LEHMAN ADVANCED DERMATOLOGY
MEDICAL. SURGICAL. COSMETIC

MM000000_____

Lehman Advanced Dermatology, PLC
Patient Information and Insurance Authorization

PATIENT INFORMATION

First Name _____ Last Name _____ Middle initial _____

Mailing Address _____ Apt. # _____

City _____ State _____ Zip Code _____

Date of Birth _____/_____/_____ Age _____ Social Security # _____-_____-_____

Phone # _____ _____ _____
CELL HOME WORK

EMAIL ADDRESS: _____

I MAY BE CONTACTED BY THE CLINIC AT (*Check all that apply*): ☐ Cell ☐ Work ☐ Home

Marital Status : ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Gender : ☐ Male ☐ Female

EMERGENCY CONTACT

Name _____ Relationship _____ Phone _____

PRIMARY CARE PHYSICIAN

Doctor's Name _____ Did this Doctor refer you to us?_____

PREFERRED PHARMACY

Name _____ Location _____

EMPLOYMENT

Employer Name _____ Phone _____

Occupation _____

MEDICAL INSURANCE

PRIMARY MEDICAL INSURANCE

Insurance Company _____ Employer _____

Policy Holder Name _____ Policy Holder Date of Birth _____/_____/____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other _____

SECONDARY MEDICAL INSURANCE

Insurance Company _____ Employer _____

Policy Holder Name _____ Policy Holder Date of Birth _____/_____/____

Policy Holder Relationship to Patient: ☐ Self ☐ Spouse ☐ Parent ☐ Child ☐ Other _____

MEDICAID PARTICIPATION ACKNOWLEDGEMENT

I acknowledge that I do not participate and/or am not insured in any way by a state funded Medicaid program.

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____

ACKNOWLEDGEMENT OF ACCURACY

BY SIGNING BELOW, I ACKNOWLEDGE THE ABOVE INFORMATION PROVIDED IS TRUE AND CORRECT

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE: _____

PRINTED NAME: _____ DATE: _____

RELATIONSHIP TO PATIENT: _____

Dr. Lehman and the Lehman Advanced Dermatology staff appreciate your trust and patronage!

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HOW A DERMATOLOGY VISIT IS BILLED

At LEHMAN ADVANCED DERMATOLOGY, we want you to have the best possible experience when it comes to your healthcare services. Part of that experience involves making sure you are fully informed about all aspects of your care, including insurance and billing.

There are many insurance plans with varying rules that apply to coverage of services, co-pays, and deductibles. This can often create confusion. Therefore, we recommend you have a clear understanding of your coverage before your visit.

Dermatology visits can sometimes be challenging to understand with regard to insurance coverage. We find that the most common questions involve billing of procedural treatments that take place the same day as the evaluation of the skin condition.

What is a dermatology visit?

Dermatology visits are classified either new patient visits or follow-up visits, during which a concern regarding skin, hair, nails or mucous membranes is addressed. The evaluation may be very focused, or may require a more extensive evaluation of the entire skin system.

Dermatology visits usually include the following with your co-pay (if a co-pay is required by your insurance plan) :

- A review of your medical, surgical, family and social history
- An in-depth review of the history regarding your dermatologic concerns
- A physical examination
- Education and counseling
- Prescriptions
- Ordering of labs (performance of ordered labs is billed separately)

Many times, the treatment of dermatologic conditions is only achieved or most effectively achieved through **dermatologic procedures**, and not by prescription medicines. Sometimes a combination of both procedural and prescription treatments will provide the most effective means of improvement of your condition.

The following treatments may be offered during your dermatology visit, but they are considered **procedures**, and **will be billed separately from the office visit** (this list is not all-inclusive) :

- Liquid nitrogen treatment (cryotherapy, “freezing” or “burning”) of benign, pre-malignant, or malignant lesions
- Intralesional injections
- Intramuscular injections
- Electrodessication and curettage (“scrape and burn”)
- Biopsies

Procedure list continued:

- Excisions
- Removal of any skin lesions
- Incision and drainage of abscesses/cysts
- Photodynamic therapy (PDT or Blue Light)
- Acne surgery
- Patch testing
- Wart treatments

In addition, all pathology services regarding removed skin lesions will be billed separately by Pathology Associates of St. Thomas.

While a dermatologic procedure may be considered medical in nature (not cosmetic), there may still be an out of pocket expense to you, depending upon **the status of your insurance deductible or the nature of your plan**.

If you desire to have a skin lesion treated, and it is deemed **cosmetic** in nature, the procedure will be performed on a separate day after you have had an opportunity to discuss charges with our billing specialist.

If you have questions about your dermatology visit, please do not hesitate to ask your physician or staff prior to your exam and treatment.

By signing below, I acknowledge that I have read this form in its entirety, and understand its contents.

_____ _____

PATIENT OR PERSONAL REPRESENTATIVE SIGNATURE **DATE**

_____ _____

PRINTED NAME **RELATIONSHIP TO PATIENT**

MM000000_____

Financial Responsibility

In order to establish an optimal relationship and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office.

Payment is required at the time that services are rendered. You will be provided with a good faith estimate of charges. We accept payment in the form of Cash, Credit Card, Debit Card.

1. I understand it is my responsibility to cancel my appointment with Lehman Advanced Dermatology no later than 24 business hours prior to the appointment date and time or 72 business hours prior to the scheduled surgical date and time, or I may be billed $50 for the missed appointment and $150 for a missed surgery.
2. I understand that it is my responsibility to present accurate and current insurance coverage information at the time of check-in. At that time, I will be asked to pay for all services not covered, deductible amounts, co-pays, past due balances, as well as balances due to invalid insurance information. For patients with HMO coverage or other third party insurance that requires authorizations, I will be held responsible for payment if the referral authorization is not provided at the time of service. I, as the patient or responsible party for the patient, agree to be responsible for charges or services referred to another physician or laboratory by any physician or practitioner of Lehman Advanced Dermatology, PLC.
3. I consent to the release of medical information necessary to process any insurance claims. I also consent to the release of medical information to other physicians who may participate in my treatment.
4. I understand that failure to make payment when due is the basis for legal action, and agree to pay all reasonable costs of collection, including attorney's fees.
5. I understand it is the policy of Lehman Advanced Dermatology, PLC, to collect any outstanding balance before additional services are rendered.
6. I understand Lehman Advanced Dermatology, PLC, does not accept personal checks.
7. I authorize and request that payment by an authorized insurance company be made payable to Lehman Advanced Dermatology, PLC, on my behalf for the services furnished to me by the physician(s)/practitioner(s) of Lehman Advanced Dermatology, PLC.

The signature below verifies my agreement to the above policies, as the patient or the responsible party for the patient.

Signed: _____ Date: _____/_____/_____

Printed Name: _____Relationship to Patient: _____

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Lehman Advanced Dermatology, PLC
OFFICE POLICIES

CANCELLATION/NO-SHOW

Dermatology appointments can be challenging to come by due to the high demand of dermatologic services and the small number of dermatologists in the area. Because of this, patients may wait several weeks to be seen. In order to improve wait times, keeping and arriving on time to your office or surgical appointment is crucial.

If you find the need to cancel, kindly give our office no less than 24 business hours of notice for an appointment and no less than 72 business hours of notice for a surgery. This will allow us to fill the available time with another patient that requires care. For example, if your appointment is scheduled for Monday at 9:00am, you must cancel no later than the prior Friday at 9:00am.

Should you fail to provide the requested cancelation notice or fail to show-up for the appointment or surgery (no-show), the following charges will apply: **$50 charge for a missed office appointment, and a $150 charge for a missed surgery. These charges will be due and payable before another appointment will be scheduled. These charges are not reimbursable by your insurance company.**

In order to provide the most effective and safe dermatologic care, rescheduling of (3) appointments within a (6) month period **FOR ANY REASON**, may result in discharge from the clinic.

If you fail to show for your initial appointment at Lehman Advanced Dermatology, you will not be afforded the opportunity to reschedule. If you are an established patient and no-show (2) appointments in a six-month period, you may be discharged from the clinic.

LATE ARRIVAL

At Lehman Advanced Dermatology, we make an effort to remind you of your appointment several days in advance; however, this is strictly a courtesy. It is ultimately your responsibility to remember your appointment. Your time is very important to us. In order for you to get the maximum amount of time that your visit requires, we ask that you arrive in a timely fashion.

Patients who are new to Lehman Advanced Dermatology and do not have their initial paperwork completed, please plan to arrive 20 minutes prior to the appointment. Failure to arrive as requested may result in rescheduling of the appointment.

LATE ARRIVAL continued

For follow-up visits, please plan to arrive 15 minutes prior to your scheduled appointment time. You will be asked to update personal and medical information.

If you arrive more than 10 minutes past your appointment time, you may be asked to reschedule your appointment.

CHILDREN IN THE CLINIC

Due to the nature of our business and for safety precautions, no children under the age of 12 are allowed in the clinic unless he or she is the patient. The clinic reserves the right to ask anyone 12 or over accompanying the patient to remain in the waiting area while services are rendered. Anyone who arrives at the clinic and is unable to comply with this policy will be asked to reschedule.

PATIENT GUESTS

Due to our clinic flow and space constraints, we ask that you limit the number of guests which accompany you to the clinic. The number of patient guests is limited to (1) in the patient room. The clinic reserves the right to ask any guest to remain in the waiting area while services are rendered.

The scheduled patient is ultimately responsible for the conduct of their guest. Under NO CIRCUMSTANCES is a guest allowed to engage the doctor or provider with a personal health concern. The doctor/provider WILL NOT look at a live patient, pictures, answer questions or render advice to anyone but the scheduled patient – no matter how small of a matter it may appear to be. If a guest requires dermatologic care, we are happy to assist in scheduling their own appointment so they can get the proper time allotted with the provider for their concern.

If any of the patient guest policies are violated, the patient may be discharged for non-compliance.

PRODUCT SALES AND COSMETIC SERVICES

All product and cosmetic service sales are final.

Product Sales and Cosmetic Services continued

Results are not guaranteed. There are many variables that are beyond our control that affect product and procedure outcomes, especially individual expectations. We maintain our equipment and continue staff education and training regarding technique. There are times when the human body does not respond as well as we would like. Lifestyle choices, diet, exercise, hydration, prior skin damage, sun exposure and many other factors affect the end results. All of our patients are unique and have unique needs and expectations. Please discuss your treatment expectations with us prior to your treatment. No products purchased or services provided by the injection nurse or aesthetician will be submitted to the patient's insurance.

PRESCRIPTION REFILLS

If you require a refill of your prescription, please allow 72 business hours for the refill to be processed. If the medication requires a prior authorization from your insurance company, more time may be required to fill your request. Prescription refill requests will not be performed after clinic hours, on weekends, or on holidays – so please plan ahead.

Depending upon the type of medication or length of time since last seen in the clinic, you may be asked to schedule a follow-up appointment before a medication refill is authorized.

CLINICAL PHONE CALLS

Your calls and concerns are very important to us. We will make every effort to ensure your call is handled by the most appropriate staff member. Calls regarding urgent medical matters will be handled with priority. Please allow up to (48) hours for return of non-medically urgent phone calls.

The signature below verifies my agreement to the above policies, as the patient or the responsible party for the patient.

Signed: _____ Date: _____/_____/_____

Printed Name: _____

Relationship to Patient: _____

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Lehman Advanced Dermatology, PLC

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name	Date of Birth

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in the treatment both directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand a copy of the Lehman Advanced Dermatology Notice of Privacy Practices is available upon request. It contains a more complete description of the uses and disclosures of my patient health information.

I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact Lehman Advanced Dermatology at any time to obtain a current copy of the Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature **Date**

LEHMAN ADVANCED DERMATOLOGY USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date :	Initials:	Reason:

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Lehman Advanced Dermatology, PLC

HIPAA AUTHORIZATION

Patient Name	Date of Birth

CHOOSE ONE:

☐ I DO NOT authorize Lehman Advanced Dermatology to release my medical and billing information to anyone other than myself.

OR

☐ I authorize Lehman Advanced Dermatology to release my medical and billing information to the individuals listed below:

RELATIONSHIP	PERMISSION	NAME OF DESIGNATED PERSON	PHONE #
SPOUSE	☐ YES ☐ NO	_____	_____
CHILDREN	☐ YES ☐ NO	_____	_____
PARENTS	☐ YES ☐ NO	_____	_____
CAREGIVERS	☐ YES ☐ NO	_____	_____
IN-LAWS	☐ YES ☐ NO	_____	_____
OTHERS	☐ YES ☐ NO	_____	_____

I authorize Lehman Advanced Dermatology, PLC, to leave information on my voicemail:

HOME: ☐ YES ☐ NO CELL: ☐ YES ☐ NO WORK: ☐ YES ☐ NO

The HIPAA privacy rule permits health care providers to communicate with patients regarding their healthcare, including protected health information (PHI) and billing information. This includes communicating with the patient through mail, phone, fax or another manner.

I understand that Lehman Advanced Dermatology (LAD) is permitted by the HIPAA privacy rule to leave information regarding my appointment, including, the date and time, on any phone number(s) provided. LAD may request a return phone call to our office by leaving a message or when speaking to any individual who answers the phone. If I only want confidential communication between myself and LAD, I must provide written notice to LAD.

I understand that it is my responsibility to keep LAD informed of any changes to this information and that I may revoke this authorization at any time by written notice.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Print Name **Relationship to Patient**

MM000000_____

Lehman Advanced Dermatology, PLC

PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

Patient Name	Date of Birth

I consent for medical photographs to be taken of:

☐ Self

☐ Person for whom I am legal guardian

☐ Person for whom I have Power of Attorney with medical decision making privileges

I understand that the information will be used in my medical record, for purposes of evaluation and treatment of my skin condition. The photographs will be maintained in a secure manner. By consenting to the taking of medical photographs, I understand that I will not receive payment from any party. Refusal to consent to photographs may have a negative impact on my medical care, as the designation of a specific site for further treatment may be unidentifiable without referencing the photograph. I understand that I may withdraw my consent at any time.

By signing this form below, I confirm that this consent has been explained to me in terms with which I understand.

_____ _____

Patient or Personal Representative Signature **Date**

_____ _____

Print Name **Relationship to Patient**

MM000000_____

Health Questionnaire

Patient Name: _____ Date: _____

Past Medical History					
YES	**NO**		**YES**	**NO**	
☐	Patient denies any past medical history				
		Acid Reflux			GI / Stomach ulcers
		ADD / ADHD			Heart disease / Heart attack
		Anemia			Heart murmur
		Anxiety			High blood pressure
		Arthritis			Insomnia
		Asthma			Irritable bowel syndrome
		Atrial fibrillation / irregular heartbeat			Kidney disorder
		Bipolar disorder			Leukemia / Lymphoma
		Bleeding disorder			Liver disorder
		Blood transfusion			Lupus
		BPH (enlarged prostate)			Migraine headaches
		Breast cancer			Other internal cancer
		Celiac disease			Overactive bladder
		Clotting disorder			Pulmonary embolus
		Chemotherapy or radiation treatments			Raynaud's
		Colon cancer			Sarcoidosis
		COPD / Emphysema			Scleroderma
		Crohn's Disease / Ulcerative colitis			Season allergies
		Deep venous thrombosis			Seizures / epilepsy
		Depression			Sexually transmitted disease
		Dermatomyositis			Stroke
		Diabetes			Thyroid Disorder
		Elevated Cholesterol / lipids			Tuberculosis
		Fibromyalgia			Vitamin B12 deficiency
		Food Allergies			Vitamin D deficiency

Past surgeries / hospitalizations (EXCLUDING skin surgeries) *Write NONE if no previous surgeries*			
	Surgery	**Date (mm/yy)**	**Notes**
1		/	
2		/	
3		/	
4		/	
5		/	

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Patient Name: _____ Date: _____

YES	NO	FEMALE ONLY QUESTIONS	Notes
		Are you currently pregnant? **If yes, when is your due date?	
		Are you currently breastfeeding?	
		Are you currently planning a pregnancy?	
		Have you had a hysterectomy?	
		Have you had a tubal ligation?	
		Are you currently on contraception? (birth control)	
		Are your periods irregular?	
		Are you post-menopausal?	

YES	NO	Past Skin History	Year	Notes
		*No significant skin history		
		Acne		
		Actinic keratosis		
		Basal cell carcinoma		
		Dysplastic nevi (pre-cancerous mole)		
		Eczema		
		Herpes (cold sores / fever blisters)		
		Keloids		
		Malignant Melanoma		
		MRSA / Staph infection		
		Psoriasis		
		Seborrheic dermatitis		
		Rosacea		
		Sensitive skin / allergies		
		Squamous cell carcinoma		
		Urticaria (hives)		
		OTHER: _____		

Sun Exposure History				
BLISTERING SUNBURNS		SUNSCREEN USE		TANNING BOOTH USE

YES	NO	Other Sun Exposure History

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Patient Name: _____ Date: _____

Current Medications (if none, please write none)				
	Medication Name	**Dosage**	**# of times daily**	**Notes**
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

Allergies (if none, please write none)		
	Causative Agent	**Reaction**
1		
2		
3		
4		
5		

Social History			
Alcohol Use:	☐ Never drink alcohol ☐ Occasionally drink alcohol ☐ Drink alcohol daily	Relationship Status:	☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Domestic partner
Tobacco Use:	☐ Never smoker ☐ Former smoker ☐ Current every day smoker ☐ Current occasional smoker ☐ Chewing tobacco/dip currently ☐ Former chewing tobacco user Date Started: _____ Date Ended: _____	Occupation: Hobbies: Number of Children:	

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Patient Name: _____ Date: _____

YES	NO	Family History	Affected Family Member	Notes
☐		*No Contributing Family History		
		Adopted		
		Alopecia (hair loss)		
		Asthma/Seasonal allergies		
		Autoimmune Disorders (lupus, etc.)		
		Diabetes		
		Dysplastic Nevi		
		Eczema / sensitive skin		
		Malignant Melanoma		
		Non-melanoma Skin Cancer		
		Psoriasis		
		Other Cancer (Breast/Colon)		
		Other		

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms?

- ☐ Fevers/Chills
- ☐ Night sweats
- ☐ Unusual Weight Changes
- ☐ Loss of Appetite
- ☐ Swollen Glands
- ☐ Arthritis/Joint Pains
- ☐ Difficulties w/Hot or Cold Temp.
- ☐ Muscle Weakness
- ☐ Sun Sensitivity
- ☐ Fatigue
- ☐ Flushing
- ☐ Excessive Sweating
- ☐ New Onset Headaches
- ☐ Hair Loss/Hair Growth
- ☐ Itching
- ☐ Mouth or Throat Sores
- ☐ Genital Sores
- ☐ Painful Urination
- ☐ Nausea/Vomiting/Diarrhea
- ☐ Visual Symptoms
- ☐ _____

YES	NO	Other Medical History	Notes
		Hepatitis B	
		Hepatitis C	
		HIV / AIDS	
		Pacemaker	
		Defibrillator	
		Artificial joints	
		Artificial heart valves	
		Antibiotics prior to dental procedures **If yes, please list name of antibiotic you typically take	
		Organ transplant or stem cell transplant	
		Oxygen use	
		Mitral valve prolapse	

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Patient name: _____

Please share your interest levels. Please CIRCLE your answers. Thank you!

Products for dry skin?	Very Interested ☐	Interested ☐	Not Interested ☐
Wrinkle reduction products or treatments?	Very Interested ☐	Interested ☐	Not Interested ☐
Products or treatments for brown spots from sun damage?	Very Interested ☐	Interested ☐	Not Interested ☐
Products or treatments for red spots or unwanted vessels?	Very Interested ☐	Interested ☐	Not Interested ☐
Cosmetic injectables for fine lines and wrinkles?	Very Interested ☐	Interested ☐	Not Interested ☐
Cosmetic filler for volume loss in the face?	Very Interested ☐	Interested ☐	Not Interested ☐
Cosmetic filler for the lips?	Very Interested ☐	Interested ☐	Not Interested ☐
Temporary fillers?	Very Interested ☐	Interested ☐	Not Interested ☐
Longest lasting fillers?	Very Interested ☐	Interested ☐	Not Interested ☐
Botox?	Very Interested ☐	Interested ☐	Not Interested ☐

Yes: _____ No: _____ Email:_____