OWENSBORO Dermatology
2821 New Hartford Road
Owensboro, KY 42303
Tel: (270) 685-5777 | Fax: (270) 685-0190

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Board-Certified: Micrographic Dermatologic Surgery American Board of Dermatology

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Sandra B Cox, APRN-C

Katie Glenn, PA-C

Trevor Warfield, PA-C

Privacy Practices

I acknowledge that Owensboro Dermatology Associates, PSC has provided me a copy of their Notice of Privacy Practices, which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information.

_____

Patient Name *(please print)*

_____

Patient Date of Birth

_____ _____

Signature of Patient/Guardian **Date**

Affiliated Locations:

HENDERSON Dermatology
Atkinson Medical Building
1413 N. Elm St. • Suite 202
Henderson, KY 42420
Tel: 1 (888) 337-6722
Fax: (270) 830-7575

NEWBURGH Dermatology
Newburgh Dermatology
10788 Stahl Road
Newburgh, IN 47630
Tel: 1 (888) 337-6722
Fax: (270) 852-8075

ADVANCED Aesthetics
Advanced Aesthetics
2821 New Hartford Road
Owensboro, KY 42303
Tel: (270) 852-4785
Fax: (270) 852-8061

SKIN CANCER AND LASER SURGERY CENTER
Skin Cancer and Laser Surgery Center
10788 Stahl Road
Newburgh, IN 47630
Tel: 1 (888) 337-6722
Fax: (270) 685-0190

MEDICAL CONSENT AND RELEASE OF INFORMATION

Consent to Treat

I voluntarily request a physician, and/or Advanced Practice Provider (Nurse Practitioner or Physician Assistant), and other health care providers or designees as deemed necessary, to perform reasonable any necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. You have the right at any time to discontinue services.

Release of Information

I authorize all Providers associated with Owensboro Dermatology Associates and affiliate locations to release information for the purpose of payment, treatment, and routine healthcare operations, including medical research studies.

The consent will remain fully effective until it is revoked in writing.

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Patient Name (please print) **Date of Birth**

Thank you for choosing Owensboro Dermatology Associates for your skin care needs. We are dedicated to providing the best possible care and service for you. We realize the challenges with health care costs today and we do our best to inform you of your personal and financial responsibility in obtaining that care. You may request a copy of this form at any time.

Please read carefully and sign below to confirm your understanding.

1. **Insurance and Billing: The patient is responsible for providing accurate insurance and personal information.** If your insurance requires a referral, it is your responsibility to provide the referral prior to your visit or the visit's fee will be your responsibility. You will be responsible at the time of service for the payment of copays and any past due balances. Laboratory/pathology services are separate from the provider's fee. Questions regarding insurance coverage and network participation should be directed to your insurance company.
   Self-Pay Patients & Cosmetic Procedures – Payment is expected in full at the time of service.

2. **Cancellation & Missed Appointments:** We understand that urgent issues arise, and illnesses occur. When this happens, call our office as soon as possible to inform us. If not, a charge will ensue. I understand that it is my responsibility to cancel my appointment more than 24 hours in advance of my appointment, otherwise a $50 fee (which is not covered by my insurance plan) will be charged to my account. For missed surgical or cosmetic visits, a $150 fee will be charged to my account.

3. **Pre-payment for Services:** Due to the increase in high deductible health plans, patients with commercial insurance who are expected to have a remaining in-network balance will be responsible for a deposit due at the time of service. This pre-payment will be applied to any remaining balance on the account as determined by the insurance carrier. Any credit on the account will be refunded to the card on file.

4. **Credit Card on File:** Owensboro Dermatology and affiliate locations securely store an updated credit card on file for all patients with commercial insurance. This information is stored securely with the same HIPAA-compliant software that protects your personal medical information. Should you have a balance after your visit, we will mail a statement. If that statement is not paid, we will charge your card on file up to $500. If you have a remaining balance, you will receive another statement, and we will continue charging your card every 30 days until the balance is paid in full. **If I do not submit payment within 30 days of receiving my billing statement, I agree to have my card on file charged automatically for my patient-responsible amount up to $500 per transaction.**

5. **Accepted Methods of Payment: Cash, Visa, Amex, Discover and personal checks with proper identification (valid photo ID). A $35 overdraft charge will be added to any insufficient funds amount on any returned checks.**

I authorize payment of medical benefits from my insurance company to all Providers associated with Owensboro Dermatology Associates and affiliate locations.

_____ _____

Signature of Patient/Guardian **Date**

_____ _____

Patient Name (please print) **Date of Birth**

Patient Information

Please complete. We need this information before we see you.

First Name:_____MI:_____Last:_____

Billing Address:_____City:_____State:_____ Zip:_____

Date of Birth: _____/_____/_____ Sex: ___M ___F Social Security # _____

Email Address:_____

**A valid email address provided by you, authorizes us to e-mail both medical & account information.*

Marital Status:_____ Home Phone: (_____) _____ Cell Phone: (_____) _____

Employer:_____ Work Phone: (_____) _____

Primary Language: _____ Have you been here before? ____Yes _____No

Student: ____Full Time _____Part Time *(Please check one for insurance purposes.)*

In case of EMERGENCY, who should we notify?_____ Phone (_____) _____

Primary Care Physician:_____ Phone (_____) _____

Referring Physician:_____ Phone (_____) _____

How did you hear about us? (Please be specific. For example, tell us which newspaper, yellow page directory, etc.)

Newspaper:_____ Website:_____ Social Media:_____ Radio:_____

Yellow pages:_____ Health Fair:_____ Cancer Screening:_____ Lecture:_____

Relative/Friend:_____ Address:_____ City/Zip:_____

Parent or Responsible Party

Name: _____ Address:_____

Home Phone: (_____)_____Work Phone: (_____)_____ Cell Phone: (_____) _____

Date of Birth: _____/_____/_____ SS#: _____ Sex: ___M ___F Relationship:_____

Employer: _____ Address: _____

Do we have your permission to:

Leave a message on your answering machine at home?	____Yes	____No
Leave a message at your place of employment?	____Yes	____No
Discuss your medical condition with any member of your household?	____Yes	____No

If yes, whom: _____ Relationship**:** _____

Patient's Signature _____ **Date:** _____

[CONTINUED ON BACK]

Reason for Appointment

OWENSBORO Dermatology
Advanced care for healthy skin
HENDERSON Dermatology · NEWBURGH Dermatology · ADVANCED Aesthetics · SKIN CANCER AND LASER SURGERY CENTER

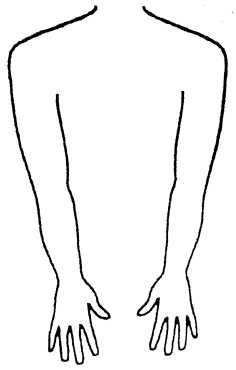
Please PRINT CLEARLY, as this will be part of your permanent medical records.

NEW RETURNING Referred by: _____ Room #: _____

Reason for appointment today: _____

_____

_____

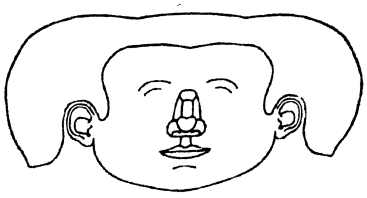


How long has this condition been present? _____

What are your symptoms, if any (itching, burning, bleeding, etc.)? Please list: _____

_____

Please list the names of prescription and over the counter medications that have been used to treat your condition (topically–creams/ointments, orally–pills) and their results?
Note: You may need to call your pharmacy for names/correct spellings:



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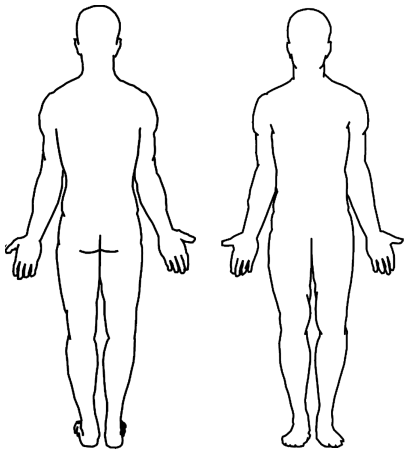

NOTES: _____

_____

_____

_____

_____

_____

_____

_____

Patient: _____ DOB: _____ Age: _____ Date: _____ Chart #: _____

Medication List

Please PRINT MEDICATIONS CLEARLY, as this will be part of your permanent medical records. Note: You may need to call your pharmacy to get the names of your medications.

Patient: _____ DOB: _____ Age: _____ Date: _____ Chart #: _____

ALLERGIES TO MEDICATIONS:_____

_____

MEDICATIONS	DATE OF SERVICE	REASON FOR TAKING

Preferred Pharmacy: _____ Phone: (_____)_____ City/Zip Code:_____

Patient Medical History

Please CHECK THE BOX if you have had any of the following medical conditions.

Past Medical History:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Parkinson's Disease
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ NONE
- ☐ Other:_____

_____

Past Surgical History:

- ☐ Appendix Removed
- ☐ Bladder Removed
- ☐ Mastectomy (Right, Left, Bilateral)
- ☐ Lumpectomy (Right, Left, Bilateral)
- ☐ Breast Biopsy (Right, Left, Bilateral)
- ☐ Breast Reduction
- ☐ Breast Implants
- ☐ Colectomy: Colon Cancer Resection
- ☐ Colectomy: Diverticulitis
- ☐ Colectomy: IBD
- ☐ Gallbladder Removed
- ☐ Coronary Artery Bypass
- ☐ Heart Transplant
- ☐ Joint Replacement, Knee (Right, Left, Bilateral)
- ☐ Joint Replacement, Hip (Right, Left, Bilateral)
- ☐ Joint Replacement within last 2 years
- ☐ Kidney Biopsy (Nephrectomy)
- ☐ Kidney Removed (Right, Left)
- ☐ Kidney Stone Removal
- ☐ Ovaries Removed: Endometriosis
- ☐ Ovaries Removed: Cyst
- ☐ Ovaries Removed: Ovarian Cancer
- ☐ Prostate Removed: Prostate Cancer
- ☐ Prostate Biopsy
- ☐ TURP (Prostate Removal)
- ☐ Spleen Removed
- ☐ Testicles Removed (Right, Left, Bilateral)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ NONE
- ☐ Other:_____
- ☐ Solid Organ Transplant
  - ☐ Heart
  - ☐ Lung
  - ☐ Kidney
  - ☐ Other: _____

Skin Disease History:

- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Asthma
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Skin Cancer
- ☐ NONE
- ☐ Other:_____

_____

Do you wear Sunscreen? _____Yes _____No
If yes, what SPF? _____

Do you tan in a tanning salon? _____Yes _____No

Do you have a family history of Melanoma?_____Yes _____No
If yes, which relative(s)? _____

[CONTINUED ON BACK]

Social History:

Cigarette Smoking

- ☐ Currently Smokes
- ☐ Has smoked in the past
- ☐ Never smoked
- ☐ Former Smoker
- ☐ Other:_____

Alcohol Use

- ☐ None
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day
- ☐ Other:_____

Family History *(Only first degree relatives):*

_____

_____

_____

Review of Symptoms:

- ☐ New or recent changes in moles
- ☐ Trouble taking oral antibiotics
- ☐ Enlarged lymph nodes
- ☐ Immune system problems
- ☐ Rash to bandages or tape
- ☐ Rash from oral antibiotics
- ☐ Rash from antibiotic ointment
- ☐ Other:_____

Alerts:

- ☐ Allergy to Adhesive
- ☐ Allergy to lidocaine
- ☐ Allergy to topical antibiotics
- ☐ Artificial heart valve
- ☐ Artificial joint replacement
- ☐ Blood thinners
- ☐ Defibrillator
- ☐ MRSA
- ☐ Pacemaker
- ☐ Require antibiotics prior to a surgical procedure
- ☐ Rapid heart beat with epinephrine
- ☐ Are you pregnant or currently trying to get pregnant?
- ☐ Other:_____

Thank You

One of our goals is to be known for exceptional patient care by providing the best possible service with the use of modern technology and the most effective treatments available. With a combined total of more than 60 years of experience in dermatology, you can feel confident that our dermatology specialists will provide reliability, experience, and quality you can trust.

On behalf of our physicians and staff, we would like to personally **thank you** for allowing us to serve you at one of our four convenient locations: Owensboro Dermatology, Henderson Dermatology, Newburgh Dermatology, and Advanced Aesthetics.

OWENSBORO Dermatology
Advanced care for healthy skin

HENDERSON Dermatology
NEWBURGH Dermatology
ADVANCED Aesthetics
SKIN CANCER AND LASER SURGERY CENTER

MIPS Questionnaire

Patient Name: _____

DOB: _____

Visit Date: _____

Primary Care Physician: _____

Have you had your flu shot this year? _____Yes _____No *If yes, when?* _____

Have you had a Pneumonia vaccination? _____Yes _____No *If yes, when?* _____

Do you have a living will? _____Yes _____No
If yes, who is your surrogate or power of attorney? _____

Do you drink alcohol? _____Yes _____No *If yes, what quantity?* _____

Smoking Status *(please check one)*

- ☐ Current Smoker - *sometimes*
- ☐ Current Smoker - *daily*
- ☐ Never smoked
- ☐ Former Smoker