REVELUS Dermatology

PATIENT DEMOGRAPHICS INTAKE

Board-Certified Dermatologists

PATIENT

Full Name _____ Marital Status _____

Social Security Number _____ Employment Status _____

Date of Birth _____ Gender _____ Referral Source _____

CONTACT

Address _____ Home Phone _____

City _____ State _____ ZIP _____ Work Phone _____

E-Mail _____ Mobile Phone _____

Primary Care Physician _____ Emergency Contact _____

Referring Physician _____ Emergency Phone _____

GUARANTOR / FINANCIAL RESPONSIBILITY (ONLY FOR MINORS, LEGAL GUARDIANS, OR POWER OF ATTORNEY)

Guarantor Name _____ Address _____

Relationship _____ City _____ State _____ ZIP _____

Phone _____ E-Mail _____ DOB _____

E-MAIL LIST SIGN-UP:

☐ Cosmetic Specials ☐ Flash Sales ☐ Newsletter

FINANCIALS

Self-Pay: ☐ Yes ☐ No

Primary Insurance Company _____ Relationship to Policy Holder _____

Primary Policy Number _____ Policy Holder Name _____

Primary Policy Group _____ Address _____

Policy Holder DOB _____ Gender _____ City _____ State _____ ZIP _____

Secondary Insurance Company _____ Relationship to Policy Holder _____

Secondary Policy Number _____ Policy Holder Name _____

Secondary Policy Group _____ Address _____

Policy Holder DOB _____ Gender _____ City _____ State _____ ZIP _____

SIGNATURE

I understand that my signature below confirms that the information on this form is accurate and complete to the best of knowledge.

_____ _____

Patient, Guardian, or Responsible Individual Signature Date Signed

REVELUS Dermatology

PATIENT MEDICAL HISTORY INTAKE

Board-Certified Dermatologists

PAST MEDICAL HISTORY

Check any medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH
- ☐ Blood clot
- ☐ Cerebrovascular accident
- ☐ Obstructive lung disease
- ☐ Coronary arteriosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ Elevated Blood Pressure
- ☐ End Stage Renal Disease
- ☐ Epilepsy
- ☐ Gastroesophageal reflux disease
- ☐ Gout
- ☐ Hypertension
- ☐ Hearing Loss
- ☐ Viral Hepatitis
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Liver Disease
- ☐ Kidney Stone
- ☐ Leukemia
- ☐ Lymphoma
- ☐ Liver Cancer
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Kidney Cancer
- ☐ Lung Cancer
- ☐ Ovary Cancer
- ☐ Prostate Cancer
- ☐ Thyroid Cancer
- ☐ Prostate Cancer
- ☐ Bone Marrow Transplant
- ☐ **None**

If other, what conditions?

List any surgeries that you have ever had:

- ☐ Coronary artery bypass graft
- ☐ Excision of Basal Cell
- ☐ Excision of Melanoma
- ☐ Excision of Squamous Cell
- ☐ Artificial Heart Valve
- ☐ Tubal Ligation
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Heart Valve Replacement
- ☐ Cystectomy
- ☐ Hysterectomy
- ☐ Pacemaker
- ☐ Lumpectomy: Left breast
- ☐ Mastectomy: Left Breast
- ☐ Mastectomy: Right Breast
- ☐ Oophorectomy
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ Nephrectomy
- ☐ Organ Transplant
- ☐
- ☐ **None**

If other, what surgeries?

SKIN DISEASE HISTORY

Check any skin conditions that you have ever had:

- ☐ Acne
- ☐ Actinic keratoses
- ☐ Asteatosis cutis
- ☐ Basal cell skin cancer
- ☐ Dysplastic nevus
- ☐ Eczema
- ☐ Asthma
- ☐ Herpes zoster (shingles)
- ☐ Herpes Simplex
- ☐ Keloid
- ☐ Melanoma
- ☐ Lymphoma of the skin
- ☐ Partial loss of hair
- ☐ Psoriasis
- ☐ Rosacea
- ☐ Squamous cell carcinoma
- ☐ Sunburn of second degree
- ☐ **None**

If other, what skin diseases?

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, who?

MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No

If yes, what medications? If you have a list, please provide it.

DRUG ALLERGIES

Do you have drug allergies or reactions? ☐ Yes ☐ No

If yes, what medications? If you have a list, please provide it.

ADVANCE CARE PLANNING (Quality Measure)

Do you have a healthcare Proxy? ☐ Yes ☐ No
Do you have a living will? ☐ Yes ☐ No

Not selecting an answer will be an assumption of "No"

SOCIAL HISTORY

Check your Smoking Status (any nicotine):

☐ Everyday ☐ Some days ☐ Former Smoker ☐ Never

Check all Social History Details that Currently Apply:

- ☐ Not sexually active
- ☐ 1 Sexual Partner
- ☐ Multiple Sexual Partners
- ☐ Same Sex Partner
- ☐ Drug Use
- ☐ No Alcohol Consumption
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day
- ☐ IV Drug use

FAMILY HISTORY

Check any conditions that run in your family.

First degree relatives only (mother, brother, sister etc.)

- ☐ Arthritis Who?
- ☐ Asthma Who?
- ☐ Psoriasis Who?
- ☐ Cancer Who?
- ☐ Skin Cancer Who?

If yes, what type of skin cancer?

If there is additional family history, what conditions and family which family members?

CONTACT INFORMATION

OK to leave a Detailed Voicemail? ☐ Yes ☐ No

PHARMACY

Provide the name and intersection or address:

If you don't have a pharmacy or want to support local businesses, we suggest Victory Medical across from Target

PRACTICE INFORMATION

Do you have a primary care physician? ☐ Yes ☐ No

If yes, who is the physician?

Were you referred by a Physician? ☐ Yes ☐ No

If yes, who was the physician, PA, or nurse?

REVIEW OF SYSTEMS

Check any situations that apply:

- ☐ Changing Moles/Lesions
- ☐ Itchiness
- ☐ Rash
- ☐ Extreme Fatigue
- ☐ Unintentional Weight Loss
- ☐ Problems with Bleeding
- ☐ Swollen Glands/Lymph Nodes
- ☐ Numbness/Tingling
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Frequent Urination
- ☐ Muscle Weakness
- ☐ Allergy to Adhesive
- ☐ Allergy to Topical Antibiotic
- ☐ Pacemaker/Defibrillator
- ☐ Bone Marrow Transplant
- ☐ Blood Thinner /Daily Aspirin
- ☐ Immunosuppression
- ☐ MRSA (Resistant Staph)
- ☐ Accutane in the 6 months
- ☐ Artificial Joint in the last 2 years
- ☐ Hair Loss
- ☐ Problems with Scarring
- ☐ Blood Clots
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Headaches
- ☐ Insomnia
- ☐ Excessive Thirst
- ☐ Shortness of Breath
- ☐ Bloody Stool
- ☐ Difficulty Swallowing
- ☐ Joint Aches
- ☐ Chest Pain
- ☐ Allergy to Lidocaine
- ☐ Artificial Heart Valve
- ☐ Pregnant or Planning
- ☐ Stomach Ulcers
- ☐ Organ Transplant
- ☐ Hepatitis B or C
- ☐ HIV/AIDS

SIGNATURE

I understand that my signature below confirms that the information on this form is accurate and complete to the best of knowledge.

Patient, Guardian, or Responsible Individual Signature | Patient Name | Patient DOB | Date Signed

REVELUS Dermatology

PATIENT FINANCIAL POLICY AGREEMENT
APRIL 2023

Board-Certified Dermatologists

Thank you for choosing Revelus Dermatolgoy for your care. We aim to deliver outstanding and transparent service. It is important that patients understand their rights and responsibilities. Herein, Westgate Skin & Cancer, PLLC dba Revelus Dermatology will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH POLICY

Scheduling Policy: The Practice requires a Credit Card on File (CCOF) or an on-account deposit to hold appointments. The Practice securely stores and encrypts (vaults) card information, and once stored, card information cannot be retrieved.

_____

Select One (Required)

☐ **CCOF**: I understand, consent, and authorize Revelus Dermatology to securely store my card on file and charge my card for any cancellation or rescheduling fees, telemed visits, or release of record requests.

☐ **Deposit**: I understand, consent, and authorize Revelus Dermatology to keep a $50 deposit for consults or a $200 deposit for advanced procedures

Select One (Optional)

Auto Bill: I do not want to receive a paper statement. You may automatically charge the card on file for any balance under:

☐ **$100** ☐ **$300** ☐ **$1,000** ☐ **All**

Financial Responsibility and Authorization to Treat: I acknowledge that, except as outlined by my health insurance, I am financially responsible for all charges associated with services, including non-covered services, rendered by the Practice. I understand that I may consult my insurance company before receiving care if I have any inquiries. I reserve the right to refuse treatment for any reason, including financial limitations. I authorize the Practice's providers and staff, at their discretion, to perform medical treatment and procedures on myself or the designated patient.

_____

In-Network Insurance Claims, Assignment, and Estimates: I understand and authorize the Practice to bill all provided in-network insurance policies for covered services rendered. I understand and consent to the release medical documentation to my insurance company associated with covered services. I authorize assignment of insurance payments to be made directly to the Practice for all insurance benefits. I understand that the Practice will verify my eligibility and benefits for covered care with my insurance company, but verification of benefits is not a guarantee of payment or coverage. I understand that I have the right to seek care outside of the Practice should I require that my covered care not be disclosed to my insurance carrier.

_____

I consent to pay at the time of service for:

- Co-Pay estimates
- Deductible estimates
- Co-Insurance estimates
- Any other estimated out-of-pocket costs

I understand that I will be billed if:

- My insurance company pays less than what is estimated
- My insurance company denies my claim
- My insurance company does not pay within 90 days
- My insurance company recoups payment or benefits at a later date

Self-Pay, Out-of-Network Insurance Claims, and Packages Policy: I acknowledge that payment is due in full at the time of service and I am responsible for obtaining a receipt. Out-of-network benefits are between myself and my insurance company, and I am responsible for filing and managing out-of-network insurance claims. I understand that elective services or packages must be purchased in full during my visit and previously rendered services are considered separate. Packages expire one year from the purchase date. All completed services are non-refundable.

_____

Practice Fees and Appointment Cancellation Policy: I understand and consent to pay the following fees not covered by my insurance. All appointments must be cancelled or rescheduled 24 business hours in advance.

_____

- **No-Show Fee** – $50 for all medical consults, cosmetic consults, basic medical procedures, and basic cosmetic procedures
- **No-Show Procedure Fee** – $200 for all advanced procedures that are 20 minutes or more such as fillers, surgeries, etc.
- **Returned Check Fee** – $50 in addition to any outstanding balance if my check is returned for any reason
- **Delinquent Account Fee** – I will pay my past due balance and an additional 34% service fee if my account is sent to collections
- **Re-Instatement Fee** – $200 if I am dismissed from the practice, and upon approval from the medical director, reinstate my care
- **Release-of-Records Service Fee** – $25 for the first 500 pages, $50 for over 500 pages for any request received with my signature
- **Prior-Authorization Appeal Letter Fee** – $50 fee per appeal letter at my provider's discretion. Payment not a guarantee of approval
- **Prior-Authorization Peer-to-Peer Review Fee** – $150 fee per review at my provider's discretion. Payment not a guarantee of approval

Pathology and Lab Fees: I authorize to be billed by an external lab for ordered services rendered. I understand that certain procedures, such as biopsies or cultures, necessitate pathology and/or lab services. I will make financial arrangements directly with these entities. Fees may vary from $100 to $400 per sample/specimen, and determination of fees may only be possible after orders are processed.

_____

Product Purchases: Product Purchases: I acknowledge that the Practice collaborates with Dermly for product purchases and fulfillment. All product purchases are final. In the event of an issue with the product, a one-time courtesy exchange for a similar or like product is allowed. Products used more than 25% are ineligible for exchange. Additional terms and conditions can be found at dermly.com/terms.

_____

SIGNATURE

I understand that my signature below confirms that I have read, understand, and consent to Revelus Dermatology's Financial Policies.

Patient, Guardian, or Responsible Individual Signature	Patient Name	Date Signed

REVELUS Dermatology

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

Board-Certified Dermatologists

Thank you for choosing Revelus Dermatology for your care. We aim to deliver outstanding and transparent service.It is important that our patients understand their rights and responsibilities. Herein, Westgate Skin & Cancer, PLLC dba Revelus Dermatology will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH SECTION

_____ **Receipt of Practice's Policies Acknowledgement:** I understand and acknowledge that I have been given the opportunity to read the Practice's policies. This includes the Notice of Privacy Practices, Financial Policies, and Office Policies. I have the right to request a copy of these documents in office or I can acquire them by visiting www.revelusdermatology.com.

- **Notice of Privacy Practices** – Your rights under HIPAA and how the Practice follows HIPAA law.
- **Financial Policies** – Your Financial Responsibilities and how the Practice addresses financial matters.
- **Office Policies** – General office policies and how the Practice handles care

_____ **Contact and Communications Consent:** I understand and acknowledge that I have been given the opportunity to confirm my communication rights under HIPAA. In the event the practice needs to communicate my information that is protected under HIPAA, I confirm that it is permissible to:

☐ Speak to a spouse or trusted person about my information. **Name**: _____

☐ Speak to an additional trusted person about my information. **Name**: _____

☐ Leave a message on a voicemail system that includes my information. **Number**: _____

☐ **Dr. Epstein Patients:** Gather, digitize, and organize my medical records that you may already have.

_____ **Insecure, Timely, and Limited Communication Acknowledgement:** I understand and acknowledge that e-mail, text, and some phone conversations are considered insecure under HIPAA privacy laws. The Practice cannot secure in-bound communications that I initiate. I understand and acknowledge that priority or emergency communications must be made via voice phone call and that any other form of communication may take several business days before being received. Additionally, I understand that if I release my information or make public commentary, in most cases, no response will be provided since HIPAA law prohibits the Practice from acknowledging patients in a public forum.

_____ **Contact Method and Entity Acknowledgment:** I understand and acknowledge that my address, phone number, and or e-mail may be used as contact methods for the purposes of clinical care and or informative information. I understand that I may be contacted based on my selected contact interests at any point in the future by our Providers, the Practice, and or associated clinical parties (labs, referrals, etc.) as per HIPAA guidelines and HIPAA privacy protections.

_____ **Photography, Videography, and Recording Devices Privacy Acknowledgement:** I understand and acknowledge that any photos or videos taken by the Practice are protected under HIPAA law. Some procedures, such as cosmetic and or elective procedures, require photos per office policy in order to provide care. The release of videos or photos by the Practice requires my written consent. The use of personal photography, videography, and or recording devices by patients is forbidden. I understand and acknowledge that the use of these devices and or in conjunction with social media puts other patients' privacy at risk and may lead to a breach of privacy under HIPAA law. The Practice, its facilities, and its staff do not consent to being captured or recorded by any photography, videography, and or recording devices under any circumstances unless written approval by the practice manager is obtained in advance.

_____ **Telemedicine Acknowledgement:** I understand and acknowledge that the Practice provides telemedicine in accordance with HIPAA guidelines should I choose to schedule a telemedicine appointment. Telemedicine has been found to be effective in treating many disorders and conditions, however; there is no guarantee that treatments will be effective due to inherit limitations in video technology and the inability to perform physical procedures such as, but not limited to, injections, destructions, and biopsies etc.

_____ **Patient Dismissal Acknowledgement:** I understand and acknowledge that the Practice is committed to service and reserves the right to dismiss patients for breaking office policies. Examples include, but are not limited to, financial negligence, abuse of staff, falsification of information, non-compliance with a care plan, unauthorized use of personal recording devices, and or derogatory or defaming commentary. In extreme cases, the Practice reserves the right to seek damages.

SIGNATURE

I understand that my signature below confirms that I have reviewed and agree to the privacy, financial, and office polices of the Practice.

_____ _____ _____

Patient, Guardian, or Responsible Individual Signature | Patient Name | Date Signed