EVI Dermatology New Patient Intake

PATIENT DEMOGRAPHICS

First Name: ____________________ Last Name: ______________________

Date of Birth: ___________________ Gender: ☐ Male ☐ Female ☐ Other

Street Address: ____

City: ____________________ State: ________________ ZIP Code: _______________

Home Phone: ____________________ Mobile Phone: ___________________________

Social Security Number: ____________________ E-Mail: ________________________

Ethnicity/Race: ____________________ Weight: _______ Height: _______________

Primary Language: ☐ English ☐ Spanish ☐ Other: ________________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

EMERGENCY CONTACT

Emergency Contact Name: ______________________________

Relationship: ____________________ E-Mail: ____________________

Home Phone: ____________________ Mobile Phone: ______________________

PRIMARY INSURANCE POLICY

Primary Insurance Company: ____

Group #: __________________________ ID #: __________________________

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: _____________

Complete the following if you are *not* the policyholder for your primary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: _____________

Policyholder Name: ____________________ Date of Birth: ________________

Policyholder Social Security Number: __________________________________

SECONDARY INSURANCE POLICY (IF ANY)

Secondary Insurance Company: ___________________________

Group #: _____________________ ID #: _____________________

Primary Insurance Type: ☐ HMO ☐ PPO ☐ Medicare ☐ Other: ______________

Complete the following if you are *not* the policyholder for your secondary insurance:

Insurance Policyholder: ☐ Spouse ☐ Child ☐ Parent ☐ Other: ______________

Policyholder Name: _____________________ Date of Birth: ______________

Policyholder Social Security Number: _____________________

TREATING PHYSICIANS

Primary Care Physician: _____________________ Phone: _____________________

Referring Provider: _________________________ Phone: _____________________

PREFERRED PHARMACY

Pharmacy Name: _____________________ Phone: _____________________

Street Address: ____

City: _____________________ State: _____________________ ZIP Code: ________

General Office Policy

Thank you for choosing our dermatology practice for your skin health needs. Our mission is to provide high-quality, compassionate dermatologic care for patients of all ages. To ensure an efficient and respectful experience for all our patients, we have established the following office policies.

OFFICE HOURS

- Monday – Thursday: 8:00 AM – 4:30 PM
- Friday: 8:00 AM – 12:00 PM
- Saturday & Sunday: Closed

In the event of a family emergency or inclement weather, we will need to reschedule your appointment. These hours are subject to change at the discretion of EVI Dermatology.

APPOINTMENT AND SCHEDULING

- Appointments are required for all visits.
- We make every effort to stay on schedule. Please arrive 10–15 minutes early for check-in and paperwork.
- If you arrive 15 minutes or more late, your appointment may need to be rescheduled out of respect for other patients.
- **Patients under 18 must be accompanied by a parent or legal guardian** unless our consent to treat a minor is signed by a legal guardian

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CANCELLATION AND MISSED APPOINTMENTS

We understand that unexpected issues or illnesses can arise. We also hope that you understand that late-cancellations really affect our ability to operate. Please notify us as soon as possible if you need to cancel or reschedule.

Appointments **must be canceled at least 24 hours in advance** to avoid a fee.

- Missed or late-canceled **medical appointments** will incur a **$50 fee**.
- Missed or late-canceled **surgical or cosmetic procedures** will incur a **$200 fee**.
- These fees are not covered by insurance.

ADMINISTRATIVE FEES FOR PAPERWORK

Medical records requested by another healthcare provider will be sent at no charge.
However, completion of non-visit related forms such as FMLA, AFLAC, patient assistance, or cancer policy forms will incur a **$40 administrative fee** and must be paid at the time it is given to our office.

DIAGNOSTIC TESTS AND RESULTS

- Certain conditions may require diagnostic testing such as skin biopsies, cultures, patch testing, or blood work.
- All tests are ordered based on medical necessity and discussed with you prior to being performed.
- Biopsy and lab results are typically available within 7–14 business days, depending on the laboratory.
- Our office will contact you promptly once results are reviewed by the physician.
- Please note: for your privacy, results will not be released to family members or others without a signed HIPAA authorization.
- If you have not heard from our office within **two weeks** after your procedure or test, please call us to ensure results have been received and reviewed.

You may receive a separate bill for these diagnostic services from an off-site lab for any tests your physician may order. All questions regarding the bill should be directed to the laboratory or pathology performing the test.

PRESCRIPTION REFILLS

- Please request medication refills through your pharmacy.
- Allow 2–3 business days for refill processing.
- Refill requests will not be handled after hours or on weekends.
- Periodic follow-up visits may be required for chronic conditions. No refill will be given for any condition that has not been evaluated in over 1 year.

AFTER-HOURS CARE

- If you experience a medical emergency, please call 911 or go to the nearest emergency department.
- Prescription refills, test results, and routine questions will be addressed during regular office hours.

COMMUNICATIONS

- We encourage patients to use the secure patient portal for non-urgent questions, test results, and medication refill requests.
- Messages are typically answered within 2 business days.

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined in the "*General Office Policy*" and agree to abide by its rules in order to receive services from EVI Dermatology. I acknowledge that I have the right to decline agreement to these terms, which will result in refusal of services to me by EVI Dermatology and its providers.

Patient / Legal Guardian Signature: ________________________________

Patient / Legal Guardian Printed Name: ____________________________

Date: ____________________________

Financial Policy

INSURANCE CLAIMS

We participate with most major insurance plans. As a courtesy, we will file claims on your behalf. However, it is your responsibility to:

- **Bring your insurance card with you to every visit**. This allows us to verify the accuracy of insurance information at the time of your visit. If we cannot verify your insurance, you will be considered self-pay (**no exceptions**).
- Verify whether our services are covered by your insurance plan.
- Be aware of any co-payments, deductibles, and out-of-pocket costs as determined by your insurance provider.
- If your insurance denies coverage or does not pay the full allowable amount, you are responsible for any remaining balance.
- **We will collect BOTH co-pay and estimated deductibles <u>at the time of service</u>**. Once the claim has been processed, you will either be refunded the difference (overestimated), or be responsible for the remaining balance, should one exist. All unpaid balances past 90 days will be sent to collections and a 25% administrative fee will be assessed to cover collection agency cost as well as finance charges and will not be waived for any reason.
- If your insurance plan requires a referral, it is your responsibility to obtain and provide it prior to your appointment. If we are unable to verify a valid referral, you will be responsible for the full cost of your visit.
- **Statements will be provided electronically via email unless otherwise requested**

For Self-Pay and Non-covered services (i.e. cosmetic), full payment is required on the day of your appointment.

METHODS OF PAYMENT

We are a **cashless facility** and accept all major credit cards/debit cards. For large balances, payment plans may be arranged. A **$25 charge for all credit/debit card chargebacks.**

CREDIT CARD ON FILE POLICY (separate consent)

EVI Dermatology securely stores a valid credit card on file for all patients with commercial insurance. This information is stored using HIPAA-compliant, encrypted software — the same system that protects your confidential medical information.

If a balance remains after insurance has processed your claim, you will receive an electronic statement via email.

- **Thirty days after statement issuance, the remaining balance will be charged to your card on file to prevent your account from being sent to collections.**
- Accounts will be sent to collections after 3 statements and will not be able to reschedule until the balance is paid.

Disputed valid credit card charges will incur a **$50 administrative fee** to cover processing costs. If you believe there is an error in your statement, please contact our billing department prior to contacting your credit card merchant to avoid the possibility of an administrative fee.

ACKNOWLEDGEMENT

By signing below, I acknowledge that I have read, understand, and agree to the terms outlined in the *"Financial Policy"* and authorize EVI Dermatology to charge my card on file for balances as described above. I understand that I am responsible for any fees, co-pays, deductibles, and balances as per the terms of my insurance plan or in the case of self-pay services.

Patient/Responsible Party Signature: ______________________________

Patient/Responsible Party Printed Name: __________________________

Date: __________________________

The signer must be the same name as the credit card on file.

Credit Card on File Consent Form

1. Purpose of Credit Card on File:

In an effort to provide efficient and convenient billing processes, **we require a valid credit card be provided before your appointment.** Your credit card will only be charged for the following:

- Copayments, deductibles, and coinsurance as determined by your insurance provider
- Outstanding balances on your account after insurance claims have been processed
- Fees for services not covered by insurance (It is your responsibility to know if the service is covered or not, as every policy is different)
- Charges for missed appointments or late cancellations (if applicable as per clinic policy)
- Cosmetic procedures or other elective treatments

By consenting to this form, you authorize our dermatology clinic to charge your credit card for any of the above fees as detailed also in the financial policy.

2. Credit Card Information: Collected in-person or via secure method

3. Authorization for Payments:
I understand that my credit card information will be securely stored and may be used to cover the costs of any services provided by EVI dermatology. I authorize charges to my card for any outstanding balances and agree to the following:

- I will be notified via email or phone before any significant charges are made.
- I am responsible for providing up-to-date credit card information and agree to do so if the card is denied.
- I can request a detailed receipt of any transaction at any time.
- I understand that any stored credit card information will be encrypted and securely handled by the clinic's payment processing system.

4. Revocation of Consent:
I understand that I may revoke this authorization at any time by notifying the clinic in writing. However, any outstanding balances or fees incurred before revocation will still be charged to the card on file.

5. Consent for Credit Card on File:
By signing below, I authorize EVI Dermatology to keep my credit card information on file and charge it as outlined in this consent form. I acknowledge that I have read and understood the terms of this agreement, and all my questions have been answered to my satisfaction. I understand that I have a right to decline providing my credit card information, in which case I agree to pay in full for services rendered on the same day in lieu of providing my credit card information to be kept on file.

Credit Card Holder's Name (Print): ______________________________________

Credit Card Holder's Signature: ____

Date: ____

Acknowledgement

By signing below, I hereby acknowledge, agree to the, and authorize all of the following:

a) **Accurate Information**. I certify that the information provided on this form is accurate, complete, and up to date to the best of my knowledge.

b) **Patient Rights and Responsibilities**. I have received and understand that EVI Dermatology maintains a Notice of Privacy Practices, which describes how my protected health information may be used and disclosed, and how I may access my health records. I understand that I have the right to review this healthcare facility's Notice of Privacy Practices prior to signing this form.

c) **Release of Medical Information**. I authorize the release of my health information to the healthcare facility in accordance with the healthcare facility's Notice of Privacy Practices. This includes, but is not limited to, releasing medical information to my referring physician, primary care physician, and any physician(s) I may be referred to. The healthcare facility shall ensure all health information remains confidential, as required by HIPAA, and will not release any of my health information without my consent.

d) **Consent for Treatment**. I grant EVI Dermatology, including its affiliated providers, physicians, and other medical personnel, permission to use the health information provided for the purpose of my medical treatment as necessary.

e) **Consent to Communication**. I consent to receiving communications from the EVI Dermatology regarding appointment reminders, test results, and other necessary healthcare-related information via phone, email, or channels.

f) **Acknowledgment**. By signing below, I hereby acknowledge, agree, and authorize all of the above, and I authorize EVI Dermatology to retrieve and review my medical history and authorize EVI Dermatology to release the information required in obtaining procedure authorization or the processing of any insurance claims.

Patient/Legal Guardian Signature: ______________________________

Patient/Legal Guardian Printed Name: __________________________

Date: __________________________

Medical History Questionnaire

Name: ___________________________________ Date: ______________________ DOB: ____/_____/______

Medical History

☐ Anxiety	☐ COPD	☐ End Stage Kidney Disease
☐ Arthritis	☐ Coronary Artery Disease	☐ Neuromuscular Disorders
☐ Asthma	☐ Depression	☐ Enlarged Prostate
☐ Atrial fibrillation	☐ Diabetes Type 1 or 2	☐ Thyroid disease
☐ Autoimmune disorder	☐ GERD	☐ Tuberculosis
☐ Blood clots	☐ Heart attack/disease	☐ Lymphoma
☐ Cancer _______________	☐ Hepatitis	☐ Seizures
☐ _______________	☐ High blood pressure	☐ Stroke
☐ _______________	☐ HIV/AIDS	☐ Other _______________
☐ _______________	☐ High cholesterol	☐ _______________
		☐ _______________
		☐ NONE

Past Surgical History: (Please list all surgeries)

☐ Appendectomy	☐ Gallbladder surgery	☐ Hip Surgery	☐ Prostate Surgery
☐ Breast Surgery	☐ Coronary Bypass Surgery	☐ Knee Surgery	☐ Spleen surgery
☐ Bowel Surgery	☐ Heart Valve Replacement	☐ Organ Transplant	☐ Uterine Surgery
☐ Heart Stents		☐ Liver Resection	☐ Ovarian/Testicular Surgery
		☐ Kidney Stones	☐ Tubal Ligation

Other Surgeries Not Listed:

____

Cancer History and Treatment(s):

____

Skin Disease History: (Please circle all that apply)

☐ Acne	☐ Hay fever/Allergies	☐ Other _______________
☐ Actinic keratosis	☐ Hives	☐ _______________
☐ Basal Cell Cancer	☐ Melanoma	☐ NONE
☐ Blistering sunburns	☐ Cold Sores	Do you wear sunscreen? Yes No
☐ Dry skin	☐ Precancerous moles	Do you use a tanning salon? Yes No
☐ Eczema	☐ Psoriasis	
☐ Flaking/Itchy scalp	☐ Squamous Cell Cancer	

Do you have a First-Degree relative with a history of skin cancer? Yes No

If yes, which relative(s)? ____

Allergies: (Please list all allergies) Describe Reactions

____

____

Social History: *(circle one)*

Smoking Status: Never Current Former – Start/Stop Date: packs per day:

Alcohol Intake: None <1 per day 1 to 2 per day 3 or more per day

Other recreational Drugs: ____

Pregnant or Planning Pregnancy? Yes No

Pneumonia Vaccination

Flu Vaccination

Do you have a caregiver? (If so, name and relation) ______________________________

Current Prescriptions and Over-the-Counter Medications)

Medication Name	Strength	Frequency	Medication Name	Strength	Frequency

Primary Care Physician's Name: ______________________ Phone (_____) ______-__________

Specialists for chronic conditions ______________________ Phone (___)_____-_______

Type: (cardiologist, rheumatologist, etc.) ______________________

Specialists for chronic conditions ______________________ Phone (___)_____-_______

Type: (cardiologist, rheumatologist, etc.) ______________________

Specialists for chronic conditions ______________________ Phone (___)_____-_______

Type: (cardiologist, rheumatologist, etc.) ______________________

Pharmacy: ____________________________________ Phone (_____)_____-_________