Patient Name _____ Date of Birth _____

Street Address _____ City _____

State _____ Zip _____ Phone _____ Email_____

Primary Insurance _____ Policy ID # _____

Primary Policy Holder _____ Policyholder Date of Birth _____

Secondary Insurance _____ Policy ID # _____

Secondary Policy Holder _____ Policyholder Date of Birth _____

Driver's License Number _____ Driver's License State _____ ____

**1. CONSENT TO TREAT:** I hereby authorize the providers of Derma Birmingham to examine me/the patient named below and to furnish such diagnostic, therapeutic, and surgical services as deemed necessary and appropriate by my provider. If I am authorizing on behalf of someone other than myself, such examination, procedures and services may be provided in my absence.

**2. ASSIGNMENT AND RELEASE:** I authorize payment of benefits as determined by my insurance carrier directly to the physician. As the responsible party, I agree that I will be responsible for all charges incurred including cosmetic services and those amounts not paid by my insurance company. Also, if necessary, I authorize the release of my medical records to my insurance carrier to determine payment for medical services. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I understand that I will be charged for, and hereby agree to pay, all costs and expenses incurred in collecting any past due fees, and interest as allowed by law.

**3. OFFICE POLICIES:**

- Cancellation policy: We require 24 hour notice when canceling or rescheduling appointments. Failure to do so may result in a $50 fee. Any patient who is late for their appointment may be asked to reschedule.
- Referral Policy: It is the patient's responsibility to ensure that required referrals are current BEFORE their appt time.
- Co-Payments and Deductibles: Co-pays and Deductibles must be paid at the time of check-in.
- Insurance Re-billing Charge: If incorrect or outdated insurance information provided by the patient results in multiple insurance claim filings, there may be an additional $25.00 charge applied to the patient's account. If the correct insurance information is not obtained before the insurance company's filing deadline, then the patient will be responsible for the entire cost of the visit.
- Refill Policy: A follow-up visit may be required for prescriptions that are over a year old.
- Returned Check Policy: There is a $30.00 processing fee for returned checks.
- Late Payment Fee: A $35.00 late fee will be added to all accounts that are more than 90 days delinquent.
- Prior authorization support: Derma Birmingham uses an artificial intelligence company (Tandem RX) to improve medication affordability, prior authorization communications, and pharmacy coordination.
- Patient Dismissal: Derma Birmingham reserves that right to terminate patients from the practice. Reasons for termination may include, but are not limited to, disruptive and abusive behavior, non-payment, failure to follow clinical advice or treatment, and failure to keep follow up appointments.

*The undersigned, who is the patient or the patient's spouse, parent or guardian, agrees to all of the terms set forth herein. This agreement shall remain valid for all subsequent visits and all services after this date unless expressly revoked. I have read this document or it has been read to me. I understand and voluntarily accept its terms. If I am signing for someone else, I certify that I have the authority to do so.*

Patient Name _____ Date of Birth _____

Signature _____ Date _____

Patient Representative Name _____

Representative Signature _____ Date _____

## HIPAA - Health Information Privacy Policy

This document acknowledges that you were offered a copy of our Notice of Privacy Practices and Notice of Nondiscrimination and Accessibility. A paper copy is available from the receptionist for your review during regular office hours. You may also request a copy by calling 205-825-5575.

Name _____ Date of Birth _____

Signature _____ Date _____

## Helpful Links & Numbers

Our Website
dermabirmingham.com

Patient Portal
dermabirmingham.ema.md

Text Us
205.825.5575

## Personal Health Information / Patient Portal Release

I hereby give Derma Birmingham permission to share my Personal Health Information with the following individual(s):

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

Name _____ Phone _____ Relationship _____

☐ I **DO NOT** wish to communicate through my Patient Portal

☐ I **DO** want be notified about my results on the patient portal using my email address
_____

☐ I **DO** want be notified of portal results at this different email address
_____

## Other Communication

Primary Care Physician (name and phone) _____

Referring Physician (if applicable) _____

Emergency Contact (name and phone) _____

Preferred Pharmacy (location and phone) _____

☐ Do not communicate with me via text messages

☐ Do not include me on Derma Birmingham news emails

Signature _____ Date _____

## Credit Card on File Policy

By signing below:

- I understand and agree to all of the terms of Derma Birmingham Credit Card on File Policy.
- I authorize Derma Birmingham to keep my signature and valid credit card number securely on file.
- I agree to allow Derma Birmingham to automatically charge my credit card for any outstanding balance, including but not limited to insurance denials for any reason, deductibles, co-insurances, partially paid claims, and any other charge my insurance carrier (or the insurance carrier that covers any individual whose payment of services I have accepted responsibility for, including as applicable my spouse, children, or other related party) has not or I have not already paid.
- I agree to allow Derma Birmingham to charge my credit card if my insurance company delays or denies payment of any services Derma Birmingham provides.
- I agree to promptly give Derma Birmingham information for a new, valid credit if the credit card I have on file is expired, cancelled, or otherwise cannot be charged.
- I agree to give Derma Birmingham correct contact information and to promptly update my contact information if any changes.
- I agree to allow Derma Birmingham to contact me through any of the following means: by mail, by email, by telephone call.
- I understand and agree that Derma Birmingham will use the contact information I provide and that is it my responsibility to control who has access to my mail, email, and telephone.
- I understand and agree that this authorization, including all the terms above, will continue to remain valid unless and until I cancel this authorization by providing Derma Birmingham written notice that I am cancelling this authorization.

☐ I **DO NOT** want to leave my credit card information on file.

_____ _____

Signature of Patient/Guardian & Credit Card Holder | Date

_____ _____

Print Name of Person Signing Above | Relationship to Patient (if applicable)

## Quality Reporting

The government asks us to collect certain information to help improve the quality of your care here. We appreciate your cooperation. Do not hesitate to let us know if you have any questions.

**Vaccination**

Have you had a flu shot in the past 12 months? ☐ Yes ☐ No

(Age 13) Has the patient received meningitis, TDAP, and HPV vaccines? ☐ Yes ☐ No

**Tobacco**

(Age 12+) Do you smoke? ☐ No ☐ Yes (If so, _____ packs per day for _____ years.)

**Advanced Care Plan (Age 65+)**

Advance care planning is the process of making arrangements for future medical care. A health care proxy or surrogate is a designee appointed to make medical choices as well as arrangements for end-of-life care on behalf of the patient when the patient is incapacitated or lacks the ability to make their own medical decisions.

(Age 65+) Do you have a health care proxy or surrogate? ☐ Yes ☐ No

*Vaccines are some of the most effective tools we have to protect ourselves, our families, and our communities from serious, often life-threatening diseases. Quitting smoking, at any age, can dramatically improve your health and quality of life.*

## Medical History

Patient Name _____ Date of Birth _____

**Medications** ☐ No Medications
*If preferred, you may provide a separate list for photocopy.*

Today's Date _____

**Allergies to Medications** ☐ No Medication Allergies

**Medical History**
- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial fibrillation
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage kidney disease
- ☐ Hearing loss
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Seizures
- ☐ Stroke
- ☐ Cancer (type, year) _____

_____

_____

- ☐ Immune system problems (type)

_____

- ☐ Other _____

**Surgical History**
- ☐ None
- ☐ Biopsy of breast
- ☐ Biopsy of prostate
- ☐ Any cancer surgery
- ☐ Solid organ transplant (organ and year)

_____
- ☐ Splenectomy
- ☐ Other _____

_____

_____

_____

**Skin Disease History**
- ☐ None
- ☐ **Skin cancer** (body location & approx. surg. year)
- ☐ *Basal cell carcinoma*

_____

_____
- ☐ *Squamous cell carcinoma*

_____

_____
- ☐ *Melanoma* _____
- ☐ Acne
- ☐ Actinic keratoses (pre-cancers)
- ☐ Allergies or hay fever
- ☐ Asthma
- ☐ Dysplastic nevi (atypical moles)
- ☐ Eczema
- ☐ History of frequent sunburns
- ☐ Keloids or enlarged scars
- ☐ Melanoma
- ☐ Psoriasis
- ☐ Other _____

_____

_____

**Social History**
- ☐ Alcohol
- ☐ Sunscreen use
- ☐ Tanning bed use (past or present)

**Family History**
- ☐ None
- ☐ Family history of melanoma (affected family member):
- ☐ Family history of colon cancer
- ☐ Family history of breast cancer
- ☐ Family history of pancreatic cancer

**Alerts**
- ☐ None
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Allergy to lidocaine
- ☐ Artificial joint, last 2 years
- ☐ Artificial heart valve
- ☐ Pre-medication before
- ☐ procedures
- ☐ Pregnancy/planning preg.
- ☐ Breastfeeding
- ☐ Blood thinners
- ☐ History of fainting
- ☐ HIV
- ☐ Hepatitis C
- ☐ History of MRSA

**Review of Systems**
- ☐ None
- ☐ Poor appetite
- ☐ Fatigue
- ☐ Abdominal pain
- ☐ Shortness of breath
- ☐ Changing mole
- ☐ Rash
- ☐ Joint aches
- ☐ Muscle weakness
- ☐ Anxiety
- ☐ Depression
- ☐ Fever or chills
- ☐ Other _____

_____

_____

## Consent to Clinical Procedures

I hereby consent to medical and surgical care and treatment as deemed necessary or advisable by my physician or other clinician. This includes, but is not limited to, laboratory procedures (such as diagnostic testing, lab draws, and skin biopsies), medical and surgical treatments or procedures (including wart treatments, surgical removals, and excisions), or other services provided during my visit with Derma Birmingham, LLC ("Derma").

To ensure your understanding of all aspects of your visit, you are encouraged to ask questions or seek clarification about any procedures before they are performed. Our dermatology clinicians will address your questions and discuss procedures, concerns, and goals with you regarding the following:

- Benefits of the proposed procedure.
- Probable risks of not receiving the treatment.
- The way the treatment or procedure is to be performed.
- Alternative treatment options.
- The right to withdraw informed consent at any time, in writing.
- Risk and side effects involved with the procedure.
- Potential for additional incurred charges.

If a biopsy or any other procedure involving the removal of a section of your skin is performed, the specimen will be sent to a pathology lab for an accurate diagnosis, unless your clinician recommends otherwise. This process may include necessary testing such as special staining or external consultations, which may result in additional charges.

With the automatic release of test results to your electronic medical record, you may see results before your physician or other clinician. Your treating clinician is trained to interpret these results in the context of your specific medical history and condition, to provide an accurate diagnosis and develop an appropriate treatment plan. To avoid unnecessary concern, I understand that I am encouraged to discuss any new or concerning results with my clinician.

I acknowledge that some medical diagnoses (such as warts) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly.
With any procedure, there are risks involved which include, but are not limited to, the following:

- Scar – Scarring is possible with any procedure of the skin. We will do everything we can to provide you with the best cosmetic result possible, but the final cosmetic outcome is not guaranteed.
- Discoloration – pigment producing cells of the skin are sensitive and darkening or lightening of the skin may occur with any procedure.
- Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection.
- Bleeding – Some procedure may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it.
- Nerve damage – This will be discussed with you by your clinician if it is a known risk of your procedure.

Derma is dedicated to creating a safe environment for all patients and recognizes that the clinician-patient relationship requires a high level of trust and professional responsibility. This relationship may involve sensitive physical examinations. To ensure protection for both you and your clinician, Derma's policy requires a chaperone or other third party to be present during all sensitive medical examinations. The chaperone or third party, a member of our staff, provides reassurance for both you and your clinician during the exam or procedure at no additional cost. I understand that I may decline the presence of a chaperone or third party for certain examinations or procedures, but I acknowledge that the clinician may choose not to examine or treat me if a chaperone or third party is not present. I understand I can speak with a staff member or my clinician if I have any questions or concerns.

I authorize photographs to be taken before, during, and after the procedure. These photos will be included in my medical record and may be used or disclosed in accordance with HIPAA. They may also be shared with my family physician and/or referring physician.

I understand that each insurance company has its own policies regarding procedure coverage. I acknowledge that I am responsible for full payment of procedure charges, regardless of insurance coverage. If I am concerned about treatment costs, it is my responsibility to request an estimate before beginning treatment.

I confirm that I have read this consent form in full. I understand the risks associated with procedures that may occur during my visits at Derma. I do not impose any restrictions on Derma and its staff. I acknowledge that I should discuss any questions or concerns with my clinician before any procedure. By signing, I agree to proceed with any necessary procedures. I understand that I may withdraw my consent at any time by notifying Derma in writing.

The undersigned provides this consent as the patient or legal representative of the referenced patient if the patient cannot legally consent (e.g., minors under 18 years old, or 19 in Alabama, or incapacitated patients with an active power of attorney).

| | |
|---|---|
| Signature of Patient/Guardian/Healthcare Proxy | Date |
| Print Name of Person Signing Above | Relationship to Patient (if applicable) |