VITALITY
Dermatology

PATIENT INITIAL EVALUATION INFORMATION **(YOUTH)** **DATE_____**

Patient Name_____ Date of Birth____/___/____
First Middle Last Month Day Year

Mailing Address_____
Street City State Zip

Home Phone _____ Work Phone _____ Cell Phone _____

Email Address_____

Preferred language: ☐ English ☐ Other, please specify: _____ Gender: ☐ Male ☐ Female

Race: ☐ African-American ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Other _____

Occupation _____ Employer_____ City/State_____

Emergency Contact _____
Name Telephone Number Relationship

May we share medical information with your Emergency Contact? ☐ Yes ☐ No

Please list any additional people with whom your medical information may be shared:
Name _____ Relationship_____
Name _____ Relationship _____

INSURANCE INFORMATION

PLEASE PRESENT INSURANCE CARDS AND PHOTO ID TO THE RECEPTIONIST*

Primary Insurance Company _____ Secondary Insurance Company_____
Name of Policy Holder _____ Name of Policy Holder _____
Relationship to Patient _____ Relationship to Patient_____
Policy Holder's Date of Birth _____ Policy Holder's Date of Birth _____
Policy Holder's SS# _____ Policy Holder's SS#_____
Policy Holder's address (if different from patient) _____
Patient's SS# _____

**** Vitality Dermatology sends all appointment reminders via text*****

May we leave a voicemail message should we need to contact you for any reason? ☐ YES ☐ NO
May we contact you by email? ☐ YES ☐ NO
Would you like to receive emails regarding Vitality Dermatology specials and events? ☐ YES ☐ NO

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Authorization, Release & Agreement To Pay For Services Rendered

Last name, First

As a patient, I authorize the healthcare providers at Vitality Dermatology to perform diagnostic procedures and treatments as may be necessary for proper medical care. I understand that in certain circumstances, biopsies or other skin tests may be sent to an outside facility for diagnostic purposes and that I am responsible for any charges incurred. All attempts will be made by Vitality Dermatology to send your biopsies to labs within your insurance network. I understand that separate charges will be filed from the outside laboratory. I understand that it is my right to inquire about my insurance coverage of potential services at any time during my treatment at Vitality Dermatology and that the medical providers encourage all patients to be familiar with their policies, deductibles, and benefits prior to their evaluation. Any questions or concerns should be directed to Vitality Dermatology Insurance Department.

Medicare: I hereby request that payment of authorized Medicare benefits to or on my behalf for services furnished in or by Vitality Dermatology, shall be made to the clinic and I specifically assign such benefits to the clinic. I hereby certify that all information given by me in connection with applying for benefits under Title XVIII of the Social Security Act is true, correct and complete in all respects. I understand that payment for *certain services not deemed medically necessary* are not authorized under the Medicare/Medicaid Program and that I shall be responsible for such charges unless other third-party coverage is available.

Insurance: I hereby give Vitality Dermatology all rights, benefits, and interest under any insurance policy, health plan, or third-party payer liable to me, in consideration for services rendered by the physician. I hereby authorize payment to Vitality Dermatology by any insurance policy, health plan or third-party payer for treatment received at the clinic. Secondary third-party insurance claims (i.e. cancer policy) will not be automatically filed by Vitality Dermatology; however, we will be happy to assist you with such policies when applicable.

Financial Responsibility: I understand that I am financially responsible to the clinic for all charges not covered or paid by insurance. I also understand and agree that all deductibles, coinsurance, non-covered charges, and other items not paid by insurance, health plan or other third-party payers are due and payable at time of service. I understand that following collection of insurance payment after filing on my behalf, I will receive a statement from Vitality Dermatology for either the remainder of amount on my deductible, copayment, coinsurance, or non-covered services and that payment is expected. I understand that Vitality Dermatology has a billing policy of mailed statements and that past-due accounts will be given to a reputable collection agency if statements go unanswered. I agree that in the case of default of payment, if this account is placed in the hands of a collection agency or attorney for collection or suit, 30% collection fees, finance charges, attorney fees, costs and other expenses will be paid by me.
Responsible Party Name: _____ **SS#**: _____
Address (if different from patient): _____

Non-Certification: I hereby agree that as the policyholder/beneficiary of insurance, health plan or other third-party payer, I am responsible for assuring certification is obtained from the insurance company, third party administrator or health plan for the procedure date. If certification is not obtained, I further agree that in the event the insurance health plan or other third-party payer denies either all or part of the payment on the account, I will pay the account in full upon demand from the clinic.

Consent for Release of Health Information for Billing and Payment Purposes: I consent to the release of my health information (medical records, medical results, and any and all other health information) by the clinic or any physician involved in my care for the purpose of billing, claims management, medical data processing, reimbursement, certification to any insurance company, third party payer, health plan or government agency necessary for the billing and payment of my account.

_____ _____ _____
Name (Printed) Patient or Legal Guardian Signature Date

Notice of Privacy Practices / Written Acknowledgement Form

Vitality Dermatology supports and fully participate in the H.I.P.A.A. program, which protects your privacy as a patient. Please take a few moments to review H.I.P.A.A. guidelines, which we take very seriously and then sign below to state that you have received the information.

Vitality Dermatology is required to provide you with this information and request documentation that you received it from us. Thank you!

I have reviewed a copy of Vitality Dermatology's Notice of Privacy Policies.

_____ _____
Patient Name (Printed) Date

_____ _____
Patient or Legal Guardian Signature Relationship to Patient

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Last name, First

What is the primary reason for your visit today?
_____

Have you ever had skin cancer before? ☐ YES ☐ NO If yes, what type? _____
_____

Primary Care Physician_____ Location (City /State) _____

Did another healthcare provider refer you to this office? ☐ YES ☐ NO

If YES their name_____

Female Patients: Are you currently pregnant? ☐ YES ☐ NO Are you currently breastfeeding? ☐ YES ☐ NO

Name of your pharmacy and city/state: _____

Patient Height: _____ Patient Weight: _____

CURRENT MEDICATIONS (*Please List)* ***If you do not take any medication, write none.***

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____
Others_____

DRUG ALLERGIES

Name of Drug & reaction (rash, hives, nausea, etc.) ***If there are no allergies, write none****.*

1._____
2._____
3._____
4._____

PAST SURGICAL PROCEDURES

	Surgery	*Hospital*	*Date*
1.			
2.			
3.			
4.			

FAMILY HISTORY (*Please Check Box*)

Is there a family history of skin cancer? ☐ YES ☐ NO Type _____
Is there a family history of any skin disorder? ☐ YES ☐ NO Type _____
Is there any other important family medical history: ☐ YES ☐ NO Explain _____

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REVIEW OF SYSTEMS: Check your recent symptoms (in the last month):

☐ Abnormal Wound Healing
☐ Antibiotics Prior to Dentist
☐ Changes in Bowel Habits
☐ Changes in Menstrual Cycle
☐ Changes in Vision
☐ Chest Pains
☐ Chills
☐ Chronic Rashes
☐ Cough
☐ Depression
☐ Diarrhea
☐ Difficulty Hearing
☐ Difficulty Sleeping
☐ Dizziness
☐ Double Vision
☐ Ear Pain
☐ Fainting
☐ Fatigue
☐ Fevers
☐ Headache
☐ Heart Palpitations
☐ Inability to Urinate
☐ Incontinence
☐ Indigestion/Reflux
☐ Joint Pains
☐ Joint Swelling
☐ Loss of Consciousness
☐ Muscle Pains
☐ Nausea
☐ Night Sweats
☐ Numbness
☐ Painful Bowel Movements
☐ Painful Urination
☐ Paralysis
☐ Prolonged Bleeding
☐ Seizures
☐ Shortness of Breath
☐ Skin Growths
☐ Ulcers ☐ (Skin) ☐ (Stomach)
☐ Vomiting
☐ Weight Loss

****The above-mentioned symptoms are being managed/treated by_____.**
(Medical Provider)

PAST MEDICAL HISTORY: Check medical conditions you have been diagnosed with:

☐ Allergies (seasonal)
☐ Anemia
☐ Arthritis
☐ Artificial Heart Valve
☐ Asthma
☐ Autoimmune Disorder
☐ Bleeding Disorder
☐ Diabetes
☐ Emphysema
☐ Gastric Ulcer
☐ Gastrointestinal Disorder
☐ Glaucoma
☐ Gonorrhea
☐ Heart Arrhythmia
☐ Heart Attack
☐ Heart Disease
☐ Heart Defibrillator
☐ Heart Failure
☐ Heart Murmur
☐ Heart Surgery
☐ Hepatitis
☐ High Blood Pressure
☐ High Cholesterol
☐ HIV/AIDS
☐ Keloids
☐ Kidney Problems
☐ Lung Disease
☐ Lyme Disease
☐ Menstrual Dysfunction
☐ Miscarriages
☐ Mitral Valve Prolapsed
☐ Nerve Damage
☐ Pacemaker
☐ Pneumonia
☐ Psychiatric Condition
☐ Prostate Disease
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Seizures
☐ Stroke
☐ Syphilis
☐ Thyroid Abnormality
☐ Tuberculosis
☐ Vascular Disease
☐ Visual Impairment

Do you have any disease, condition or problem not listed? _____

As part of the Affordable Care Act we are required to obtain the following information.

TOBACCO STATUS:
Are you a current Tobacco user? ☐ YES ☐ NO

FLU SHOT:
Have you received a Flu Shot this year? ☐ YES ☐ NO

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CONSENT FOR TREATMENT OF MINOR

This section must be completed if the patient is under the age of eighteen:

It is usually best for the parent to be present during a visit to Vitality Dermatology. Questions regarding medical history are an integral part of the evaluation, and parents are often the best historians for their child. A person is considered a minor in the state of Mississippi until the age of 18.

Many times, parents find themselves unable to accompany their minor child to appointments. We require that this form be completed to ensure that your child can receive medical treatment without your presence with your permission.

I authorize my child, _____, to receive medical treatment at Vitality Dermatology in my absence if I am unable to attend the appointment and another adult accompanies them. Specifically, my child may be accompanied by the following specific persons:

1._____

2._____

3._____

Please provide telephone number to contact you at the time(s) of your child's evaluation, if needed:

_____

☐ I authorize that the above child may attend their evaluation without myself or another guardian. I understand that Dr. Hairston, NP Kala White, NP Michelle Beasley, or Allison Thomas, Laser Specialist may call me during the course of the evaluation/treatment.

_____
Name of Parent / Legal Guardian (Printed)

_____ _____
Signature Date