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DERMATOLOGY

Patient Information				
Last Name	First Name	M.I.	DOB	Preferred Name
Gender ☐ Male ☐Female Other: _____	Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed			
Home Phone	Cell Phone	Email Address		
Physical Address	City	State	Zip Code	
Mailing Address	City	State	Zip Code	
Race (Please Select) ☐ White ☐ American Indian/Alaska Native ☐ Asian ☐ Hispanic ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Decline				
Ethnicity (please select) ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Decline	Preferred Language (please select) ☐ English ☐ Spanish ___ Other: _____			
Primary Care Physician	Phone Number	Fax Number		
Referring Physician	Phone Number	Fax Number		
Preferred Pharmacy	Phone Number	Fax Number		

Responsible Party/Guarantor _____ Same as Patient			
If the patient is a minor (under the age of 18), the parent/guardian accompanying the patient will be listed as the responsible party/guarantor.			
Last Name	First Name	Middle	Relationship to Patient
DOB	Phone Number	Email Address	

Emergency Contact			
If the patient is a minor (under the age of 18), the section may be used for another parent/guardian.			
Last Name	First Name	Phone Number	Relationship to Patient

Advanced Directives
☐ None ☐ Do Not Resuscitate ☐ Durable Power of Attorney ☐ Living Will ☐ Healthcare Proxy

I hereby authorize employees and agents of Luma Dermatology (including physicians, physician assistants, nurse practitioners, and other employees) to render medical evaluations and care to the patient indicated. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency. I hereby authorize payment directly to Luma Dermatology for any surgical and/or medical benefits, if any, otherwise payable to me. I authorize Luma Dermatology to release medical information to my insurance carrier or third party payer to facilitate processing my insurance claims. I understand such records may include information regarding HIV/AIDS testing, substance abuse and/or mental health issues. I understand I am financially responsible for all charges incurred for medical services which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Luma Dermatology. I understand that this authorization will be effective until revoked by me in writing.

Signature	Date	Relationship to Patient

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Insurance Information	
Please present insurance cards at time of check-in – if you do not have your insurance cards at the time of your appointment, please complete the following:	
Primary Insurance	**Secondary Insurance**
Claims Mailing Address	Claims Mailing Address
Phone Number	Phone Number
Policy Holder Name	Policy Holder Name
Policy Holder DOB	Policy Holder DOB
Policy Holder Social	Policy Holder Social
Policy ID Number	Policy ID Number
Group Number	Group Number

Consent to Treat

I hereby authorize employees and agents of Luma Dermatology (including physicians, physician assistants, nurse practitioners, and other employees) to render medical evaluations and care to the patient indicated. I understand that by not signing this consent, the patient will not be provided medical care except in a case of emergency. I understand that this authorization will be effective until revoked by me in writing.

Initial _____ **Date**_____

Financial Responsibility

I hereby assign all medical and/or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to Luma Dermatology for all medical services rendered. Authorization is hereby granted to release information contained in the patient's medical record to the patient's medical insurance company (or its employees or agents) as may be necessary to process and complete the patient's medical insurance claim. I understand that I am financially responsible for all charges incurred for medical services which may include services not covered by the patient's insurance companies. I agree that all amounts are due upon request and are payable to Luma Dermatology. I understand that this authorization will be effective until revoked by me in writing.

Initial _____ **Date**_____

Privacy Practice Acknowledgement

I acknowledge that I have received Luma Dermatology's Notice of Privacy Practices, which describes the ways in which the practice may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures. I understand that I may contact Luma Dermatology if I have a question or complaint. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice's Notice of Privacy Practices. I understand that this authorization will be effective until revoked by me in writing.

Initial _____ **Date**_____

Patient Portal

I understand that Luma Dermatology will automatically register me for a secure patient portal account using the email address provided. I understand that this authorization will be effective until revoked by me in writing.

Initial _____ **Date**_____

Prescription History

I voluntarily consent to provide Luma Dermatology access to and use of my prescription medication history from other healthcare providers or third-party pharmacy benefit payers for treatment purposes. I understand that my prescription history (which includes but is not limited to prescriptions, labs, and other health care drug historical information) from unaffiliated medical providers, insurance companies and pharmacy benefit managers may be viewable by my medical

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provider. I acknowledge that Luma Dermatology may use health information exchange systems to electronically transmit, receive and/or access my prescription history. I understand this authorization will be effective until evoked by me in writing.

Initial _____ **Date**_____

Designation of Authorized Adult to Consent to Medical Treatment of Minor Patients

I do hereby state and represent that I have legal custody of the minor patient listed below and that I have the authority to consent to any and all medical/surgical care of said minor. By signing below, I grant my authorization and consent for the Designated Adult(s) listed below to accompany the minor to Luma Dermatology for medical care and treatment. I state that the Designated Adult(s) listed below are at least 18 years of age and competent to make decisions on my behalf. I authorize the Designated Adults to consent to any treatment for the minor that is covered under Luma Dermatology consent to treat that I have previously signed, including, but not limited to, routine medical examination and treatment, cryotherapy, intralesional injection(s), comedone extraction(s), skin scraping and counseling. I agree to assume financial responsibility for all expenses of the minor's medical care authorized by the Designated Adult(s). I understand that the healthcare provider, at his or her discretion, may require a parent or legal guardian to be present for certain non-emergent medical treatments, and in such cases, I may be required to accompany the minor. I further understand that this authorization does not authorize the Designated Adult(s) to give written consent to use or disclosure of the minor's protected health information, as those terms are defined by federal law. I understand that I may revoke or change this authorization at any time by notifying Luma Dermatology in writing.

Patient Name: _____ Patient DOB: _____

Designated Authorized Adult (s):

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Name: _____ Phone Number: _____ Relationship to Patient: _____

Parent/Legal Guardian Signature	Printed Name	Date

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Request for Confidential Communication

I authorize Luma Dermatology and its assignees, including but not limited to its authorized agents, affiliates, and contractors, to utilize all contact information I have provided to communicate with me. I hereby grant permission and consent to Luma Dermatology and its assignees, including and not limited to its authorized agents, affiliates, and contractors to communicate with me via phone call, text messaging and/or voicemail. I understand that this authorization will be effective until revoked by me in writing.

Initial _____ **Date**_____

I request for the following individuals to be allowed access to my information:

Name: _____ **Phone Number:** _____ **Relation to Patient:** _____

Authorized to Access: ☐ **Billing Information** ☐ **Medical Condition Information**

Name: _____ **Phone Number:** _____ **Relation to Patient:** _____

Authorized to Access: ☐ **Billing Information** ☐ **Medical Condition Information**

Name: _____ **Phone Number:** _____ **Relation to Patient:** _____

Authorized to Access: ☐ **Billing Information** ☐ **Medical Condition Information**

Name: _____ **Phone Number:** _____ **Relation to Patient:** _____

Authorized to Access: ☐ **Billing Information** ☐ **Medical Condition Information**

Initial _____ **Date**_____

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Medical History Intake Form

Patient Name: _____ **DOB:** _____

Do you have a Primary Care Physician? ☐ Yes ☐ No **Physician Name:** _____

Past Medical History (please check if yes)		
☐ Congenital Heart Disease	☐ COPD	☐ Blood Clots
☐ Heart Attack	☐ Asthma	☐ Diabetes: Type 1 Type 2
☐ Congestive Heart Failure	☐ Seasonal Allergies	☐ Inflammatory Bowel Disease
☐ Infective endocarditis	☐ TB (Tuberculosis)	☐ End Stage Renal Disease
☐ High Blood Pressure	☐ HIV	☐ Cancer: _____
☐ High Cholesterol	☐ Hepatitis: A B C	☐ History of Chemo/Radiation
☐ Anxiety	☐ HSV	☐ Transplant: _____
☐ Depression	☐ Cirrhosis	☐ Autoimmune: _____
Other: _____		

Please list any surgeries: (include date or year)
_____
_____
_____
_____

Skin cancer history: (please check if yes)	
☐ Previous Dermatologist: _____	☐ Do you use Sunscreen? Yes No SPF: _____
☐ Squamous cell carcinoma	☐ Basal Cell Carcinoma
☐ Melanoma Location: _____ Date: _____ ☐ Lymph nodes removed? Yes No	☐ Tanning Bed Use
☐ Family history of melanoma? If so, please list. _____	☐ Blistering Sunburn

Please list any medications you are currently taking: (if you have a list, please provide a copy)
_____
_____
_____

Allergies: (please list)
☐ No Known Drug Allergies
_____

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Medical History Intake Form

Patient Name: _____ **DOB:** _____

Social: (please check if yes)
☐ Tobacco use – if yes, packs per day? _____
☐ Alcohol use – if yes, drinks per week? _____
☐ Drug use – if yes, please list? _____

Review of Systems: (please check if yes)	
☐ Fever or chills	☐ Irregular heartbeat
☐ Unintentional weight loss or gain	☐ Leg swelling
☐ Fatigue	☐ Abdominal Pain
☐ Headaches	☐ Nausea or Vomiting
☐ Seizures	☐ Diarrhea
☐ Changes in vision	☐ Difficulty urinating
☐ Changes in hearing	☐ Bloody urine
☐ Changes in taste	☐ Joint Pain
☐ Sore throat	☐ Muscle weakness
☐ Cough	☐ Rash
☐ Shortness of breath	☐ Problems with healing
☐ Wheezing	☐ Problems with scarring (hypertrophic or keloid)
☐ Chest Pain	☐ Easy bleeding

Other medical history: (please check if yes)	
☐ Allergy to adhesive	☐ Artificial heart valve
☐ Allergy to lidocaine	☐ Blood thinners
☐ Rapid heartbeat with epinephrine	☐ MRSA history
☐ Pacemaker or Defibrillator	☐ Pregnancy or Planning a pregnancy
☐ Artificial joints within past two years	

Vaccination/Immunization history: (please check if yes)
☐ Shingles Vaccine Date received: _____
☐ Pneumonia Vaccine Date received: _____
☐ Flu Vaccine Date received: _____
☐ COVID Vaccine Date received: _____

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Financial Policy

Thank you for choosing Luma Dermatology for your skin care needs. We are dedicated to providing the best possible dermatologic care. Knowing your financial responsibility is an essential element of your care. With healthcare costs rising, it is essential that you understand the details of your health insurance plan. We provide an estimated cost of our most common procedures, available upon request.

Please read carefully and sign at the bottom to confirm your understanding

1) Insurance:
    a. Payment of copays, co-insurance, remaining deductibles, and past due balances are due at the time of service
    b. Charges pertaining to your visit are filed with your insurance carrier if we have valid contract. It is your responsibility to provide *accurate insurance and personal information* including any preferred laboratory cards. It is your responsibility to let us know when your insurance changes. We will also ask you to present your insurance cards at every visit for verification. Not all medical services are a covered benefit of insurance. Therefore, you will be responsible for any charges deemed not covered by your insurance.
    c. There are certain elective services we know are generally not covered by insurance. We will always let you know of these before rendering the service. You will have the option to proceed or decline the service. We will require a signature of approval and payment at the time of service if you elect to proceed.
    d. If your insurance requires a referral and/or authorization for a visit or procedure, the referral and authorization must be received *prior to your visit.* Your visit may need to be re-scheduled if it has not been received.
2) Self-pay and cosmetic: Payment is expected in full at the time of service.
3) Cancellation and Missed Appointments: We understand that unexpected events, illnesses, etc. occur. When this happens, call our office as soon possible to inform us of such issues. In the case of appointment **cancellations less than 24 hours before your scheduled appointment or missed appointments without notification**:
    a) Office Visit- a **$35 fee** will be billed to my account which is not covered by my insurance plan.
    b) Surgical/cosmetic procedure appointments- a **$150 fee** will be charged to my account which is not covered by my insurance plan.
4) Requests for Medical Records/forms (i.e., FMLA): Medical records may be sent to another provider at no charge. Printed medical records for patients are available at a **fee of $25** with written request. If requesting that they be mailed, then the **cost of postage is additional**. FMLA, medical and other such policy forms will be completed for a **$15 fee**.
5) Accepted methods of payment: Cash, Visa, Mastercard, Discover, American Express, Apple Pay, and personal checks with proper identification (valid Driver's license or photo ID).
    a. A **$50.00 charge** will be incurred for any insufficient funds or returned checks. In the event of a returned check, all future payments will be required in the form of cash or credit card.
    b. If you elect to use a credit card for your services, please understand that in the event of a credit card dispute we will release the minimum necessary protected health information to your credit card company as part of the dispute resolution process.
6) We understand that temporary financial problems may affect timely payment of your account. If you are facing financial hardship, please let us know so that we can work together towards a mutual solution.
7) Failure to pay a bill may result in your account being turned over to collections. In the event that your account is turned over to a collection agency, you will be responsible for any costs incurred by collection. Collection agency fees may be upwards of 35% of your outstanding balance.

I have read the above financial policies and understand my financial responsibilities as a patient.

Patient Name:_____

Patient Signature:_____ Date: _____

POA/Responsible Party Name: _____

POA/Responsible Party signature: _____ Date: _____