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Patient Medical History and Intake Form

Full Name: _____ Date of Birth: _____

Medical History: Please circle any of the following medical conditions you have:

Anxiety/Depression	Diabetes	Neuropathy
Asthma	Organ Transplant	Seizures
Seasonal Allergies	High/Low Thyroid	Stroke
A-Fib	Hearing/Vision Problems	GERD
Heart disease/Valve Problems	COPD	Kidney Disease
Heart Attack	Radiation Treatment	Liver disease
High Cholesterol	Lymphoma	Leukemia
High/Low Blood Pressure	Enlarged Prostate	

Other Cancer:_____

Other:_____

Surgical History: Please list any surgeries you have had:

_____

_____

Previous Skin Conditions: Please circle any of the following skin conditions you have:

Eczema	Acne	Rosacea
Psoriasis	Actinic Keratoses (PreCancers)	Hives/Urticaria
Dry Skin	Seborrheic Keratoses	Itchy Scalp
Itching	Lupus	Hair loss/Alopecia
Vitiligo	Melasma	Dandruff/Flaky scalp
Fatty Tumors	Sweating	Keloids/Scars
Nail Disorders	Toe Nail Fungus	Warts
Blistering Sunburn		

Other: _____

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Skin History: Do you have a history of Skin Cancer: YES/NO

If yes, please circle which type if known: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

If Melanoma:

Where was your melanoma located:_____

What year was it treated:_____

Did you have Lymph nodes sampled: YES/NO

Do you have a **family history** of Melanoma: YES/NO

Relationship to you: _____

Do you regularly wear sunscreen: YES/NO

SPF:_____

Have you had exposure to a tanning bed, even a single time in your life: YES/NO

Medication:

Please list the medications you take on a daily basis.

If you brought a list with you, please hand it to the front desk for a copy to be made.

If you forgot your list, the medical staff can get this information from the pharmacy for you.

_____
_____
_____

Allergies:_____
_____

Family History:

Please list your families history of serious medical conditions if known:

_____
_____

Smoking History: Current Smoker/Former Smoker/Never Smoker

If current or former smoker: Packs per day: _____Started _____Stopped_____

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Questions Required by Insurance Companies:

Do you have someone that can make decisions on your behalf if you cannot speak for yourself (healthcare proxy)?: YES/NO

If so, please provide their contact information: (Name) _____

(Phone number) _____

In the event of an emergency do you wish to be resuscitated? YES/NO

Race: White/African American/Asian/Native American/Unspecified or Other: _____

Ethnic group: Hispanic or Latino/Nonhispanic or Latino/Unspecified/Unknown/Decline to Specify or Other: _____

Approximate height:_____ Approximate weight:_____

Review of Systems:

How are you feeling today?

Please circle any of the following symptoms you **currently** have:

Fever	Sinus problems	Chest Pain
Chills	Ear Pain	Shortness of Breath
Night sweats	Mouth Sores	Racing Heart
Blurry Vision	Trouble swallowing	Cough
Dizzy	Muscle Weakness	Blood in Urine/Stool
Nausea/Vomiting	Bruising/Bleeding	Urge to pee
Diarrhea	Abdominal Pain	Pain with urination

Joint/MusclePain: _____

Other: _____

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Office Policies & Patient Financial Obligations:

Insurance Information: Insurance card(s) must be presented at time of visit. Cards will be scanned and entered for the patients file. It is the patients responsibility to provide any updated information or changes regarding the patients insurance at the time of service. If insurance information is not provided at the time of visit, the charges are the patients responsibility.

Referrals: In the case that the patients insurance requires a referral, the patient is responsible for obtaining the referral from their primary care physician prior to their scheduled appointment. If the patient chooses to be seen without a referral, they may be responsible for the charges. Straits Dermatology has the right to postpone any visit until referral is provided, if required.

Payment at time of Service: If the patients insurance plan participates with us, the patient will be responsible to pay their co-pay, deductibles and /or co-insurance **at time of service**. The patient may also **be responsible for payment of services related to conditions that are not covered by your Plan.** It is the patients responsibility to know and understand their own insurance plan and benefits. If the patient has not met their deductible, they will be responsible for the deductible and whatever amounts the insurance company does not pay at the time of service. If the insurance company denies payment or will only pay a portion of the medical bill, the patient is responsible for payment of services rendered and will be billed accordingly. If the patient's insurance plan does not participate with us, the patient will be responsible for the total cost of services provided at the time of service.

Laboratory Bills: If the patient should undergo a biopsy or excision in our office, the Lab will bill their insurance carrier separately. The patient will receive a separate bill from the Lab for any uncovered charges.

Payment Methods: For your convenience, we accept the following forms of payment: Cash, Check, and credit cards (Visa, MasterCard, Discover or American Express) as well as Google Pay, Apple Pay, Samsung Pay, and Cash App.

Credit card on file and Autopay: Our software has the ability to store the patient's credit card information. This information is stored in accordance with each card's individual requirements and only the last four numbers are visible to us. The patient may also enroll in Autopay to process payments and bills from our office more conveniently. A limit can be set for autopay and can be customized per patient and per bill. The patient may opt out of credit card on file and autopay at any time.

Payment plans: All patients can opt for a payment plan to decrease the financial burden of care.

Account Balances: If the patient's account stays delinquent for more than 90 days and or if the patient carries a balance that exceeds **$300**, they may not be able to schedule any future appointments and could be subject to collections.

Divorce or Custody Situations and Minors: The parent/guardian who has signed the Minor Consent for Treatment Form will be responsible for any co-pays or balances that are due at time of service.

Cancellation and No-Show Policy: Our Cancellation and No-Show Policy is designed to optimize appointment availability for all patients while minimizing any inconvenience caused by last-minute cancellations or missed appointments. If the patient needs to cancel or reschedule their appointment, we kindly request that you provide at least a **24-hour notice**. If appointments are canceled within 24 hours of the scheduled visit or the appointment is missed without notice (no-shows) the patient may be subject to a **charge of $50 for all medical visits and $200 fee for surgical and cosmetic visits including consultations**, which is not covered by insurance. To cancel an appointment please call our office at 231-268-3033.

I, (the patient) _____ have read the above disclaimer and fully understand my financial responsibilities to Straits Dermatology.

Patient/Guardian Signature: _____

Date: _____

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PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ Patient DOB: _____

I authorize the disclosure and use of my protected health information by Straits Dermatology as described below:

Who may receive and use this information?

We Cannot discuss any of your Protected Health Information to anyone who is not on this form:

Name: _____ Relationship to you: _____

Address: _____Phone number: _____

Name: _____ Relationship to you: _____

Address: _____Phone number: _____

List any restrictions on the information to be released:

_____

I understand that:

- Voluntary Consent: My consent to release my PHI is entirely voluntary and I have a right to decline or withdraw my consent at any time, except to the extent that action has been taken based on this consent.
- No Effect on Treatment: Refusal to sign this form will not affect my ability to receive treatment, payment, or eligibility for benefits.
- Re-disclosure: Once my PHI is disclosed to the recipient, it may be re-disclosed by the recipient, and my PHI may no longer be protected by federal privacy regulations.
- Revocation: I may revoke this authorization at any time by providing a written request to Straits Dermatology. However, this revocation will not apply to actions taken in reliance on this authorization before its revocation.
- Access to Information: I have the right to request a copy of this authorization at any time.

Signature of Patient or Patient's Representative_____

Date: _____

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HIPAA Privacy Notice

Your Privacy is Important to Us: At Straits Dermatology, we are committed to safeguarding the privacy of your protected health information (PHI) as mandated by the Health Insurance Portability and Accountability Act (HPIAA). This notice describes how medical information about you may be used and disclosed, and how you can access this information.

What is Protected Health Information (PHI)? PHI includes any information about your health status, provision of healthcare, or payment for healthcare that can be linked to you. This includes medical records, treatment plans, insurance claims, and other individually identifiable health information.

How Your PHI May Be Used and Disclosed:
Treatment: We may use and disclose your PHI to provide, coordinate, or manage your healthcare and related services. For example, sharing information with specialists or labs.
Payment: We may use and disclose your PHI for billing purposes, including working with your insurance company to obtain payment for your treatment.
Healthcare Operations: We may use and disclose your PHI for activities such as quality improvement, staff training, and legal compliance.

Your Rights Regarding Your PHI:
Access: You have the right to see, receive a copy of, and request changes to your medical records.
Restrictions/Confidential Communications: You can request that we communicate with you about your health in a certain way or at a specific location to maintain privacy.
Amendment: If you believe your PHI is incorrect or incomplete, you have the right to request changes.
Accounting of Disclosures: You can request a list of certain disclosures of your PHI that we have made.

Our Responsibilities:
We are required by law to maintain the privacy and security of your PHI.
We will provide you with a copy of this Privacy Notice and abide by its terms.
We will not use or disclose your PHI without your consent or authorization, except as described in this notice.

Complaints: If you believe your privacy rights have been violated, you can file a complaint with us by contacting our Privacy Officer/Office Manager. You can also file a complaint with the U.S. Department of Health and Human Services.

A copy of the full privacy practice laws can be found at www.hhs.gov/orc/privacy/hipaa. I have read and understand the above HIPAA Privacy Notice for Straits Dermatology:

Signature of Patient or Patient's Representative_____

Date: _____

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Consent for Office Procedure

Skin biopsy, cryotherapy, extraction, skin tag removal, laser treatment or Injection of steroid or biologic medication

I hereby consent to the medical and surgical care and treatment, as may be deemed necessary or advisable in the judgment of my physician or other provider at Straits Dermatology. This may include but is not limited to skin biopsies of any kind, cryotherapy with liquid nitrogen in any form for both benign and malignant or premalignant skin conditions. As well as the removal or extraction of non-medically necessary skin conditions such as milia or skin tags which may require cryotherapy, shave removal, or snip removal with skin scissors. I hereby consent treatment with Neo Aerolaser Laser and or for the injection of intralesional or subcutaneous steroid into my skin for treatment of my skin condition or injection of prescription biologic medication by the provider or the medical assistant. All of which can occur during my office visit at straits dermatology.

Our dermatology providers will explain any and all procedures and answer any questions with you in regard to the following: Benefits of the proposed procedure. The way the treatment or procedure is to be performed. Alternative treatment options. Probable consequences of not receiving the treatment. The right to withdraw informed consent at any time, in writing. Risk and side effects involved with the procedure. Potential for additional incurred charges.

Should a procedure be performed in which a section of your skin is removed, the specimen will be sent to a pathology lab for an accurate diagnosis, unless otherwise recommended by your clinician. This process will involve any testing necessary including special staining or outside consultations which will incur additional charges. I acknowledge that some medical diagnoses (such as warts or actinic keratosis or keloids) will require multiple treatments with one or more methods that may change throughout the course of treatment and each office visit and procedure will be billed accordingly.

With any procedure, there are risks involved which include, but are not limited to the following: Scar – Scarring is possible with any procedure of the skin. Infection – The entire procedure will be done in a sterile and/or clean fashion. Still, a small number of people will get a wound infection. Bleeding – Some procedures may create some bleeding. Rarely will someone have significant bleeding after they leave such that they would have to come back to have us treat it. Nerve damage – This will be discussed with you by your provider if it is a known risk of your procedure. Regarding laser treatment - blindness, if protective glasses are not worn property.

I authorize pictures to be taken before, during and after the procedure. These pictures will become part of your medical record and may be used or disclosed as permitted by HIPAA. They may also be sent to your family physician and/or referring physician. I have read the consent form in its entirety. I understand the risks associated with procedures that may occur during my visits at Straits Dermatology. I do not impose any limitations on Straits Dermatology and its staff. I understand that I should discuss any questions or concerns with my dermatology provider prior to any procedure and therefore, with my signature, agree to have any necessary procedures performed.

Printed Name of Patient or Parents Representative: _____
Signature of Patient or Parents Representative: _____
Date: _____

Printed Name of Witness: _____
Signature of Witness: _____
Date: _____

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