☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

***Please present ALL Insurance cards and Drivers License to the receptionist. If patient is a minor, and you are not the legal guardian, please speak with the receptionist immediately. Thank you.**

Patient Information: Please Complete All Fields Using Legal Names of the Parties Involved.

Name: (First)________________________ (MI)______ (Last)________________________

Date of Birth: ____________ Age: _____ Sex: □ Male □ Female Marital Status: Single Married Div Widow

Mailing Address:____

City: ________________________ State: _____ Zip: ________ Social Security#:________________

Home Phone: __________________ Cell: ______________ Email:__________________

Occupation: ____________________Employer: _______________ Work Phone: ______________

Emergency Contact: ______________________ Phone#:__________________________

Relationship:____

Primary Doctor Name: _________________ Town: ____________Phone#:__________________

Referring Physician __________________Town: _____________ Phone#:__________________

New Patients: How did you hear about us? ____

Primary InsurancePlan:__________________________ID#______________________________

Primary Insurance Plan Holder's Name:_________________ DOB:___________ Relationship:______________

Mailing address of Plan Holder if different from patient: ________________________________

Home Phone of Plan Holder: ____________________________ Cell phone of Plan holder:______________

Secondary Insurance Plan: ____________________________ID#____________________________

Secondary Insurance Plan Holder's Name:_________________ DOB:__________ Relationship to patient:__________

Patient Release: MUST BE SIGNED BY PATIENT OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I understand I am responsible for co-insurances, copayments and deductibles. If I am not insured or Aura Dermatology does not participate in my plan I am responsible for payment in full at the time of service

I certify that I hereby authorize Aura Dermatology, its providers and staff to provide my minor child in my absence with examinations and basic treatments following the initial visit for which additional consents are not required I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

I agree to receive news and information about the practice via email, which may include offers and announcements for special events or offers from the practice and my physician. __________ *(initial)*

PATIENT OR LEGAL GUARDIAN SIGNATURE: __________________________ Date: ______________

Patient Name: ____ DOB: ____________________

Our goal is to provide you and your family with the very best care in a warm, supportive environment. We wish to provide you with information that helps us to maintain this goal and through our Patient Policies. These Policies manage expectations and assure understandings to develop a long-lasting relationship. We remain available for any questions you may have.

Appointment Cancellations and No Shows

- I understand late cancellation or missing an appointment keeps other patients from being seen.
- I understand failure to give 24-hours' notice of cancellation for a medial appointment will result in a charge of $50; failure to provide 48-hours' notice for a surgical or cosmetic procedure may result in a charge of $100 or forfeit of my cosmetic deposit or one treatment in my laser package.
- These charges cannot be billed to my insurance company.

Late Arrivals for Appointments

- I understand Aura Dermatology will do its best to accommodate me should I arrive late for an appointment. I understand arriving late means I have forfeited my appointment time and will need to wait to be worked back into the schedule if possible or be placed with another provider who may have availability. I also understand that there may be times when these accommodations are not available, and I will be asked to reschedule my visit.

Co-Payments, Deductibles and Co-insurances and Balances

- Copayments are due and collected at check in on the day of the appointment. I understand I may be charged a $25.00 administrative billing fee for each co-payment that is not paid at the time of service.
- Insurance Deductibles, including Medicare, will be verified prior to your visit. All unmet deductibles will be collected at the time of service.
- Medicare patients without a secondary insurance will be charged their 20% co-insurance at the time of service.
- All balances are due in full within 30 days of my first billing.
- Any balance left unpaid after 90 days without attempt at resolution will be considered for collections.
- Should my account be sent to collections, I understand I will be responsible for an additional 15% administrative collection fee plus any attorney / court fees which may be added to my account during efforts to obtain payment.
- I am responsible for any bank fees associated with returned check fees plus a $25.00 administrative processing fee. Any returned check must be paid in full via credit card or cash within 15 days of notice or legal efforts to collect balance will be instituted.

Referrals

- *It is my responsibility to know if my insurance plan requires a referral to see a specialist and will obtain referrals, track usage, and verify* Aura Dermatology *has referrals in their office prior to my visit.*
- I understand that should I fail to have a valid referral for my visit, Aura Dermatology is not authorized to see me. I will either need to reschedule my appointment or pay in full at the time of service for my visit.
- If I decide to see the provider without my referral my insurance company will not reimburse me, and I will be considered a self-pay patient for that visit and be responsible for the balance at the time of service.
- I understand trying to contact the referring office to obtain or inquire about my referral at the time of my visit with Aura Dermatology will not allow enough time to maintain my scheduled appointment and doing so will forfeit my scheduled time at Aura Dermatology

Insurance Policies

- I will confirm my insurance is current at each visit. If there is a change to my insurance, I will provide a valid insurance card or temporary print out at the time of my visit.
- If I am unable to produce this documentation I will either need to reschedule my appointment or pay in full at the time of service for my visit. I will be responsible for submitting my receipts to my insurance company should I wish to be reimbursed for my visit.
- My insurance carrier may consider certain routine services in dermatology to be surgical in nature and separate co-insurances, deductibles or co-payments may apply. Each insurance plan is different, and I understand it is my responsibility to understand my policy and what will be covered.
- I understand in signing below that I am responsible for notifying Aura Dermatology contact information. If insurance or referral information I present at the time of my visit is not correct, I will be responsible for all charges incurred.

Pharmacies

We will attempt to send your prescriptions to the pharmacy of your choice. Should your insurance require a pre-authorization, we will automatically transfer your prescription to a specialty pharmacy for processing.

Minor Patients

As a practice with a significant Pediatric and Adolescent population, we recognize the stress a family may encounter navigating the healthcare of the children under the best of circumstances. We also recognize this may be even more difficult in families where the parents are not together. We are here to provide treatment and support to you and your children, not to be incombered in the legal issues and responsibilities of the family.

- I understand a ***legal guardian*** MUST ACCOMPANY my child under the age of 18 to their initial appointment.
- I understand a ***legal guardian*** MUST ACCOMPANY my child under the age of 18 to subsequent appointments where an additional consent will be required.
- I understand as significant information is needed at the initial visit and treatment plans are created, it is essential for a parent/ legal guardian to be present at the initial visit. ***Children without legal guardian at their initial visit will be rescheduled***. Notes from legal guardians with permission to treat is not acceptable.
- I acknowledge that Grandparents, older siblings, step-parents etc. are not considered legal guardians without a court document that must be presented at the time of service.
- I understand that unless documents are provided showing otherwise, both parents are assumed to make appointment and treatment decisions for their child. Disagreements on approach to treatment is between the parents to discuss.
- **I understand ALL Payments (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. We will collect payment due from the parent who brings the child to the visit.** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- **I understand there may be times when I may allow my adolescent child to be unaccompanied for a follow-up visit and all payments that are due at the time of service will be handled by me either prior to the visit or with the credit card on file for my child.**

Insurance Inquiries

- From time to time I may receive a letter from my insurance company requesting information about my coverage.
- I understand that claims will not be paid without my providing this information.
- I will reply to all insurance inquiries within 30 days of receipt or may be responsible for the entire balance.

Credit Card on File

- We have implemented a policy requiring a credit card held on file. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured.
- Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and we have received an EOB. At that time, you will receive a statement.
- Should the patient balance not be paid within 30 days of the statement date, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.
- This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Cosmetic Deposits

A significant amount of time is reserved for our patient's cosmetic appointments, and therefore a deposit of $200 is required for all injectable and laser appointments, payable at the time of scheduling. Aesthetician services require a 50% deposit to schedule your appointment. Your deposit will be charged immediately and will be noted as a credit on your account. The deposit will be applied to the total charges on the day of your treatment. Cancellations/ reschedules with greater than 48-business-hours notice will be refunded or applied to the new appointment in full. Changes made with less than 48-business hours notice may forfeit the deposit in total.

Patient or Legal Guardian Signature: ____ Date: ____________________

Name of Legal Guardian: ____ Relationship: ______________

aura DERMATOLOGY

Patient Name: DOB: Height: Weight:

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow
Transplantation
Breast Cancer
Colon Cancer
COPD

Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol

Thyroid Problems
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

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
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)

Joint Replacement within last 2 years
Kidney Biopsy (Nephrectomy)
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Skin Disease History: (please circle all that apply)

Acne
Actinic Keratoses
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

NONE

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)?
____

Medications: (Please enter all current medications *including* **dosage** and **frequency**)
____
____
____

Allergies: (Please enter all allergies)
____
____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Family History (Only first-degree relatives)
____
____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heartbeat with epinephrine
Are you pregnant or currently trying to get pregnant?

Have you received the Flu Vaccine? Yes No

65 and older:

Do you have an Advanced Care Plan? Yes No
If yes please provide the name and relation of the surrogate decision maker:
Name:_______________________________________Relation:______________________________

Have you received the Pneumonia Vaccine? Yes No

Patient Name: ________________________________ **DOB:**_______________

HIPAA

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Aura Dermatology from discussing appointments, medications, test results or treatment plans with anyone other than the patient.

Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. **This becomes especially important if your spouse or adult children assist with making appointments for you or if you are an adult college student away at school and your parents assist with prescriptions and appointments**.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information about you. Should you wish to update the names below, please ask the receptionist for a HIPAA form.

Please place a check mark next to the following methods we may use to contact you regarding your appointments and medical information and indicate below any persons authorized to speak with our office on your behalf.

You may leave a message	**Regarding Appointments**	**Regarding Medical info**
Home Answering Machine	________	________
Mobile phone Voice Mail	________	________
Mobile text	________	________
Work Phones	________	________
With another person that may answer	________	________
Information through the mail	________	________
Information through email	________	________

Name of Individual (please print)	**Relationship to Patient**
______________________________	________________________
______________________________	________________________
______________________________	________________________

Patient/ Guardian Signature: __________________________ **Date:** ___________

I acknowledge and understand the above HIPAA policies and understand I may request a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.