

Title: _____ First Name: _____ M.I. _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Home Phone: _____ Cell Phone: _____

Female Male Date of Birth: _____ Social Security No: _____

Single Married Domestic Partner Spouse/Partner's Name: _____

Where would you like to be called with results? Home Work Cell Other _____

EMAIL Address: _____

Employer: _____ Work Phone: _____

Address: _____ Occupation: _____

City: _____ State: _____ Zip: _____

Primary Physician: _____

How Did You Hear About the Practice: _____

Should Bill Be Sent To: _____ Patient _____ Responsible Party

Responsible Party Name: _____ Telephone Number: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Nearest Relative Not Residing With You: _____

Address: _____ Telephone Number: _____

City: _____ State: _____ Zip: _____

PRIMARY INSURANCE

Carrier: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relation: _____ Self _____ Spouse _____ Child

Policy Number: _____ Address: _____

Group Number: _____ City: _____ State: _____ Zip: _____

SECONDARY INSURANCE

Carrier: _____ Policy Holder: _____

Policy Holder Date of Birth: _____ Relation: _____ Self _____ Spouse _____ Child

Policy Number: _____ Address: _____

Group Number: _____ City: _____ State: _____ Zip: _____

I authorize the release of any information including the diagnosis and records of any examination or treatment rendered to me or my child or to third party payors and/or other health practitioners. For billing purposes it is required that this office keep a copy of your signature on file. This enables us to bill your insurance company for services rendered without your signature at the time of each visit.

I agree to be responsible for payment of all services rendered on the behalf of my dependents and authorize the use of this signature for billing my insurance company. I agree to be responsible for payment for all cosmetic and non- covered services.

Patient's Signature: _____ Date: _____

(Responsible party if minor)

Southern Connecticut Dermatology, P.C.

Medical Information

Patient's Name: _____ Date: _____

Reason for today's visit? _____

Medical History:

Do **YOU** currently have or do you have a history of: (Please check all that apply)

- | | |
|--|---|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Migraine Headaches |
| <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Neurologic Disease |
| <input type="checkbox"/> Herpes Simplex (cold sores or genital) | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Keloids | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Skin Cancer <input type="checkbox"/> Melanoma | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Cancer – Type: _____ |
| <input type="checkbox"/> Coronary Heart Disease | <input type="checkbox"/> X-Ray Therapy |
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other Medical Problems |
| <input type="checkbox"/> High Cholesterol or Triglycerides | |

Family history of **MELANOMA** skin cancer: Yes No Relationship: _____

Do you have a pacemaker? Yes No

Do you need to take an antibiotic pill before any dental work? Yes No

Medication taken regularly (including over the counter)? _____

Allergies to medications: _____

Do you smoke Yes No Amount

Do you drink Yes No Amount

GYN History (for women):

Are you pregnant: Yes No Type of Birth Control: _____

Are you trying to become pregnant? Yes No

Irregular Menstrual Cycles: Yes No

Southern Connecticut Dermatology, P.C.
Robin D. Evans, M.D.

Office Billing Policy

1. You are required to provide our office with accurate up-to-date insurance information. Failure to do so results in delayed insurance filing and may lead to denials of insurance payments. If your insurance denies payment due to inaccurate information provided, you will be responsible for all incurred charges.
2. Appointments must be cancelled with 24 hours advance notice. Failure to do so will result in a \$50 no-show fee. In case of emergencies, please contact our office manager.
3. All managed care companies require co-payments to be paid on the date of service. Copays not paid at the time of service will be charged a \$20 copay fee.
4. Our office participates in a number of insurance plans. We will bill your insurance company for covered services. If we do not participate in your insurance plan, all fees are payable on the date of service. Charges for cosmetic services, skin care products and supplements are also to be paid on the date of service.
5. All unpaid balances over a 60 day period will be charged an annual interest rate of 18%.

Please note that all of the above charges are not paid by your insurance carrier; and, therefore, are your responsibility.

If you have any questions, please call and our office manager will be happy to assist you.

Thank you for your consideration and understanding.

Patient Signature: _____ Date: _____

11/09

Southern Connecticut Dermatology, P.C.

**Patient Consent For Use And Disclosure
Of Protected Health Information**

HIPPA

With my consent, Southern Connecticut Dermatology, PC may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operation (TPO). Please refer to Southern Connecticut Dermatology, PC's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Southern Connecticut Dermatology, PC 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 Southern Connecticut Dermatology, PC's Privacy Officer at 1275 Summer Street, Stamford, Connecticut 06905.

With my consent, Southern Connecticut Dermatology, PC 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, Southern Connecticut Dermatology, PC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Southern Connecticut Dermatology, PC may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders cards and patient statements. I have the right to request that Southern Connecticut Dermatology, PC restrict how it uses or discloses my PHI to carry out TPO.

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 Southern Connecticut Dermatology, PC's use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice had made disclosures in reliance upon my prior consent. If I do not sign this consent, Southern Connecticut Dermatology, PC may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Patient's Name

Date

11/09