

# FERRARA DERMATOLOGY CLINIC, P.C.

20045 Mack Ave, Grosse Pointe Woods, MI 48236 Phone: 313-884-5100

## 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 a family member?  Yes  No

Name / Relationship: \_\_\_\_\_

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 Ferrara Dermatology Clinic, P.C. for services rendered." Your signature below also authorize the clinic to release any such medical information necessary to process your insurance claims.

\_\_\_\_\_  
Patient or Authorized Signature

\_\_\_\_\_  
Date

## 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 voice mail?  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.

# FERRARA DERMATOLOGY CLINIC SKIN AND LASER CENTER OF GROSSE POINTE

## Patient Consent For Use and Disclosure of Protected Health Information

I consent that, **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** 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, P.C. & Skin and Laser Center PLLC'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. & Skin and Laser Center PLLC** reserves the right to revise its Notice of Privacy Practices at any time. 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. & Skin and Laser Center PLLC** may call my home or other designated location and leave a message on voicemail 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. & Skin and Laser Center PLLC** 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. & Skin and Laser Center PLLC** 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. & Skin and Laser Center PLLC** 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. & Skin and Laser Center PLLC** 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. & Skin and Laser Center PLLC** may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Patient's Name

\_\_\_\_\_  
Print Name of Patient or Legal Guardian

## FINANCIAL & OFFICE POLICY

Thank You for choosing Ferrara Dermatology Clinic for your dermatology care. It is important that our patients understand office policies regarding credit, debt, and collections. The goal is to provide and maintain a good provider-patient relationship and keep policy as transparent as possible. Please read each section carefully and sign at the bottom.

### CREDIT CARD ON FILE PROGRAM

We offer a credit card program to help manage your health care costs. With the credit card on file program we can securely save your credit or debit card that can be used to pay your bill or set up a payment plan through an automatic payment option. This eliminates the hassle of mailing in a payment.

Please complete the Authorization Form to begin enjoying the benefits today!

#### Appointments:

- We value the time we set aside to see and treat you. If you are not able to keep an appointment, we would appreciate no less than 24-hour notice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, it may be necessary to reschedule your appointment.
- All children under the age of 18 must be accompanied by an adult unless we have a current minor consent to treat on file. An authorization for treatment must be on file for all minors with an adult that is not a guardian and all children 16 and older unaccompanied.
- Saturday appointments require a deposit, or a credit card be kept on file. A no show or cancel less than 24 hours will be charged a fee of \$40.
- If you have repetitively “no-showed” for appointments or surgery, we reserve the right to charge a non-refundable deposit fee to reschedule. This fee will reflect the nature of the appointment and the allotted time. This will be refunded or applied to your visit when you keep the appointment.

#### Insurance Plans:

- It is your responsibility to keep us updated with the correct insurance information. Upon arrival we ask that you come prepared to present your current and active card.
- If the insurance card/plan you present is incorrect or invalid, you will be responsible to furnish us with the correct information. If correct information is not furnished you will be responsible for the payment.
- 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.

#### Referrals:

- You are responsible to make sure the referral is at our office on the day of your appointment. Ordinarily we will give you a courtesy call 2 days prior to the appointment to try to notify you if the referral is not available.

- If you do not have your referral at the time of your visit you will have to reschedule your appointment or you can opt to pay based on out-of-pocket cash pricing.

**Financial Responsibility:**

- We do not get involved with domestic disputes or custody issues. Our policy is to obtain payment at the time of service from the parent/guardian bringing the child to the office.
- 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.
- If a balance incurs of \$500 or greater after insurance payment you will be required to set up a payment plan and keep a credit card on file.
- 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.
- 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.
- Returned checks will incur a \$40.00 service charge.
- Patient balances are billed monthly and we ask that you pay your statement in a timely manner.
- If previous arrangements are not made any account balances over 90 days will be referred to a collection agency.

**Medical Records:**

- Printed copies of medical records provided to a patient are charged based on current Michigan guidelines. The fee must be paid at the time of receipt.

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

NAME: \_\_\_\_\_

DATE OF BIRTH: \_\_\_\_\_

**History and Intake Form**

**Past Medical History:** (please circle all that apply)

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

**Past Surgical History:** (please circle all that apply)

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

**Skin Disease History:** (please circle all that apply)

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

**Immunizations:**  
Have you ever had a pneumonia shot? Yes      No  
If yes when? \_\_\_\_\_  
Have you had a Flu shot this year? Yes      No

**Social History:** (Please circle one)

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

<u>Race:</u>	<u>Ethnicity:</u>
White	Hispanic/Latino
Black/African American	Non-Hispanic/Latino
Asian	
American Indian or Native Alaskan	
Native Hawaiian/Pacific Islander	

**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:**

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

**Check any item that applies to you:**

- |  |  |
|--|--|
| <input type="checkbox"/> Pacemaker                         | <input type="checkbox"/> Artificial Joints within past two years |
| <input type="checkbox"/> Defibrillator                     | <input type="checkbox"/> Premedication prior to procedures       |
| <input type="checkbox"/> Artificial heart valve            | <input type="checkbox"/> Blood thinners                          |
| <input type="checkbox"/> Rapid heartbeat with epinephrine  | <input type="checkbox"/> Allergy to topical antibiotic ointments |
| <input type="checkbox"/> Yeast infections with antibiotics | <input type="checkbox"/> Allergy to lidocaine/Novocain           |
| <input type="checkbox"/> Allergy to adhesives              | <input type="checkbox"/> Pregnancy or planning pregnancy         |