Lexington Dermatology
& LASER CENTER, PSC

4071 Tates Creek Centre Drive | Suite 202
Lexington, Kentucky 40517 | 859-226-0206

PATIENT INFORMATION

NAME (Last First Middle)	SSN#	BIRTH DATE	AGE	SEX

ADDRESS	CITY, STATE, ZIP

HOME PHONE	WORK PHONE	ALTERNATE PHONE (CELL)	PREFERRED PHONE: ❑ Home ❑ Work ❑ Alt/Cell

MARITAL STATUS (Circle One) MARRIED SINGLE WIDOWED DIVORCED SEPARATED

Who may we discuss your health information with?
❑ NO ONE OTHER THAN SELF ❑ SPOUSE ❑ PARENT ❑ VOICEMAIL (Cell/Home) ❑ OTHER (Name): _____

May we leave detailed personal health information on your contact phone number voice mail?
This information may include pathology results, lab results, appointments, etc.
HOME PHONE: ❑ Yes ❑ No ALT/CELL PHONE: ❑ Yes ❑ No BUSINESS PHONE: ❑ Yes ❑ No

Can we notify you of specials and events via email? ❑ Yes ❑ No EMAIL ADDRESS: _____

PHARMACY OF CHOICE: _____

How did you hear about our practice? ❑ PHYSICIAN ❑ FRIEND ❑ OTHER: _____

PRIMARY EMPLOYER	ADDRESS	CITY, STATE, ZIP

EMERGENCY CONTACT NAME	EMERGENCY CONTACT PHONE NUMBER

REFERRING PHYSICIAN	PRIMARY CARE PHYSICIAN

RESPONSIBLE PARTY INFORMATION (for minor patients)

NAME (Last First Middle)	SSN#	BIRTH DATE	AGE	SEX

ADDRESS	CITY, STATE, ZIP

HOME PHONE	DAY PHONE	MARITAL STATUS	RELATIONSHIP TO PATIENT

INSURANCE INFORMATION

Primary Insurance	NAME OF INSURANCE COMPANY	ID#	GROUP#

EFFECTIVE DATE	NAME OF INSURED (POLICYHOLDER)	RELATIONSHIP TO PATIENT

Secondary Insurance	NAME OF INSURANCE COMPANY	ID#	GROUP#

EFFECTIVE DATE	NAME OF INSURED (POLICYHOLDER)	RELATIONSHIP TO PATIENT

MEDICARE PATIENTS ONLY (required by Medicare Program)

- ARE YOU OR YOUR SPOUSE COVERED BY ANY EMPLOYER GROUP HEALTH BENEFIT PLAN? ❑ Yes ❑ No
- ARE YOU OR YOUR SPOUSE WORKING FOR AN EMPLOYER WITH MORE THAN 20 EMPLOYEES? ❑ Yes ❑ No
- DO YOU RECEIVE BLACK LUNG BENEFITS? ❑ Yes ❑ No
- DO YOU RECEIVE WORKERS COMP BENEFITS? ❑ Yes ❑ No
- ARE YOU BEING SEEN FOR AN INJURY OR ILLNESS FOR WHICH AN OTHER PARTY COULD BE HELD LIABLE OR IS COVERED UNDER AUTOMOBILE NO FAULT INSURANCE? ❑ Yes ❑ No

I hereby give my permission to Lexington Dermatology & Laser Center, PSC for the evaluation and treatment of the presented dermatological condition.

I hereby authorize the above physician(s) to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

I hereby authorize the physician(s) indicated above to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

I have read the financial and privacy policy statements for Lexington Dermatology & Laser Center, PSC on the reverse of this page and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

_____ _____

Patient or Responsible Party Date

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____

Printed Name - Patient or Representative

_____ ___/___/___

Signature Date

Relationship to Patient
(if other than patient): _____

Witness: _____

Printed Name - Practice Representative

_____ ___/___/___

Signature Date

Lexington Dermatology & Laser Center, PSC

Financial Policy

Thank you for allowing Lexington Dermatology & Laser Center, PSC to be your healthcare provider. We are committed to providing you with the best possible care. We wish to avoid any misunderstandings about our billing and payment procedures, so we ask you to please review this policy. If you have any questions, please do not hesitate to speak to our office staff. We may also direct your questions to our billing consultants, MDBS.

Insurance: We will be happy to process your insurance claims if you have an insurance that we participate with. **We must emphasize that our relationship is with you and not your insurance company.** All charges are your responsibility at the time of service (this excludes any amount due from your insurance company that we have agreed to accept payment from). Each insurance policy is individual and it is the member's responsibility to fully understand their benefits, eligibility dates, and what is covered or not covered by their insurance. ***Initials*** _____

Demographic Information & Insurance Cards: It is extremely important that we have updated demographic information as well as a current copy of your insurance card on file at all times. If your insurance changes, it is your responsibility to let us know as soon as possible and to inform us of the effective dates for your new policy. If prior encounters need to be refiled to a different insurance, you must notify us immediately due to "timely filing" requirements by your insurance. If we do not have your updated insurance information, then your claims may be denied for "timely filing" by your insurance and those claims would become your financial responsibility. ***Initials*** _____

Network Providers: It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify and contact our Business Office, if there are any questions regarding network eligibility. ***Initials*** _____

Co-Pays, Co-Insurances, Deductibles, HAS, HRA & Flexible Spending Accounts: I understand that any co-payments, deductibles and co-insurances are due from me at the time of service. This also applies to HSA, HRA and Flexible Spending Accounts. We will collect up front an estimated allowable for the services provided. Failure to produce payment at check-in may result in your appointment being rescheduled. I understand that I am responsible for any balance not covered by my insurance.
Initials _____

Surgical Services: Co-insurance, co-pays and deductibles are due on the day that surgical services are rendered. Our office will contact your insurance company to determine the amount due and will contact you prior to your procedure to discuss this obligation. ***Initials:*** _____

Cosmetic Services and Product purchases: Payments for cosmetic services are due in full at the time of the service. We do require a $75.00 deposit for some cosmetic services that is due at the time of scheduling your appointment. You must provide our office with 2 business days' notice to cancel a cosmetic procedure, or you may forfeit the amount of your deposit. The purchase of laser packages and skin care products are non-refundable. If you develop a reaction to a product you may return the product within 10 days and receive a credit for the full amount which may be applied to any other cosmetic procedure or service. ***Initials*** _____

Annual Skin Cancer Exams: Please note that annual skin cancer exams will be subject to your deductible and/or copay. "Preventive visit" codes are most often not recognized by insurance companies for dermatology visits. ***Initials*** _____

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 the laboratory. I understand that I am responsible for payment for all laboratory services not covered by insurance. ***Initials*** _____

Missed Appointment Fees: Lexington Dermatology and Laser Center, PSC will charge a $50.00 fee for missed office visits, surgical and laser appointments when the patient fails to give appropriate notification. A cancellation notice must be received 24 business hours in advance of a scheduled office visit appointment and a cancellation notice of 48 business hours in advance is required for a scheduled surgical or laser appointment. I understand that I will be charged a $50 cancelation fee if I do not give proper notice. ***Initials*** _____

Returned Check Policy: I understand that I will be charged a $25.00 fee for any check returned by my bank for non-sufficient funds. ***Initials*** _____

Disability/FMLA/Other Forms/Medical Records: Lexington Dermatology and Laser Center, PSC will charge a $25.00 fee per form which is due in advance. Should you need a copy of your medical records, a signed authorization is required. You will be provided your first copy at no charge after that you will be charged $25.00 for the first 50 pages, and $.10 per page for each additional page, plus any postage charges. ***Initials*** _____

Minor Patients: The parent or guardian accompanying a minor are responsible for providing current insurance information for the minor as well as the payment at the time of service. The parent or guardian must sign an Authorization for Medical Treatment Form anytime a minor arrives unaccompanied for an appointment. Without this completed form, we are unable to see a minor not accompanied by a parent or guardian. ***Initials*** _____

Payment: As a courtesy to our patients, we gladly accept cash, check, money order, visa, mastercard, discover, or care credit. Any outstanding balances more than 90 days past due will be sent to a professional collection agency and may result in dismissal from the practice. If your account is assigned to the collection agency you will be responsible for any and all fees associated with the collection effort of the account, to include reasonable attorney fees, court costs, collection charges and interest. In the event that my account is not resolved, I understand that my account may be turned over to a collection agency and I may be dismissed from the practice as a patient. ***Initials*** _____

I have read the above financial policy, and I understand my financial obligations in exchange for medical care provided by Lexington Dermatology and Laser Center, PSC.

_____	_____	_____
Print Name	**Signature**	**Date**

Dermatology Medical History

Patient: _____ **Date of Birth:** ___/___/___ **Today's Date:** ___/___/___

Reason for Today's Visit:

_____

Occupation: **Hobbies:**

_____

Medications: Include over the counter medications/supplements

_____

_____

Medication Allergies:

_____

_____

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Cigarette Smoking:
Never Smoke
Quit: Former Smoker
Smokes less than daily
Smokes daily

Any History of Drug Abuse or Dependency: YES NO

Past Medical History: **NONE (or circle all that apply)**

Arthritis	Asthma	Irregular Heartbeat	Bone Marrow Transplant	
Breast Cancer	Colon Cancer	COPD	Coronary Artery Disease (Heart Attack)	
Depression	Diabetes	End Stage Renal Cancer	Acid Reflux	
Hearing Loss	Hepatitis	Hypertension	High Cholesterol	
Hyperthyroidism	Hypothyroidism	Lung Cancer	Prostate Cancer	
Seizures	Stroke	Dementia	Ulcerative Colitis	Crohn's disease
Lupus	Blood Clots	Any other cancer-please list		

Surgical History:

Heart Surgery	Skin Cancer Surgery	Other Surgery-please list
Joint Replacement	Other Cancer Surgery	

Please Flip Me!

Patient: _____ **Date of Birth:** ___/___/___ **Today's Date:** ___/___/___

Skin Disease History: None (or circle all that apply)

Basal Cell Carcinoma	**Squamous Cell Carcinoma**	**Melanoma**
Acne	Actinic Keratosis ("pre cancer")	Asthma
Blistering Sunburns	Dry Skin	Eczema
Flaking or Itchy Scalp	Hay Fever/Allergies	Abnormal Moles (that needed further treatment)
Psoriasis		

Do you have a family history of Melanoma? YES NO

If Yes, which relative(s) _____

Do you have a family history of other skin cancers? YES NO

If yes, which relative(s) _____

Have you had your pneumonia vaccine (65 or older) YES NO

Have you had your flu vaccine? YES NO

Have you had a Covid-19 vaccine in the last 12 months? YES NO

Have you had your shingles vaccine? (50 or older) YES NO

Alerts: Do you have any of the following:

Allergy to Lidocaine	YES	NO
Allergy to Epinephrine	YES	NO
Allergy to Latex	YES	NO
Allergy to adhesive	YES	NO
Allergy to topical antibiotic ointments	YES	NO
Pacemaker	YES	NO
Defibrillator	YES	NO
Currently taking blood thinners or aspirin	YES	NO
Need antibiotics prior to dental procedures	YES	NO
Artificial Heart Valve	YES	NO
Artificial Joint	YES	NO
History of HIV/AIDS	YES	NO
Hepatitis B or C	YES	NO
Active Tb	YES	NO
Convulsions, Epilepsy, Seizures or Fainting	YES	NO
Fever Blisters	YES	NO
Keloids	YES	NO
(Females) Pregnant or Planning Pregnancy	YES	NO
(Females) Nursing Mother	YES	NO