NEBRASKA DERMATOLOGY LLC

DATE: _____

PATIENT FIRST NAME: _____ LAST: _____ MI: _____ BIRTH DATE: _____

PREFERRED NAME: _____ BIRTH SEX: M F GENDER IDENTITY: _____

AGE: _____ SSN: _____-_____-_____ MARITAL STATUS: SINGLE_ MARRIED_ WIDOWED_ DIVORCED_ SEPARATED_

RACE/ETHNICITY: _____ PRIMARY LANGUAGE: _____

EMAIL: _____

ADDRESS: _____ APT #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

HOME PHONE #: _____ CELL PHONE #: _____

WORK PHONE #: _____ EMPLOYER: _____

IS IT OKAY TO LEAVE A DETAILED MESSAGE: YES ☐ NO ☐ PREFERRED PHONE #: HOME ☐ CELL ☐ WORK ☐

IF PATIENT IS A MINOR, PARENT/LEGAL GUARDIAN NAME: _____ BIRTH DATE: _____

RELATIONSHIP TO PATIENT: _____ PHONE #: _____

ADDRESS: _____ APT #: _____ CITY: _____ STATE: ____ ZIP CODE: _____

PRIMARY INSURANCE INFORMATION

INSURANCE NAME: _____ EMPLOYER: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DATE OF BIRTH: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: _____

SECONDARY INSURANCE INFORMATION

INSURANCE NAME: _____ EMPLOYER: _____

POLICY #: _____ GROUP #: _____

POLICY HOLDER NAME: _____ POLICY HOLDER DATE OF BIRTH: _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER: _____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

MEDICAL INFORMATION RELEASE

THE FOLLOWING PEOPLE (FAMILY/FRIENDS) ARE ALLOWED TO DISCUSS BILLING INQUIRES AND/OR MEDICAL RECORDS:

NAME: _____ RELATIONSHIP: _____ PHONE #: _____

NAME: _____ RELATIONSHIP: _____ PHONE#: _____

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POLICIES

Payment:

Know that your copay and/or patient self-pay balance is due at the time of service. As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefit of your medical insurance coverage. We ask that you read and understand your insurance policy to be aware of coverage benefits and limitations. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. Ultimately, you are responsible for knowing and understanding your coverage. It is your responsibility to provide current or updated insurance information to our office at the time of service. Any balance left after insurance benefits have been paid is the responsibility of the patient, I.E., copay, co-insurance, and/or deductible.

Consent for Medical Treatment and Minor Procedures:

I understand that:

- During the course of my visit, my provider may recommend that a procedure be performed. Such procedures are not limited to but include: liquid nitrogen destruction (freezing), biopsies, shave removals, excisions, incision and drainage, scissor snip excision, curettage (scraping), electrodessication (use of cautery/heat), and steroid injections.
- The risks, benefits, and alternatives to these procedures will be explained to me at the time of my visit, prior to my provider performing the procedure(s).
- I will be allowed to ask any questions that I have.
- Any and all procedures are optional. I may choose to decline a procedure for any reason.
- There is no guarantee of results; as medicine is not an exact science.
- Some procedures may need to be performed more than once to achieve optimal results.
- Procedures may incur additional charges and I will be responsible for payment.
- If a procedure is deemed cosmetic, and therefore not covered by my insurance, I will be responsible for payment.
- For more invasive procedures and certain cosmetic procedures, a separate consent may be required.
- If I have a biopsy done, the specimen will be sent out of the office for pathologic evaluation and I will be billed for any amount not covered by my insurance.

Assignment and Release

I authorize payments to be made directly to Nebraska Dermatology LLC by my insurance company. I authorize the release of any demographic and medical information requested by my insurance company in order to pay on the claim. I accept financial responsibility for all services not covered by my insurance. I have read "Consent for Medical Treatment and Minor Procedures" and I consent to routine minor procedures and medical treatment.

Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have read the Nebraska Dermatology LLC assignment and Release statement, as well as the Notice of Privacy Practices. These statements describe how my health information may be used or disclosed in order to receive benefits. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the clinic location where I receive health care services as well as on their website.

By signing below, I am (i) providing my express consent to medical treatment and minor procedures, (ii) acknowledging the terms of the Nebraska Dermatology LLC Assignment and Release statement, as well as the Notice of Privacy Practices, and (iii) agreeing to the policies contained in this document.

_____ _____

Signature of Patient or Parent/Legal Guardian Date

_____ _____ _____

Patient Legal Name (Please Print) Parent/Legal Guardian Name (Please Print) Relationship to Patient

NEBRASKA DERMATOLOGY LLC

PATIENT DEMOGRAPHICS

Patient Name:	Date of Birth:
Preferred Pharmacy:	Pharmacy Location:
Family Physician:	Referring Physician:

MEDICAL HISTORY

- □ **NONE**
- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial fibrillation
- □ Benign prostatic hyperplasia
- □ Breast Cancer
- □ Cerebrovascular accident (stroke)
- □ Colon Cancer
- □ COPD
- □ Coronary Artery Disease
- □ Covid-19
- □ Depression
- □ Diabetes
- □ End-Stage Renal Disease
- □ Epilepsy
- □ GERD (acid reflux)
- □ Hay Fever
- □ Hearing Loss
- □ High Blood Pressure
- □ HIV/AIDS
- □ High Cholesterol
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Inflammatory disease of liver
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Transplantation of bone marrow
- □ Other _____
  _____
  _____
  _____

PAST SURGICAL HISTORY

- □ **NONE**
- □ Adenoids: Adenoidectomy
- □ Appendix (appendectomy)
- □ Bladder (cystectomy – surgical removal of bladder)
- □ Breast: Biopsy
- □ Breast: Lumpectomy (both) (left) (right)
- □ Breast: Mastectomy (both) (left) (right)
- □ Cesarean Section
- □ Colon: (colectomy)
- □ Colon: Colostomy (surgical removal of colon)
- □ Gallbladder (cholecystectomy)
- □ Heart: Coronary Artery Bypass
- □ Heart: Heart Transplant
- □ Heart: Mechanical valve replacement
- □ Heart: PTCA (angioplasty)
- □ Heart: Tissue graft valve replacement
- □ Joint Replacement: Hip (both) (left) (right)
- □ Joint Replacement: Knee (both) (left) (right)
- □ Kidney: Biopsy
- □ Kidney: Stone Removal
- □ Kidney: Transplant
- □ Kidney: Nephrectomy
- □ Liver: Hepatectomy
- □ Liver Excision
- □ Liver: Transplant
- □ Liver: Shunt
- □ Ovaries: (oophorectomy)
- □ Pancreas: Pancreatectomy
- □ Prostate: Biopsy
- □ Prostate: Transurethral Resection (TURP)
- □ Prostatectomy
- □ Rectum: Abdominal Perineal Resection (APR)
- □ Rectum: Low Anterior Resection
- □ Skin: Basal Cell Carcinoma
- □ Skin: Melanoma
- □ Skin: Biopsy
- □ Skin: Squamous Cell Carcinoma
- □ Spleen: Splenectomy
- □ Total orchidectomy
- □ Tonsils: Tonsillectomy
- □ Tubal ligation
- □ Uterus: (hysterectomy)
- □ Other_____
  _____

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SKIN CONDITIONS

□ **NONE**
□ Acne
□ Actinic Keratosis (Pre-Skin Cancer)
□ Asteatosis cutis (dry skin)
□ Basal Cell Carcinoma
□ Blistering Sunburns
□ Contact dermatitis due to Poison Ivy
□ Eczema
□ Malignant Melanoma
□ Pre-cancerous Moles
□ Pruritus of Scalp (Itchy scalp)
□ Psoriasis
□ Squamous Cell Carcinoma
□ Other_____
_____

Do you wear sunscreen? □ Yes □ No If yes, what SPF? _____

Do you tan in a tanning salon? □ Yes □ No

Family history of melanoma? □ Yes □ No If yes, which relative(s)? _____

MEDICATIONS

MEDICATION NAME	DOSAGE	FREQUENCY

DRUG ALLERGIES: _____

HEIGHT: _____

WEIGHT: _____

VACCINATION STATUS FOR PATIENTS AGES 9-13:

Meningococcal vaccine between the ages of 11-13 _____

Tdap vaccine between the ages of 10-13 _____

Two-three HPV vaccines between the ages of 9-13 _____

Did the patient not receive any of the vaccinations above because of a medical reason or allergy? _____

SOCIAL HISTORY

Tobacco product use:

□ Never smoked
□ Former smoker - Date you quit: _____
□ Daily smoker
□ Occasional smoker (tobacco)
□ Occasional smoker (cigarettes/vapor)
□ Cigar smoker

Alcohol use: □ None □ Less than 1 drink/day □ 1-2 drinks daily □ 3 or more drinks daily

Medicare One Time Authorization

Instructions: *This form must be signed and stored in the chart of every patient who has Medicare coverage. Once this form is signed, it does not need to be updated.*

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the rendering provider of Nebraska Dermatology, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering provider of Nebraska Dermatology, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company any information needed to determine those benefits or the benefits payable for related services.

This authorization applies to all services until it is revoked by me or my representative.

By signing below, I am (i) authorizing medical information about me to be released to the Center for Medicare & Medicaid Services and its agents and (ii) authorizing medical information about me to be released to my Medigap insurance carrier to determine benefits payable for related services received.

_____	_____	_____
Signature of Patient or Legal Guardian	**Date of birth**	**Date**
_____	_____	_____
Patient Legal Name (Printed)	**Legal Guardian Name (Printed)**	**Relationship to Patient**