Magnolia
DERMATOLOGY & AESTHETICS

Patient Information

Last Name: _____ First Name: _____

Date of Birth: _____ Gender:_____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Primary Phone #: _____ Secondary Phone #:_____

Martial Status: Single Married

Occupation: _____

Primary Care Physician: _____ Phone: _____

Referring Physician: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Pharmacy Information

Pharmacy Name:_____ Address: _____

City: _____ State: _____ Zip Code:_____

Mail order Pharmacy (if applicable) : _____

Insurance Information

Primary Insurance Carrier: _____ ID Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder relationship to patient: _____

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Social Security number (if Medicare): _____

Secondary Insurance Carrier: _____ID Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Prescription Coverage

RX Insurance Carrier: _____ ID Number: _____

RXGRP: _____ RXBIN: _____ RXPCN: _____

Assignment and Release

I hereby authorize the assignment of benefits (payments) directly to Magnolia Dermatology and Aesthetics for all insurance claims related to services rendered. I agree to pay all charges that exceed or are not covered by my insurance. I understand that copays, deductibles, and charges for non-covered services are due at the time of service.

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I authorize the use of this signature on all insurance submissions.

I authorize the release of any information acquired during my examination or treatment to my referring doctor and/or my insurance company.

Signature: _____ Date: _____

Name (Print) _____

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Medical History

Patient Name: _____ Date of Birth: _____

Past Medical History

Anxiety Arthritis Asthma Atrial Fibrillation Diabetes

Depression High Blood Pressure Kidney Disease COPD

Hearing Loss Hyperthyroidism Hypothyroidism HIV/AIDS Stroke

High Cholesterol GERD

History of Cancer: YES / NO If Yes: _____

Organ Transplant: YES / NO If Yes: _____

Other: _____

History of Radiation Treatment: YES / NO If Yes: _____

Bleeding Disorder YES / NO On a blood thinner: YES / NO

Pacemaker: YES / NO Defibrillator: YES / NO Rapid Heartbeat with Epinephrine: YES / NO

Pregnant or planning pregnancy: YES / NO Breastfeeding: YES / NO

Past Surgical History

Joint Replacements: YES / NO If Yes: _____

Other Surgical History: _____

_____

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Past Dermatological History

Personal history of skin cancer: YES / NO

Basal Cell Squamous Cell Melanoma Merkel Cell

Please specify body location, date and treatment: _____

Family History of Skin Cancer (first degree relatives only): YES / NO

Family History of Melanoma: YES / NO Please specify: _____

Blistering Sunburns: YES / NO Current or past use of tanning beds: YES / NO

Other pertinent skin conditions : _____

Skin Concerns

Do you have concerns about aging skin? YES / NO
Do you have concerns about fine lines and wrinkles? YES / NO
Do you have concerns about dark spots/uneven skin tone? YES / NO

Current Medications: _____
_____
_____
_____

Allergies: _____

Social History:

Tobacco Use? YES / NO Frequency: _____

Flu Vaccine? YES / NO

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Magnolia Dermatology and Aesthetics Financial Policy

Thank you for choosing Magnolia Dermatology and Aesthetics as your dermatology care provider. Our primary mission is to provide our patients with outstanding medical care. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Carefully review the following information and return this form with your signature and today's date. Please ask if you have any questions.

You will be asked to fill out a new patient demographic form at your initial visit. It is your responsibility to notify our office at your follow-up visit(s) if any demographic information has changed, as well as any necessary updates to your insurance.

Insurance

After your visit we will submit a claim to your insurance and await insurance payment. After we receive payment from your insurance, and if there is a portion left for you to pay, we will send you a statement for you out of pocket responsibility (copays, deductibles, co-insurance) and await your payment.

Self-pay visits must be paid in full at the time of service.

You may receive an EOB (Explanation of Benefits) from your insurance company. This is NOT a bill from our office. This helps you understand how much your plan covers and what you may owe. Please await a statement from Magnolia Dermatology showing the actual amount owed to the office.

Medical and Cosmetic Billing

Both medical and cosmetic dermatology services are provided in our office. It is important to understand that these services are billed separately, even if you are seen for both medical and cosmetic reasons at the same appointment. Cosmetic services and procedures are not and will not ever be billable to insurance and must be paid in full at the time of service.

Cosmetic services

Treatment packages for laser or aesthetic services are nonrefundable and expire 12 months from date of purchase

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No Show

If you are unable to keep your scheduled appointment you must notify the office 24 hours prior to the time of your appointment. If you fail to notify the office and miss your appointment it will result in you being charged a $50 no show fee. This fee is applicable to all appointment types.

Insurance Accuracy

It is the patients' responsibility to provide Magnolia Dermatology and Aesthetics with accurate and current insurance information. It is the patient's responsibility to understand the terms and coverage provided under your insurance plan. Please check with your insurance company to ensure that your physician participates as a provider in your insurance plan or network. If we do not have confirmation of your insurance coverage, you, as the patient, are responsible for any charges incurred at the time of your visit. If your insurance company does not cover services deemed necessary by your physician and you agree to proceed with these services, you are responsible for payment.

Any co-insurance, deductible, out-of-pocket and copay amounts will be the patient's responsibility. The patient shall be responsible for paying any balance remaining after the application of any insurance at the time of the visit. If any balance remains unpaid for more than 60 days after the date of service, your account may be referred for collections and you will be responsible for any collection charges or attorney's fees relating to the collection of your account.

Please note it is the patients' responsibility to file reimbursement with your insurance company if insurance was not presented at the time of visit.

By signing this form, I acknowledge that I have received and reviewed Magnolia Dermatology and Aesthetics Financial Policy.

Signature: _____ Date: _____

Name (Print) : _____

****For patients with financial hardship or other extenuating circumstances a payment plan can be worked out with the office at our discretion*

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General Consent and HIPAA

Consent for Treatment: By signing this form, I consent and authorize my health care provider to examine and treat me. I understand this could include lab tests, procedures such as biopsies and destructions, and other diagnostic testing. These services could be billed separately by different laboratory and pathology companies. I understand that my provider is available to explain the purpose of the treatment, tests, and procedures and that I have a right to refuse his or her recommendations.

Billing Authorization: I hereby authorize Magnolia Dermatology and Aesthetics to release requested medical information to my insurance company to collect payment for any charges.

Assignment of Benefits: I hereby request that payment of insurance benefits be made directly to Magnolia Dermatology and Aesthetics on my behalf for any services provided to me. I acknowledge and understand that I am financially responsible for all charges related to services for myself or my dependents. It is my responsibility to know my insurance policy and benefits coverage. If, for any reason, my insurance carrier does not pay any portion of my bill, I agree to pay and balances promptly.

Medicare Authorization: I request payment of authorized Medicare benefits be made on my behalf to Magnolia Dermatology and Aesthetics for any services furnished to be by that physician/clinic/supplier. I authorize any holder of hospital or medical information about me to release to the Health Care Financing Administration and its agents. I permit a copy of this authorization to be used in place of the original. I understand that Medicare may deem certain services as noncovered. Should I choose to receive those services; after being informed, I assume responsibility for payment of those services.

Financial Policy: I hereby acknowledge that I had access to a copy of the financial policy of Magnolia Dermatology and Aesthetics and have reviewed this policy. I know that any co-pay is due at the time of service. I am aware of Magnolia Dermatology and Aesthetics policies on finance charges and past due balances.

Patients Right to Privacy: I acknowledge that I have been made aware of Magnolia Dermatology and Aesthetics HIPAA Privacy Practice that pertain to my rights regarding the use and disclosure of my protected health information. These rights are more fully described I this offices Notice of Privacy Practices. I understand that a copy of Magnolia Dermatology and Aesthetics Privacy Practices are available to me on the website or in the office upon my request. I consent to be contacted by Magnolia Dermatology and Aesthetics at the physical address, phone numbers and emails provided

Blood Testing: I understand that while receiving care, a healthcare worked may accidentally be exposed to my blood or other bodily fluid. If this rare event occurs, I consent to my blood be tested for the presence of infectious diseases to protect the health care worker.

Electronic Prescribing: I authorize Magnolia Dermatology and Aesthetics to retrieve my medication history from my pharmacy through their e-prescribing system and then import my current medications into my electronic medical record

Signature: _____ Date: _____

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Photography: I consent to my picture being taken for medical records, communication with other health care providers involved in my care, and marketing if verbal consent is given

HIPAA Information:

I authorize Magnolia Dermatology and Aesthetics to discuss all aspects of my protected health information including all but not limited to appointments, medical diagnoses, test results, prescription information and financial information with the following individuals:

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Name: _____ Phone: _____

Relationship: _____

Signature: _____ Date: _____

Name (print): _____

Contact Preferences – Check one:

- ○ I wish for Magnolia Dermatology and Aesthetics to contact me and leave a DETAILED message with protected health information at the following number: _____
- ○ I do not wish for Magnolia Dermatology and Aesthetics to contact me and leave a DETAILED message with protected health information and instead would like them to request a call back