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Patient Personal Information **(Please Print Clearly)**

First:_____ MI:_____ Last: _____

Gender: ❑ Male ❑ Female

Mailing Address: _____ Apt #: _____

City:_____ State:_____Zip:_____

DOB: _____SS#_____

Cell#: _____Home#:_____ Work#: _____

E-Mail: _____

Emergency Contact

Name:_____ Relationship:_____ Phone: _____

Would you like access to our patient portal and newsletter via email? ❑ Yes ❑ No, I decline

It is the policy of Sanova Dermatology to not share your contact or email info with any third parties.

Preferred Language: ❑ English ❑ Spanish ❑ Other (specify):_____

Primary Race: ❑ White ❑ Black/African American ❑ Hispanic ❑ American Indian or Alaskan Native ❑ Asian

❑ Native Hawaiian or Other Pacific Islander ❑ Prefer not to answer

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other

Ethnicity: ❑ not Hispanic or Latino ❑ Hispanic or Latino ❑ Prefer not to answer ❑ Unknown

Employment Status: ❑ Employed ❑ Disabled ❑ Retired ❑ Part-time ❑ Not Employed ❑ Student ❑

Referral Source: ❑ Facebook ❑ Twitter ❑ Yelp ❑ Google+ ❑ Insurance List

❑ Other:_____

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Patient Insurance Information **(Please Print Clearly)**

PERSON RESPONSIBLE FOR BILL *(complete only if different from patient)* ❑Same as above

Name: _____ Relationship: _____

Mailing Address: _____ Apt #: _____

Zip:_____ City:_____ State:_____

DOB: _____ Phone (Home): _____ (Cell): _____

PRIMARY MEDICAL INSURANCE

Insurance Company: _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

Date of Birth **(*Required):** _____ SSN: ___ - ___ - ___

Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other (specify): _____

SECONDARY MEDICAL INSURANCE

Insurance Company: _____

Policy Number:_____ Group Number: _____

Policy Holder's Name (if different from patient): _____

Date of Birth **(*Required):** _____ SSN: ___ - ___ - ___

Relationship to Patient: ❑Self ❑Spouse ❑Child ❑Other (specify): _____

The above information is accurate and complete to the best of my knowledge.

_____ _____

Signature of Patient/Responsible Party Date

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Patient Medical History (Please Print Clearly)

Name_____ Date _____

Referring Physician_____ Primary Care Physician_____ Date of Birth___ / ___/ _____

Reason for visit?_____ Best phone # to reach you to discuss results?_____ Okay to leave a message? Y N

Preferred Pharmacy (Include Location)_____ Occupation: _____

❑Yes ❑No Do you drink alcohol? If yes, how many drinks per day?_____
❑Yes ❑No Do you smoke? If yes, how many packs per day?_____
❑Yes ❑No Do you use illegal street drugs? If yes, list _____

PAST MEDICAL HISTORY

Have you ever had any of the following?

❑Yes❑ No Anxiety
❑Yes ❑No Artificial Joints
❑Yes ❑No Asthma
❑Yes ❑No Atrial Fibrillation
❑Yes ❑No Cancer (non-skin)
❑Yes ❑No COPD
❑Yes ❑No Coronary Artery Disease
❑Yes ❑No Depression
❑Yes ❑No End Stage Renal Disease
❑Yes ❑No Other: _____

❑Yes❑ No Hearing Loss
❑Yes ❑No Hepatitis
❑Yes ❑No High Blood Pressure
❑Yes ❑No HIV/AIDS
❑Yes ❑No High Cholesterol
❑Yes ❑No Seasonal Allergies
❑Yes ❑No Seizures
❑Yes ❑No Thyroid Disease
❑Yes ❑No Valve Replacement

SKIN DISEASE HISTORY

Please check all that apply

❑Yes ❑No Actinic Keratosis
❑Yes ❑No Basal Cell Skin Cancer
❑Yes ❑No Melanoma (malignant)
❑Yes ❑No Squamous Cell Skin Cancer
❑Yes ❑No Precancerous Moles
❑Yes ❑No Atypical/Dysplastic moles/spots
❑Yes ❑No History of bad or blistering sunburns?
❑Yes ❑No Do you use Sunscreen? If yes, what SPF?_____
❑Yes ❑No Do you have a family history of Melanoma?
If yes, whom?_____

REVIEW OF SYMPTOMS

Are you currently experiencing and of the following?

❑Yes ❑No Runny Nose/Itchy Eyes
❑Yes ❑No Palpitations/Chest Pain
❑Yes ❑No Leg Swelling
❑Yes ❑No Fever/Chills
❑Yes ❑No Unplanned Weight Loss
❑Yes ❑No Cold/Heat Intolerance
❑Yes ❑No Excessive Thirst/Hunger
❑Yes ❑No Swallowing Problems
❑Yes ❑No Mouth or Cold Sores
❑Yes ❑No Nausea/Vomiting
❑Yes ❑No Diarrhea/ Constipation
❑Yes ❑No Burning with Urination
❑Yes ❑No Blood in Urine

❑Yes ❑No Enlarged Glands/Lymph Nodes
❑Yes ❑No Joint Pains
❑Yes ❑No Muscle Aches
❑Yes ❑No Headaches
❑Yes ❑No Memory Loss
❑Yes ❑No Depression
❑Yes ❑No Anxiety
❑Yes ❑No Wheezing/Asthma
❑Yes ❑No Shortness of Breath
❑Yes ❑No Suppressed Immune System
❑Yes ❑No Rash with Medication or Foods
❑Yes ❑No Problems Healing
❑Yes ❑No Scars/Keloids After Surgery

❑Yes ❑No Do you have immediate family with a history of Skin Disease?
If yes, who/type?_____
❑Yes ❑No Do you have immediate family with a history of Skin Cancer?
If yes, who/type?_____

PAST SURGICAL HISTORY

Please list previous surgical procedures.

_____
_____
_____
_____
_____
_____

MEDICATIONS

Please list all current medications (OTC, Herbal, Etc.)

_____
_____
_____
_____

ALLERGIES: Please list all allergies and/or adverse reactions

_____
_____

ALERTS

Are you currently experiencing any of the following?

❑Yes ❑No Allergy to Latex or Tape
❑Yes ❑No Artificial Heart Valve
❑Yes ❑No Blood Thinner Use/Daily Aspirin
❑Yes ❑No Medication Prior to Procedures
❑Yes ❑No MRSA (Resistant Staph)

❑Yes ❑No Allergy to Lidocaine
❑Yes ❑No Artificial Joint in Past 2 Months
❑Yes ❑No Defibrillator
❑Yes ❑No Rapid heart Rate w/ Epinephrine

❑Yes ❑No Allergy to Topical Antibiotic
❑Yes ❑No Accutane Used in Past 6 Months
❑Yes ❑No Pacemaker
❑Yes ❑No Pregnant/Breastfeeding

EDUCATE YOURSELF Our physicians are experts in Cosmetic Dermatology procedures! Please help us maintain the highest level of customer service by checking all areas that interest you:

❑ Botox
❑ Cosmetic Fillers
❑ Non-Surgical Nose Job
❑ Lip Enhancement
❑ Underarm Odor/Sweating

❑ Eyelid Rejuvenation
❑ Eyelash Rejuvenation
❑ Neck Rejuvenation
❑ Neck/Chin Tightening
❑ Sensitivity to Deodorant

❑ Chemical Peels
❑ Acne Scarring
❑ Laser Hair Removal
❑ Spider Vein Treatment
❑ Double Chin Treatment

❑ Facial Redness
❑ Sun Spots
❑ Liposuction/Body Contouring
❑ Skin Care Advice

Patient/Guardian Signature: _____ Date:_____

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MIPS

Patient Name:_____ Date of Birth:_____

In accordance with the Federal Health Policy, please answer the following questions:

1) **Flu—Asked at every eligible visit**
   - During the most recent flu season, did you receive a flu vaccination? Yes No
   - If no, why? _____

2) **Tobacco—Asked 1 time per year**
   - Do you use tobacco products? Yes Formerly Never

3) **Pneumonia (for patients 65+)—Asked 1 time per year**
   - Have you EVER received a pneumonia vaccination? Yes No
   - If yes, what year?_____

4) **Do you have a surrogate decision maker?—Asked 1 time per year** Yes No
   - If yes, enter their information:

     Name:_____

     Phone Number:_____

_____ _____

Patient Signature Date

Thank you for choosing Sanova Dermatology!

Acknowledgement of Receipt of Summary/Notice of Privacy Practices

***Please initial next to each paragraph as well as sign at the bottom of this page to acknowledge that you have read, understand, and agree to comply with each of our office's policies*.**

_____**RECEIPT OF *NOTICE OF PRIVACY PRACTICES (HIPAA)***

I have been given the opportunity to read a copy of the Notice of Privacy Practices. I also understand that I have the right to request a copy of the Notice of Privacy Practices for my records. This is also posted on Sanova Dermatology's website at sanovadermatology.com.

_____**CONTACT PERMISSION**

In the event that Sanova Dermatology needs to contact you (patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Check all that apply:

❑Leave a message on an answering machine or voice mail. Phone # _____

❑Speak with spouse/significant other. Name: _____

❑Speak with other family members. Name: _____

_____**CONSENT TO TELEPHONE/EMAIL COMMUNICATION**

I understand that any phone or email communication will be part of my medical record. I also understand that all email communication is **not** secure, **not** to be used for any emergent matters, and response will be given back within three to five business days. I understand that I have the option to "Opt-Out" of communications with Sanova Dermatology by contacting the Practice Manager or Privacy Officer.

_____**CONSENT TO TREATMENT**

I consent to the performance of those examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary in the medical provider's judgment. I authorize Sanova Dermatology to take photographs/videos of myself; I understand that the photograph/video will *only be used in my medical record and will not be released without my prior authorization*. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantees can be made or implied as to the outcome of treatment.

_____ _____

Patient/Legal Guardian Signature **Date**

Patient Printed Name/Legal Guardian _____

If Legal Guardian, please indicate relationship to the patient: ❑Parent ❑Legal Guardian

OFFICE USE ONLY

We attempted to obtain written Acknowledgement of Receipt of our Notice of Privacy Practices. Acknowledgement could not be obtained due to the following:

❑Individual waived signature

❑Communication barriers prohibited obtaining the acknowledgement

❑An emergency situation prevented us from obtaining acknowledgement

❑Other:_____

_____ _____

Signature of Practice Representative Date

Thank you for choosing Sanova Dermatology!

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Financial Policy

Thank you for choosing Sanova Dermatology! We are committed to the success of your medical treatment and care.
Please understand that payment of your bill is part of this treatment and care. We strive to take part in a large number of insurance plans in order to offer our patients more choices for reimbursement of the care we provide. As a service to you, we work to file, process, and collect your insurance claims in as timely a manner as possible. Your active involvement and understanding in this process will assist us in this mission. Please review the following:

Please initial next to each paragraph as well as sign at the bottom of this page

_____**Insurance-Claims.** If we participate with your managed care or commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans. You will be responsible at the time of service for the payment of:

- The copayments and annual deductibles
- Charges for non-covered or cosmetic services

We will call your insurance company to verify eligibility and benefits. However, verification of benefits is not a guarantee of payment. You will be billed a balance if:

- Your insurance company pays less than what we expected
- We obtain a denial from your insurance company
- Insurance companies consider any treatment or procedure that is not part of the history, physical exam or writing a prescription to be a surgery. Essentially, any physical treatment of a skin condition (including but not limited to: cutting, freezing, burning, lasering, applying chemical, caustic or blistering agents, curettage, draining or lancing, removal of a foreign body, injections, application of light therapy, scraping) is considered a surgical treatment by insurance companies.
- We have not received payment from the insurance within 60 days of our filing the claim

Please be advised that anything you choose to have removed, biopsied, or injected may not be covered under your office co-pay and might be excluded from coverage or subject to your deductible. We will make every effort to contact your insurance company to verify your benefits, but in the event we are unable to reach them, you will be responsible at the time of service for your co-payment as well as payment for procedures performed. Such procedures include but are not limited to biopsies, injections, removal of warts, moles, pre-cancers, skin cancers, or other skin lesions. Methods of removal may include but are not limited to: cutting, freezing, burning or application of a blistering agent.

_____**Authorization/Financial Responsibility**. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and responsible for obtaining referrals required by my insurance carrier. I request that my medical insurance carrier make any payment directly to Sanova Dermatology, PLLC for services rendered to me.

_____**Medicare**. We are Medicare participating providers, therefore we will bill Medicare directly. You will be responsible at the time of service for payment of:

- The copayments and annual deductibles
- Charges for non-covered or cosmetic services

You will be asked to sign a Waiver of Liability in the event a service is provided that is not covered by Medicare.

_____ **Patients without insurance coverage OR Out-of-Network coverage**. Payment is due for all services on the day they are rendered.

_____ **Returned Checks**. There will be a $25.00 service fee charged to your account if your check is returned for any reason. Upon notification from our office, payment of the entire balance is due immediately.

_____ **Skin Care products**. If you purchase skin care products/supplies from our office, please understand that these items are a non-refundable. If the product/supply is defective, we will gladly replace the item(s).

_____ **No Show Policy***. We kindly request that you give us 24-hour's notice if you are unable to keep your appointment.
Failure to give 24-hour notice will result in a missed appointment fee. *This fee is not covered by your insurance plan.* Failure to give 24-hour notice for *Cosmetic* appointments may result in the loss of your deposit.
We understand that situations may arise that prevent adequate notice of cancellation. These situations will be considered on a case-by-case basis. **If you have any questions, please do not hesitate to ask us. We are here to assist you any way possible.** *Please see attached No Show Policy.

I have read and understand the Financial Policy for Sanova Dermatology and have reviewed the above listed notices. I understand my responsibility regarding charges incurred in this office.

_____ _____

Signature Date

Thank you for choosing Sanova Dermatology!

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No Show/Late Cancellation/ Deposit Policy

This policy has been established to help serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-Shows and late cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late cancellations delay the delivery of health care to other patients, some of whom are quite ill. Due to limited availability and high demand of appointments, we would like to remind you of our scheduling policies.

A "No-Show" is missing a scheduled appointment. A "late cancellation" is cancelling an appointment without calling us 24 hours in advance for an office visit or 48 hours in advance for a procedure.

We understand that situations such as medical emergencies occasionally arise, in which case adequate notice for a cancellation is not possible. These situations will be considered on a case-by-case basis.

Medical Appointments:

- A $35.00 fee will be charged to your account for any changes or cancellations made to your appointment without a 24-hour notice.

All Appointments:

- A 15-minute grace period is allowed for patients running behind their scheduled time. Any patients arriving 15 minutes after their scheduled appointment time may be asked to reschedule their appointment. If you are running behind, please call our office and let a staff member know what time you plan to arrive.

A charge of $200.00 may be assessed for each no-show or late-cancellation for all surgery and/or cosmetic procedure appointments. A 48-hour notice must be given. We have set aside an extended amount of time for these types of appointments.

By scheduling your appointment and/or paying your deposit, you agree that you understand and accept these policies.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

Signature _____ Date _____

Thank you for choosing Sanova Dermatology!

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Secured Credit Card Policy

Poole Dermatology has a secure method through our Authorize.net/FirstData gateway connection to establish a secured credit card program to make our billing services more efficient and secure for all patients. Poole Dermatology will never maintain or document credit card numbers within the patient account, medical record, nor within our facility. This Credit Card policy agreement will only be referenced by the last four digits of the card.

Authorization for Secured Credit Card Payments

I understand that once my insurance company has reviewed the information with respect to my health care visit, Poole Dermatology and I will receive an Explanation of Benefits (EOB). Poole Dermatology's billing department will review the EOB for claims processing accuracy. In the event that we feel a claim has been denied in error or processed incorrectly, the insurance department will re-bill and/or appeal the claim as needed before any remaining patient balance is billed to my card on file. All correctly processed claims will state any balance to be paid by me for my health care visit. I agree that Poole Dermatology may charge my credit/debit, HSA card on file for any remaining balance due when they receive a copy of the EOB. Furthermore, if my card is expired or no longer valid, I agree to provide Poole Dermatology an updated credit/debit, HSA card. If there is a remaining balance due more than $250.00, you will receive a courtesy call prior to your card being charged at the phone number listed below. This Authorization form is in conjunction with any forms currently on-file with our office.

I authorize Poole Dermatology to charge the patient-responsible balances (e.g. co-pays, co-insurance, deductibles, non-covered services, elective items) on my account to the following credit/debit, HSA card:

Last 4 digits of card provided: __ __ __ __ Visa___ MasterCard___ Discover___ American Express___

Cardholder's Signature: _____ Date: _____

Patient's Name: _____

Cardholder's Name: _____

Email for Receipts: _____

Best Contact Phone #: _____

-This is a system everyone should be comfortable with— just like any hotel or rental car agency: All patients of Poole Dermatology will need to have a credit, debit or HSA card encrypted and securely stored. Once your insurance company has processed all charges and we receive their approval of exact patient responsibility, your card will be charged the remaining balance you owe, if any.

-Our system is vastly more secure than giving your credit card information over the phone or handing your card to a waiter in a restaurant: The card information is not available to our office staff, but is immediately encrypted and then securely stored with Authorize.net, our gateway provider.

-You remain in control: A receipt will be mailed to you along with a detailed explanation of services outlining the amount that your insurance has paid and the remaining balance that was owed for your dermatology visit. We will extend a courtesy call prior to charging the card on file **if the charges exceed $250.00**. We doubt there will be issues, but you remain in control by being able to decide/change which card is kept encrypted on file at any time.

-We appreciate your faith in us!: We are fortunate to have your trust in delivering health care to you, and we are confident that this policy will insure a safer and more efficient billing process for all, helping to keep health care cost down.

Thank you for choosing Sanova Dermatology!

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ATTENTION PATIENTS:

YOU MAY RECEIVE A BILL FROM AN OUTSIDE LABORATORY

At times, it may be necessary to have additional laboratory testing performed during your visit to assist in the diagnosis and proper treatment of a skin condition. If your provider performs a biopsy or other lab test during your appointment, it will be sent to an outside laboratory to be examined by a pathologist. The pathologist will communicate the test results to your provider via a pathology report.

The outside laboratory will submit a bill to your insurance company. **You may receive a bill from them if you have deductibles, coinsurance, or copayments.**

We are aware that insurance coverage varies by plan. If you know the preferred laboratory for your insurance carrier please advise our staff and we will make every effort to ensure that the specimen is sent to the correct laboratory. If you are unsure, please call your insurance company and ask if there is a preferred/In-Network laboratory.

If you're a self-pay patient, rates will be discussed with you during your visit.

If you have any questions regarding this process, please do not hesitate to ask your physician during your exam.

By signing below, you understand that you may be billed by an outside laboratory in the event that you receive a biopsy or lab test during your examination.

_____ _____

Signature Date

Understanding of Insurance and Claims Processing

Thank you for choosing Sanova Dermatology!

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111 Veterans Memorial Blvd Unit 406
Metairie, Louisiana 70005

FINANCIAL DISCLOSURE NOTICE TO PATIENTS

This is a notice informing you that Poole Dermatology, a Sanova Dermatology Company owns and operates Gulf South Pharmacy for the convenience of our patients.

As an owner, he/she will receive renumeration for securing or soliciting patients for prescriptions you have filled at this entity or any items or services you may purchase or receive.

As a patient you have the right to obtain these items or services from a pharmacy or provider of your choice. You always have a choice in pharmacies and are in no way obligated to use our pharmacy.

By signing below, you are acknowledging that you have received notice of the information provided above.

_____

Signature of Patient or Authorized Representative Date

Thank you for choosing Sanova Dermatology!

Your Medical Patient Portal

Sanova Dermatology's Medical Patient Portal is designed to work for you. Keep your information protected! Using the Portal, you can securely view your records, enter medical information, and send messages to your provider. *Missed our call?* Don't play phone tag with our nurses. **All biopsy and lab results will be published on the patient portal within 7-10 days of your office visit**. *Need a refill?* **All prescription refill requests can be submitted directly through the Portal.**

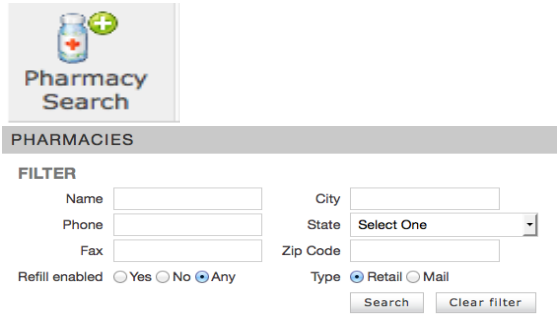
Logging On

1. Type the URL below into your browser window. **DO NOT** type *www* or *https* in front of the URL.
   sanovaderm.ema.md
2. Log in with your username and password
3. First time? A link will be emailed to you at the time of your first patient visit. You will receive an email with instructions on how to set your own password. The email link will expire in 24 hours. If the link has expired, you can use the "forgot password" link on the login page. If you do not have a username or password, please contact the office directly.

Utilizing the Patient Portal

Through the Portal, patients can view and modify their medications, allergies, pharmacy, past medical history, skin disease history, social history, and family history.

- For example, to Add a Pharmacy, select *Pharmacy Search*.
- Enter as much criteria as possible and click "Search." Click the blue link to add the pharmacy.



Your contact information and insurance information can be viewed; however you must contact the clinic by phone to make changes or corrections.

Your Visit Info

Patients can view their *visit notes, educational handouts*, and any *test results* their provider has posted.

My Health

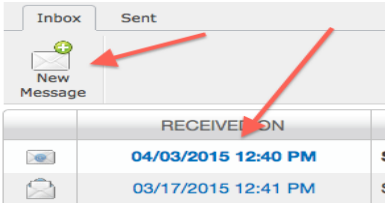
- To view records, select the date in blue pertaining to the visit you'd like to view under "Visit Date."
- To view the Education Handout of that visit, select the "Patient Education" link after clicking on the Visit Note.

Tests and Results

- Select the DATE in BLUE to view the pathology report.
- Select the blue information bubble under LEARN to the right of the result, to view more information on this diagnosis.
- Select *Compose* to generate an Intramail to ask your provider any questions.

Contact Us

Need a refill? Have a question only your doctor can answer? Patients can send messages to their provider and receive messages from their providers.



- Select the date in blue to view the Intramail.
- Select *New Message* to generate a new Intramail to your provider.

Thank you for choosing Sanova Dermatology!

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