FERRARA DERMATOLOGY CLINIC, P.C.

Dr. Richard J. Ferrara Jr., M.D.

CONFIDENTIAL PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female

Last Name First Name Middle Initial

Address Apt. #

City State Zip Code

Primary Phone # ☐ Cell ☐ Home

Secondary Phone # ☐ Cell ☐ Home

Date of Birth Age

Patient Social Security Number

E-Mail Address

Student: ☐ Full Time ☐ Part Time

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Patient Employer / School

Patient Work Phone

Spouse's Name / Parent's Name (If Minor)

Who Referred You to Our Office? _____

Who is your Primary Care Physician? _____

In Case of Emergency Contact:

Contact Name

Relationship

Phone Number

May we release medical information to family member? ☐ Yes ☐ No

Name / Relationship: _____

CONFIDENTIAL INSURANCE INFORMATION

(Please present cards for scanning)

Primary Insurance

Subscriber Name Date of Birth

Contract # Group #

Address of Subscriber if Different from Patient's

City State Zip Code

Secondary Insurance

Subscriber Name Date of Birth

Contract # Group #

Address of Subscriber if Different from Patient's

City State Zip Code

Do we have your permission to leave a message on your answering service? ☐ Yes ☐ No

Do we have your permission to call your place of employment? ☐ Yes ☐ No

As a service to our patients, we provide courtesy appointment reminder calls/e-mails and possibly other important messages that may be e-mailed or placed using a prerecorded message. By providing your cell phone number and e-mail you are consenting to receiving such messages.

The Ferrara Dermatology Clinic, P.C. accepts most major insurance plans. All insurance cards presented are verified for eligibility at the time of your visit. HMO patients must present with proper written authorization from their Primary Care Physicians before treatment can be administered. "I authorize my insurance benefits be paid directly to the Ferrara Dermatology Clinic, P.C. for services rendered." Your signature below also authorized the Clinic to release any such medical information necessary to process your insurance claims.

Today's Date: _____

Patient or Authorized Signature

Financial Policy

Ferrara Dermatology Clinic PC believes that part of good healthcare practice is to establish and communicate our financial policy. We are dedicated to providing the best care for you.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, copayment, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing clause, payment in full is expected at the time of your visit unless other financial arrangements have been made.
2. **INSURANCE** as a courtesy we will verify your benefits with your insurance company. A quote of benefits is not a guarantee of payment. Your insurance claim will be processed according to your plan. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance does not pay the practice within a reasonable amount of time you will be billed. If we later receive payment from your insurer, we will refund you any overpayment. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment.
   Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon the receipt of a statement from our office. If a service is to be performed that we know is not covered by your insurance plan, we will have you sign a non-covered services form and payment arrangements can be made.
   We highly recommend you also contact your insurance carrier and check into your coverage for dermatology. If you have more than one insurance please do not assume that all services will be paid for.
3. **COSMETIC PROCEDURES** are services not covered by insurance as they are considered not medically necessary, therefore electing to have treatment will incur an out of pocket expense due at the time of service unless other financial arrangements have been made.
4. **LATE CHARGES** of $5.00 will be charged for each time balances are unpaid at the time of service unless other financial arrangements have been made.
5. **RETURNED CHECKS** will incur a $30.00 service charge.
6. **ACCOUNTING PRINCIPALS** payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service.
7. **MEDICIAL RECORDS FEES** are a charge of $5.00 and is due before the records will be processed. You can avoid this fee by accessing your patient portal and printing them yourself if the records are recent.

Your signature below acknowledges your part in understanding the policies of Ferrara Dermatology Clinic P.C.

_____ _____

Patient/Guardian Signature Date

Medicare Patients Only

YES	NO	
☐	☐	Have you recently joined a Medicare HMO? If Yes Please identify:_____
☐	☐	Do you or your spouse work in a company, which has more than 20 employees and have coverage through the insurance at this job?
☐	☐	Are you covered by any group plan that makes Medicare Secondary?
☐	☐	Is this illness due to an auto accident or work injury?
☐	☐	Are you receiving Medicaid coverage?

This office is required to keep your signature on file authorizing us to file claims to Medicare and to release information to that payer if they require it for the proper consideration of a claim.

I authorize Ferrara Dermatology Clinic, P.C. to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself, or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Patient Signature Date

FERRARA DERMATOLOGY CLINIC

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I consent that, ***Ferrara Dermatology Clinic, P.C.*** may use and disclose protected health information (PHI) from the past, present or future about me to carry out treatment, payment and healthcare operations (TPO). Please refer to ***Ferrara Dermatology Clinic's*** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. ***Ferrara Dermatology Clinic P.C.*** reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to ***Ferrara Dermatology Clinic's*** Privacy Officer at 20045 Mack Avenue Grosse Pointe Woods, MI 48236.

I consent that, ***Ferrara Dermatology Clinic, P.C.*** may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I consent that, ***Ferrara Dermatology Clinic, P.C.*** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I consent that, ***Ferrara Dermatology Clinic, P.C.*** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that ***Ferrara Dermatology Clinic, P.C.*** restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to ***Ferrara Dermatology Clinic, P.C.***'s use and disclosure of my PHI to carry out TPO.
I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, ***Ferrara Dermatology Clinic, P.C.*** may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

NAME: _____ **DATE OF BIRTH:** _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing Loss
Hepatitis
Hypertension (High Blood Pressure even if taking Medication)
HIV/AIDS
Hypercholesterolemia (High Cholesterol)
Hyperthyroidism (Over Active Thyroid)
Hypothyroidism (Under Active Thyroid)
Leukemia
Lung Cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatments
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Coronary Artery Bypass
Defibrillator
Gallbladder Removed
Heart Transplant
Heart Valve Replacement
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Pacemaker
Prostate Biopsy
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
None
Other _____

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratosis
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
Other _____

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, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications including name, strength, and how often taken)_____
_____
_____

Allergies: (Please enter all allergies)
_____
_____

Social History: (Please circle one)

Cigarette Smoking:	Alcohol Use:	Language:
Never smoked	YES	English
Quit: former smoker	NO	Spanish
Smokes less than daily		Other: _____
Smokes daily		

Race:
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:
Hispanic/Latino
Non-Hispanic/Latino

Prescription coverage: _____yes _____no
Pharmacy: Name: _____
Street: _____ Zip code: _____

Height:_____**Weight**:_____

How often do you exercise?
Once a day
A few times a week
A few times a month
Never

What is your caffeine use?
Once a day
A few times a week
A few times a month
Never

Occupation and Workplace_____

Please make a check mark next to any condition that applies to you today:

[ ] changing mole	[ ] problems with healing	[ ] poor immune system
[ ] problems with bleeding	[ ] problems with scarring (hypertrophic or keloid)	[ ] depression
[ ] belly pain	[ ] rash	[ ] anxiety
[ ] night sweats	[ ] neck stiffness	[ ] bloody stool
[ ] fever or chills	[ ] sore throat	[ ] shortness of breath
[ ] bloody urine	[ ] hay fever	[ ] thyroid problems
[ ] chest pain	[ ] joint aches	[ ] unintentional weight loss
[ ] cough	[ ] muscle weakness	[ ] headaches
[ ] wheezing	[ ] seizures	[ ] blurry vision

Check any item that applies to you:

[ ] Pacemaker	[ ] Artificial Joints within past two years
[ ] Defibrillator	[ ] Premedication prior to procedures
[ ] Artificial heart valve	[ ] Blood thinners
[ ] Rapid heartbeat with epinephrine	[ ] Allergy to topical antibiotic ointments
[ ] Yeast infections with antibiotics	[ ] Allergy to lidocaine/Novocain
[ ] Allergy to adhesives	[ ] Pregnancy or planning pregnancy