medical treatment if that person is no longer able to express informed consent*

☐ Yes If Yes, Please explain:_____

☐ DNR (Do Not Resuscitate) ☐ DNI (Do Not Intubate)

☐ No
☐ Decline