SUNFLOWER
DERMATOLOGY & MEDICAL DAY SPA

Patient ID: _____
Provider: _____

Patient Information

Name: _____ **Date of birth:** _____ /_____ /_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Home phone: _____ **Mobile phone:** _____

Email: _____ **SS#:** _____

Marital Status: ☐ Single ☐ Married **Gender:** _____ **Race:** _____ **Hispanic/Latino?** ☐ YES ☐ NO

Primary Care Physician Name & Phone: _____

Were you referred by your Primary Care Physician? ☐ YES ☐ NO

How did you hear about our office? _____

Pharmacy name & address: _____

Emergency contact name: _____ **Phone:** _____ **Relationship:** _____

May we discuss your Protected Health Information (PHI) with the individual listed above (including bills and/or charges) ☐ YES ☐ NO **If you would us to share your PHI with someone else, please list them here:**

Name: _____ **Phone:** _____ **Relationship:** _____

Do you have a history of skin cancer? ☐ **YES, list type:** _____ ☐ **NO**

Does your family have a history of skin cancer? ☐ **YES, list type:** _____ ☐ **NO**

Smoking: ☐ **Current Smoker** ☐ **Light Smoker** ☐ **Former Smoker** ☐ **Never Smoked**

Alcohol use: ☐ **3+ drinks/day** ☐ **1-2 drinks/day** ☐ **Less than 1 drink/day** ☐ **I don't drink**

If you are 65 or older, have you received a pneumonia vaccination? ☐ YES ☐ NO

Do you have a health care proxy in the event you are unable to make your own medical decisions?
☐ YES ☐ NO **If yes, please list designees first and last name:** _____

Do you have a living will? ☐ YES ☐ NO

Please list all current medications you are taking (include over-the-counter medications and any vitamins and/or supplements): _____

_____

Reviewed by (provider signature): _____

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Allergies to medications and your reaction: _____

_____

Please list any major hospitalizations or surgical procedures you have received in the past five years:

_____

_____

Insurance Information

Insurance: _____ **ID#:** _____

Name of policy holder: _____ **Relationship to policy holder:** _____

Policy holder SS#: _____ **Policy holder date of birth:** _____ /_____ /_____

Consent to Medical Care

I understand the procedures standard to the care of dermatology and consent to undergo dermatologic care including any necessary procedures. These procedures include, but are not limited to cryosurgery, shave and punch biopsies and cosmetic and medically necessary procedures. I will be informed of potential risks/side effects PRIOR to the procedure.

Consent to Use and Disclose Protected Health Information

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"). I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly, to obtain payment from third-party payers, to conduct normal healthcare operations such as quality assessments and physician certifications, and to support day-to-day healthcare operations in the practice.

I have been made aware that there is a copy of Sunflower Dermatology & Medical Day Spa, LLC, Privacy Practices available in the waiting room or upon my request containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices at any time and that I may contact the office to obtain a current copy of the Notice. I understand that I may request in writing that you restrict how my information is used or disclosed to carry out treatment, payment, or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree, you are bound by such restrictions.

Reviewed by (provider signature): _____

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Financial Partnership

All contracted insurance is billed directly to your insurance company as a courtesy of Sunflower Dermatology & Medical Day Spa, LLC (SFD). Any remaining balances for non-covered benefit deductibles, copays and coinsurances are your responsibility. These may be collected prior to any potential procedure. It may take up to three months or longer for your insurance to process your claim, which may delay the charge to your credit/debit card. **We require a copy of a valid credit, debit or HSA card to be kept on file. You will receive an explanation of benefits from your insurance company explaining costs incurred. Monies due to Sunflower Dermatology based on your bill and explanation of benefits will be charged to the card on file upon our receipt of the explanation of benefits.**

Please initial acknowledging the above statement: _____date_____

- We accept cash, check, Visa, Master Card, Discover, American Express, Money Order, HSA cards, and CareCredit.
- There is a $30 fee for all returned checks.
- Out of respect for all patients waiting to see any provider (physicians, physician assistants, nurses or aestheticians), **there will be a $125 fee if you do not show up to any appointment without cancelling the appointment prior to the appointment time.** 48 hour notice is appreciated.
- All accounts that become past due 45 days after your insurance pays, we reserve the right to send your account to a collection agency if the balance is not paid in full within 60 days.
- For all skin lesion removals (i.e. cosmetic or medical), a skin specimen is sent to the pathology lab for testing and to confirm clinical diagnosis. There may be additional charge by the lab, unrelated to any fee paid directly to Sunflower Dermatology & Medical Day Spa, LLC
- A copy of this form will be available at your request.
- I authorize the release of medical information to my primary care or referring physicians, to consultant if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.
- I hereby acknowledge that I have read, understand and agree with the policies set forth by Sunflower Dermatology & Medical Day Spa, LLC and any change made by me will be made only in writing. I give my authorization for the charge of my valid debit, credit or HSA card and my consent for procedure as outline above.

I have had the opportunity to review the Notice of Privacy Practices and consent above for Sunflower Dermatology & Medical Day Spa, LLC. I consent to the medical/cosmetic care and financial agreements above.

_____	_____	_____
Print name of patient	**Signature of patient**	**Date**
_____	_____	_____
Print name of parent/guardian	**Signature of parent/guardian**	**Date**

Reviewed by (provider signature): _____