Dermatology
Specialists of Greater Cincinnati, Inc.

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Appointment Date:	Account:

PATIENT INFORMATION

Last name:	First:	MI:	Marital status: S M D W

Birth date: / /	Age:	Gender: ☐ M ☐ F	Social Security #: - -

Preferred Method of Contact: ☐ Text Message ☐ Cell Phone ☐ Email/Patient Portal ☐ Home Phone ☐ Work Phone

Home Address:

Street City State Zip Code

Home Phone:( ) -	Cell Phone:( ) -	Work Phone: ( ) -

Email:	Ethnicity: ☐Hispanic/Latino ☐ Not Hispanic/Latino	Race: ☐ Asian ☐ African American ☐White ☐Pacific Islander ☐Native Hawaiian ☐ Other

Occupation:	Employer:	Employer phone: ( ) -

Employer Address:

Street City State Zip Code

Primary Care Physician:	
Phone: ( ) -	Address:

FAMILY INFORMATION

Names of family members seen here:

_____

Would you prefer: ☐ One Monthly Bill Per Family Member Or ☐ One Monthly Bill Per Family

SPOUSE INFORMATION

Last name:	First:	MI:	Birth date: / /

INSURANCE INFORMATION (PLEASE GIVE YOUR INSURANCE CARD TO THE RECEPTIONIST)

Primary Insurance:	Secondary Insurance:	Tertiary Insurance:
Subscriber Name & Relationship to Insured:	Subscriber Name & Relationship to Insured:	Subscriber Name & Relationship to Insured:
Subscriber SS #:	Subscriber SS #:	Subscriber SS #:
Subscriber DOB:	Subscriber DOB:	Subscriber DOB:

Insured Employer Name:

The above information is true to the best of my knowledge. I hereby authorize Dermatology Specialists of Greater Cincinnati to treat the above-named patient and I authorize Dermatology Specialists of Greater Cincinnati to release any information required to process my claims. I authorize my insurance benefits be paid directly to Dermatology Specialists of Greater Cincinnati.

Signature of Patient/Guardian _____Date: _____

FINANCIAL POLICY

1. **Insurance.** Dermatology Specialists of Greater Cincinnati participates in most insurance plans in the area, including Medicare. All patients must complete a registration form before seeing the doctor. We must also obtain a copy of your driver's license and proof of insurance coverage. Every six months you will be asked to present the insurance cards for all insurances you have (primary, secondary, etc.). Additionally, it is your responsibility to promptly notify us of any changes to the insurance information you have provided us and ensuring your insurance plan doesn't require a referral. Please contact your insurance company with any questions you may have regarding your coverage or benefits.

2. **Co-payments and Deductibles**. Co-payments must be paid at the time of service to the front desk during the check-in process. Additionally, it is your responsibility to ensure that deductibles and co-insurances are paid in a timely manner. This arrangement is part of your contract with your insurance company.

3. **Claims Submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request.

4. **Self-Pay.** If you have no medical insurance, we may offer a discount if payment is made at the time of service. For an initial consult with a physician, patients with no insurance will be required to pay a $70.00 deposit prior to being seen. Any additional charges for the visit, tests or other services rendered, you will be notified and expected to pay at the end of the visit.

5. **Cosmetic.** All cosmetic procedures and products are paid in full at the end of the visit. Unopened products can be returned within seven days of purchase. We do not accept personal checks as a form of payment for these services.

6. **Credit Card on File (CCOF).** This policy is mandatory for new patients and volunteer for established patients in 2023. Starting in 2024 all patients will be required to have a CCOF to be seen at the practice. The CCOF will pay any account balance applied to your responsibility once your insurance carrier processes your claim.

7. **Nonpayment.** Balances are expected to be paid in full. We can offer a payment plan to resolve balances in a timely manner. Please be aware that if a balance remains unpaid for 90 days, we will refer your account to a collection agency.

8. **Return Check.** The charge for a returned check is $25 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount.

9. **Credit Balances.** Patients credit balances will be refunded timely or at patient request. Any credit balance under $50 may not be returned without a written request after three years.

10. **Forms of Payment.** We accept cash, personal checks, MasterCard, Visa, American Express and Discover.

Dermatology Specialists of Greater Cincinnati is committed to providing the best experience possible for our patients. As a patient of Dermatology Specialists of Greater Cincinnati, you are ultimately responsible for understanding your insurance benefits and meeting your financial obligations. As your health care partner, we are here to help you throughout the process. If you have questions about this policy, please call (513) 231-1575.

I have read and understand the financial policy and agree to abide by its guidelines:

_____ _____

Signature of Patient or Responsible Party **Date**

PRIVACY & COMMUNICATION PREFERENCES

Patient Last name: First: MI:

Do you give our office permission to discuss your medical information with family members? ☐ Yes ☐ No
If yes, please provide names, phone numbers and relationship of those family members: _____

_____

May we leave personal medical information on your answering machine or cell phone? ☐ Yes ☐ No
May we email personal medical information to you using our Patient Portal? ☐ Yes ☐ No

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to: Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from third party payers, and/or conduct normal healthcare operations such as quality assessments and physician's certification. I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my 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 Dermatology Specialists of Greater Cincinnati at 7794 Five Mile Road Suite 240 Cincinnati, Ohio 45230 to obtain a current copy of the Notice of Privacy Practices. The complete Privacy Practices Notice for this office is displayed in the waiting room or a copy can be given to you. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature: _____

Date: _____ Relationship to Patient:_____

Patient Name: **Patient Date of Birth:** **Chart #:**

CONDITION	Yes	No	Comments
Anxiety			
Asthma			
Blood Clots			
Bowel			
Cancer			Type:
COPD			
Depression			
Diabetes			
Eczema			
GERD/Reflux			
Headaches/Migraines			
Heart Attack			
Heart Disease			
Hepatitis			
High Cholesterol			
HIV/AIDS			
High Blood Pressure			
Inflammatory Bowel			
Irregular Heartbeat			
Kidney/Liver Disease			
Lung			
Melanoma			
Mitral Valve Prolapse			
Pacemaker			
Psoriasis			
Seizures			
Skin Cancer			
Stomach			
Stroke			
Tuberculosis			
Thyroid Disease			Hypo / Hyper
Other:			

Preferred Pharmacy Information
Pharmacy Name:
Pharmacy Phone:
Pharmacy Address:

Please list all current medications below OR if patient is taking no medications X here ☐
1.
2.
3.
4.
5.
6.
7.
8.
9.
10.
Family History of Multiple Myeloma Yes or No _____

PREVIOUS SURGERIES:	SMOKING STATUS:	YES	NO
1.	Current Every Day		
2.	Current Some Days		
3.	Former Smoker		
4.	Never Smoker		

LIST ANY ALLERGIES TO MEDICATIONS:	ALLERGIES TO:	YES	NO	SUN EXPOSURE:	YES	NO
1.	Polysporin			History of excessive sun exposure?		
2.	Neosporin			Continues sun exposure without protection?		
3.	Band Aids			History of or current tanning bed use?		
4.	Adhesives			Uses high SPF sunscreen during sun exposure?		
5.	Latex			Wears a hat?		
6.	Local Anesthesia			Wears sunscreen only sometimes?		
7.	Other:			Avoids sun exposure?		

COMPLETE SKIN EXAM: A complete skin exam is very important for early detection of skin cancer. A complete skin exam would require you to undress. We recommend a yearly skin exam.	YES	NO	WAIST UP

FEMALES ONLY:	YES	NO	
Do you have a regular monthly period?			If no, please explain:
Are you pregnant?			What form of contraception do you use?
Are you trying to become pregnant?			Date of your last period: / /
Are you currently breastfeeding?			