HMGS

HEALTH HISTORY INTAKE FORM

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

PATIENT EMAIL ADDRESS: _____

PRIMARY CARE PROVIDER: _____ **CITY/STATE** _____

PREFERRED PHARMACY: _____ **PHONE:** _____

PHARMACY ADDRESS: _____

PAST MEDICAL HISTORY

Anemia	Yes ☐	No ☐	Depression	Yes ☐	No ☐	Hypertension	Yes ☐	No ☐
Anxiety	Yes ☐	No ☐	Diabetes	Yes ☐	No ☐	Hypothyroidism	Yes ☐	No ☐
Arthritis	Yes ☐	No ☐	Eczema	Yes ☐	No ☐	Hyperthyroidism	Yes ☐	No ☐
Asthma	Yes ☐	No ☐	Glaucoma	Yes ☐	No ☐	Lupus	Yes ☐	No ☐
Bleeding	Yes ☐	No ☐	HIV	Yes ☐	No ☐	Psoriasis	Yes ☐	No ☐
Chronic Heart Failure	Yes ☐	No ☐	Hay fever	Yes ☐	No ☐	Reflex/GERD	Yes ☐	No ☐
COPD	Yes ☐	No ☐	Heart Disease	Yes ☐	No ☐	Seizures	Yes ☐	No ☐
Cataracts	Yes ☐	No ☐	Hepatitis A/B/C	Yes ☐	No ☐	Stroke	Yes ☐	No ☐
Clotting Problems	Yes ☐	No ☐	High Cholesterol	Yes ☐	No ☐	Ulcerative Colitis	Yes ☐	No ☐
Crohn's Disease	Yes ☐	No ☐	Hives	Yes ☐	No ☐	Tuberculosis	Yes ☐	No ☐

Other (Not listed): _____

Personal History of Cancer: _____

☐ **Implants/Devices:** select type below
☐Artificial Joint ☐Pacemaker ☐Defibrillator **Month/Year?** _____

☐ **Past Surgical History** Include the month/year: _____

Personal Skin Cancer History
☐Basal Cell ☐Squamous Cell ☐Melanoma Other: _____ **Month/Year?** _____

Family Skin Cancer History Yes☐ No☐ If Yes, Whom? _____

Do you wear sunscreen regularly: Yes☐ No☐ **Have you used a tanning beds:** Yes☐ No☐

☐ Do you have family history of melanoma: Yes☐ No☐ If yes, whom? _____

Smoking History: ☐Never Smoker ☐Former Smoker ☐Every day Smoker ☐Some Day Smoker

Do you have any allergies to medications: Yes☐ No☐ If yes, please list: _____

___ Please indicate the reaction you had: _____

HMGS

☐ **Current Medications**

Name of Medication	Dose	Name of Medication	Dose

Patient or Guardian Signature: _____ **Date:** _____

HMGS

Patient Name: _____ DOB: _____

Address: _____ City/State: _____

CONSENT, DISCLOSURE AND AUTHORIZATION FORM

As used in this form, the words "I", "me", "my" and similar references means the patient whose name appears above, or the parent, legal guardian, or other legally responsible person on behalf of the minor or incapacitated patients named above.

1. **General Consent for examination and treatment**

I hereby consent and authorize Heymann, Manders, Green & Sommer, LLC ("HMGS" and all physician, physician assistants, nurses, and other ancillary medical personnel of HMGS, to perform medical examinations and provide routine dermatologic care for all my visits to HMGS. This may include diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment, and healthcare operations of HMGS, as further described below. Any photographs or other images taken will become part of my medical record. HMGS will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that HMGS will provide me with information and forms prior to such procedures.

2. **Acknowledgement of Receipt of Notice of Privacy Practices**

I have received a copy of the HMGS HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that HMGS has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, HMGS will post a new notice in the office. I may contact HMGS at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I also may access a copy on its website.

3. **Consent to Use and Disclose Protected Health Information for Treatment, Payment and Healthcare Operations**

I hereby consent and authorize HMGS to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the healthcare operations of HMGS. I understand that, for example, my health information may be used or disclosed by HMGS to: Provide for my care and treatment; communicate among various healthcare professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by HMGS; provide information to obtain payment from my health insurance company or plan; access and review the quality of my care; and conduct its business and healthcare operations. In addition, I understand HMGS may release my protected health information as required by law or court order.

HMGS

4. Disclosures to Authorized Individuals

I understand that HMGS may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my healthcare and/or payments for my healthcare

Name	Phone Number	Relationship	DOB	Health Information	Payment information
				Yes☐ No☐	Yes☐ No☐
				Yes☐ No☐	Yes☐ No☐
				Yes☐ No☐	Yes☐ No☐
				Yes☐ No☐	Yes☐ No☐

5. Emergency

In case of an emergency, please contact the below individual. You may provide general information about me, including as necessary to communicate information about the emergency. If this person is also listed above, you may provide information as authorized above.

Name	Phone Number	Relationship

6. Contact Information

I wish to be contacted in the following manner (Please circle all that apply)

Type	Detailed message	Call back message only	Phone number
Home	Yes☐ No☐	Yes☐ No☐	
Work	Yes☐ No☐	Yes☐ No☐	
Cell Phone	Yes☐ No☐	Yes☐ No☐	
Text Message	Yes☐ No☐	Yes☐ No☐	
Email	Yes☐ No☐	Yes☐ No☐	

My preferred Mailing address is:

- ☐ Home Address
- ☐ Work Address _____
- ☐ Other Address: _____

I understand that if I have checked the box "detailed message", I agree that HMGS may leave any of the following detailed messages at the indicated telephone number: Appointment reminders, insurance/financial issues, biopsy or other test results and any other information regarding care/treatment.

HMGS

Use of Consent and Authorization

A copy of this consent and authorization may be used in place of the original.

Consent and Authorization:

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use of disclosure of my health information and about the contents of this form. I acknowledge and agree to the terms and conditions of this document:

Patient Signature: _____ Date: _____

Authorized Individual (Parent/Guardian) Name: _____

Authorized Individual Signature: _____

Basis of Authority (e.g. Parent, guardian): _____

(Authorized individuals will be required to provide proof of authority)

HMGS

FINANCIAL RESPONSIBILITY AND BILLING POLICY

1. **Identification and Referrals:** At each visit, you must bring identification (e. g. current driver's license or government issued ID) and a copy of your insurance card. If a referral is required by your insurance company, please bring it with you to your visit to avoid having your appointment rescheduled.
2. **Participating Insurance Plans:** Please be advised we do not participate with all insurance plans at our facilities. Please call your insurance to make sure your provider is participating at the location you are being seen.
3. **Financial Responsibility:**
    a. **Medicare:** Patient is responsible for the annual deductible and/or 20% of the Medicare allowable for all covered services.
    b. **In Network Insurance:** If HMGS participates with your insurance plan, patient is responsible for paying all copayments at the time of service. Annual deductibles and coinsurances will be billed to patient in accordance with the explanation of benefits (EOB) from your insurance. Patient will dispute claims not processed or processed incorrectly according to their plan, directly with their insurance company.
    c. **Out of Network Insurance:** If HMGS does not participate with your insurance plan, the following applies:
        i. Patient will be responsible for contacting their insurance to ensure they have out of network benefits and to understand what their out of network benefits cover and the out-of- pocket costs.
        ii. Patients are financially responsible for all services more than the allowable amount of your insurance plan.
        iii. As a courtesy we will submit a claim to your insurance plan. You will have financial responsibility for the entire amount of the balance due.
        iv. You may incur additional out of network charge for ancillary services (see ancillary services below)
    d. **Non-Covered Services and Self pay:** If our services are not covered by your insurance plan or if you have no insurance, you agree you will be financially responsible.
    e. **Ancillary Services:** Certain laboratory, pathology or radiology services may be required in connection with our healthcare services or as coordinated or referred to by us. These ancillary services may be provided by:
        Quest Diagnostics, 900 Business Center Drive, Horsham, PA 19044: 866-697-8378
        LabCorp, 69 First Avenue, Raritan, NJ 08869: 800-762-4522
        DermPath Diagnostics Institute, 3805 West Chester Pike, Newtown Sq, PA.19073: 800-257-0117
        Heymann, Manders, Green & Sommer, LLC, 10000 Sagemore Drive, Suite 10103 Marlton, NJ 08053: 856-596-3040

We advise that patients contact each of these providers and your insurance plan prior to receiving any health services to determine if these providers participate with your insurance plans, and to contact your insurance plan for further consultation on costs.

The patient is responsible for understanding what is covered by their insurance plan, including copayments, deductibles, co-insurance, noncovered services, out of network benefits and financial responsibilities. Many insurances now offer high deductible plans. Please contact your insurance prior to coming so you have a clear understanding of your responsibilities.

Payment: Payment for all services is expected on the day services are rendered. Payment may be made in cash or check, Visa, Mastercard, Discover or American Express.

Billing practices: Once we have received payment from your insurance company you will begin to receive a monthly statement of fees you are responsible for. Please contact our billing department if you will not be paying your balance in full after the 1st statement. You will only receive 3 statements before your account will be sent to a collection agency. You agree to be responsible for all costs of collection, including court costs, collection agency costs and legal fees.

Cancellations/No Show Policy: If it is necessary to cancel, we require that a 24-hour notice is given. You will be charged $50 fee if you do not provide a 24-hour notice of cancellation or do not show up the day of your scheduled appointment. We reserve the right to discharge patients who miss multiple appointments or fail to give 24-hours prior notice of cancellation.

Returned checks for insufficient funds: You will be charged a fee of $35 for any checks that are not payable by your bank in the event you have insufficient funds.

Assignment of Benefits:

HMGS

By signing below, I hereby authorize Heymann, Manders, Green & Sommer, LLC (hereafter HMGS) and its providers and staff to release to the applicable payor, insurance plan, intermediary, plan administrator or third party covering the patient (identified below) any information, including without limitation protected health information needed for the processing of claims for payment for services rendered to the patient.

- I hereby authorize HMGS:
  - To submit claims to the applicable payor, insurance plan, intermediary plan administrator or third party for all services rendered to the patient and to exercise any appeals and other rights on the patient's behalf.
  - The right to file suit, obtain counsel, and enter legal or other actions on the patient's behalf, including arbitration or dispute resolution processes for any claims against the applicable payor, insurance plan, intermediary plan administrator, or third party covering the patient. This authorization includes alignment of the right to pursue declaratory, equitable and compensatory relief or other legal remedies.
  - To appoint an attorney to represent the patient directly for the collection of all insurance plan or other benefits through the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient.
  - To appoint an attorney to represent the patient to appeal a claim to the applicable payor, insurance plan, intermediary, plan administrator or third party
  - To act on the patient's behalf and report any suspected violations of proper claims practices to the proper regulatory authorities
- I hereby direct the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient to issue a payment check directly to HMGS. If payment will not be made directly to HMGS, I hereby authorize and direct the payor, insurance plan, intermediary, plan administrator or third party covering the patient to send all checks and copies of EOB forms in connection with the service provided by HMGS to 100 Brick Road Suite 306, Marlton, NJ 08053
- I understand and agree that, should I, the patient, my dependents, or my beneficiaries receive funds from the applicable payor, insurance plan, intermediary, plan administrator or third party for services performed by or at HMGS, that it is my responsibility to endorse the checks and send them to HMGS.
- I understand and agree that, should I, the patient, my dependents, or my beneficiaries receive funds from the applicable payor, insurance plan, intermediary, plan administrator or third party for services performed by or at HMG, that it is my responsibility to endorse the checks and send them to HMGS.

Please sign below to confirm that you have read and understand the foregoing financial responsibility and billing policy.

_____ _____

Print Name of Patient

Print Name of Guardian /Responsible Party
If different from the patient

_____ _____

Signature of Patient/Guardian/Resp Party
Date: _____

Signature of Witness