________________________ Age ________ Pt # ________ Date ________

Allergies:	
Current medications:	

Reason for today's visit: (chief complaint)

____

____

____

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	☐	☐	
Eyes	☐	☐	
Ears/Nose/Throat/Mouth	☐	☐	
Heart	☐	☐	
Lungs	☐	☐	
Stomach/bowel	☐	☐	
Kidneys	☐	☐	
Arthritis/muscles/joints	☐	☐	
Skin Cancer	☐	☐	
Headaches/seizures	☐	☐	
Psychological disorder	☐	☐	
Thyroid/diabetes	☐	☐	
Blood/bleeding disorder	☐	☐	
Allergic/immunologic	☐	☐	

Females: are you pregnant? __yes __no planning to become pregnant? __yes __no

Family History: (Past family & social history)

Mother: living/deceased__________ age____ Father: living/deceased__________ age____ No of children____ age(s)______

Check following medical conditions that have occurred in your family:

Disease	Mother	Father	Blood Relative
Allergies	☐	☐	☐
Arthritis	☐	☐	☐
Asthma	☐	☐	☐
Cancer	☐	☐	☐
Diabetes	☐	☐	☐
Eczema	☐	☐	☐
Hayfever	☐	☐	☐
Heart disease	☐	☐	☐
High blood pressure	☐	☐	☐
Lung disease	☐	☐	☐
Malignant Melanoma	☐	☐	☐
Psoriasis	☐	☐	☐
Skin cancer	☐	☐	☐
Tuberculosis	☐	☐	☐

Social History:

Do you live alone? __no __yes

Do you drink alcohol? __no __yes-frequency______

Occupation____________________________

Do you smoke? __no __yes-frequency______

Do you use recreational drugs? __no __yes-frequency______

Hobbies/leisure activities____________________________

Reviewed____________________________
(MD signature)

Date________________ Update________________

DATE:______________

Patient's Full Name (last, first, middle)____

Date of Birth____________________________

INFORMATION PERTAINING TO PERSON RESPONSIBLE FOR ACCOUNT

Full Name (last, first, middle)____

Date of Birth____________Relationship________________________SS#________________

Spouse____SS#________________

Present Address____

City________________________State_____________Zip________Phone#________________

Present Employer____

Employers Phone#____________________Yrs There_________Address________________

Nearest Relative____Phone#____________

Referred By: ( ) Friend/Relative ( ) Phonebook ( ) Doctor ( ) Other

Their Name____

Any Other Family Member Being Seen In Clinic___________ If So: Name________________

INSURANCE INFORMATION

PRIMARY Insurance: ______________________________

Address ______________________________ Policy# ______________

Name of Policyholder ______________________________ SS# ______________

Date of Birth ______________ Relationship ______________________

Deductible Amount $ ________ How much of this amount have you paid for the current year? __________

SECONDARY Insurance: ______________________________

Address ______________________________ Policy# ______________

Name of Policyholder ______________________________ SS# ______________

Date of Birth ______________ Relationship ______________________

Deductible Amount $ ________ How much of this amount have you paid for the current year? __________

Should your account become past due with our office, the undersigned will be responsible for paying any collection charges or attorney fees used in collecting your account.

authorization to release information — authorization for payment to Dr.

Signed ______________ Date ________ Signed ______________ Date ________

DERMATOLOGY CENTERS
GALESBURG DERMATOLOGY
ADVANCED DERMATOLOGY
KEWANEE DERMATOLOGY
PATIENT INFORMATION POLICY

AT DERMATOLOGY CENTERS WE STRIVE TO INFORM YOU OF THE OFFICE POLICY AND EXPECTATIONS EVERY STEP OF THE WAY, IF AT ANY TIME YOU ARE UNSURE OF SOMETHING PLEASE SPEAK TO SOMEONE ON OUR STAFF TO GET CLARIFICATION.

AT THIS TIME WE ARE PROVIDERS FOR MEDICARE, BLUE CROSS, AND CHAMPUS. ALL APPLICABLE CO-PAYS AND/OR DEDUCTIBLES NEED TO BE PAID AT TIME OF SERVICE AS PART OF YOUR CONTRACT WITH THESE INSURANCES. YOUR INSURANCE CARD SHOULD TELL YOU YOUR CO-PAY AND NETWORK. SHOULD YOU STILL HAVE QUESTIONS PLEASE ASK US FOR HELP IN DETERMINING YOUR CULPABILITY OR CALL YOUR CARRIER DIRECTLY.

NEW PATIENTS WHO ARE NOT PART OF ANY CONTRACTED PLAN WILL BE REQUIRED TO PAY A DEPOSIT , THE GREATER OF 125.00 OR 20% OF CHARGES ON THEIR FIRST DATE OF SERVICE. ANY ADDITIONAL CHARGES CAN BE BILLED TO THE INSURANCE. AFTER YOUR INITIAL VISIT YOU MAY PAY YOUR COPAY % IF ADDITIONAL VISITS ARE NECESSARY.

AS A COURTESY WE FILE TO BOTH YOUR PRIMARY AND SECONDARY INSURANCE. PLEASE KEEP IN MIND THAT YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND THE CARRIER, WE ARE NOT A PARTY IN THAT. WHILE WE WILL DO EVERYTHING IN OUR POWER TO OBTAIN PAYMENT FROM THEM YOU ARE ULTIMATELY RESPONSIBLE FOR THE BILLED AMOUNT.

COSMETIC PROCEDURES OR THOSE DEEMED BY YOUR INSURANCE AS SUCH ARE ALWAYS PAID IN FULL AT THE TIME SERVICES ARE RENDERED. WE STRONGLY ENCOURAGE YOU TO DISCUSS FEES FOR SURGERY, COSMETIC AND NON COSMETIC PROCEDURES IN ADVANCE AS YOU DO NOT WANT ANY SURPRISE BILLS TO PAY. ALSO, SHOULD YOU HAVE ANY SPECIFIC FINANCIAL NEEDS, THIS IS THE TIME TO DISCUSS THEM.

ANY AMOUNT LEFT OWING GREATER THAN 90 DAYS WILL BE CHARGED INTEREST AT 18%(1.5% per month). FOR THIS REASON YOU SHOULD FOLLOW-UP IF YOU HAVE NOT HEARD FROM YOUR INSURANCE COMPANY WITHIN 45 DAYS OF YOUR VISIT.

REGARDLESS OF THE REASON FOR YOUR VISIT TODAY, WE ENCOURAGE YOU TO SEEK A FULL SKIN EXAM TO SCREEN FOR ANY POSSIBLE MALIGNANCIES. ASK THE DR. IF THIS IS SOMETHING YOU WOULD BE INTERESTED IN.

IN ORDER TO KEEP AN ORDERLY SCHEDULE AND MINIMIZE WAIT TIME , AN OFFICE VISIT WILL BE CHARGED FOR ALL MISSED APPOINTMENTS OR CANCELLATIONS WITH LESS THAN 24 HOUR NOTICE. IF A TRUE EMERGENCY OCCURS, EXCEPTIONS TO THIS MAY BE MADE BY THE PHYSICIAN ONLY.

THE PARENT OR GUARDIAN ACCOMPANYING MINOR CHILDREN WILL BE RESPONSIBLE FOR PAYMENT OF SERVICES.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS OUTLINED. MY SIGNATURE BELOW ACKNOWLEDES THIS AND GIVES THE PHYSIAN AUTHORITY FOR EXAMINATION AND TREATMENT CONCERNING TODAYS VISIT AS WELL AS ANY FUTURE VISITS I MAY REQUIRE.

X____________________________________DATE____________________

(Signature of patient , parent or legal guardian)

The Dermatology Centers:
Galesburg Dermatology Center
Advanced Dermatology Center
Kewanee Dermatology Center

____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

FOR THE PURPOSE OF THE FOLLOWING CONSENT, THE DERMATOLOGY CENTER(S) INCLUDE ANY AND ALL OF THE ABOVE LISTED OFFICES. EACH OWNED AND OPERATED BY DR. SAM FAYMAN.

With my consent, The Dermatology Centers may use and disclose **protected health information (PHI)** about me to carry out **treatment, payment and healthcare operations (TPO).** Please refer to The Dermatology Center'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.

The Dermatology Centers reserve the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Galesburg Dermatology Center; Privacy Officer at 201 N Prairie, Galesburg Il 61401.**

With my consent, The Dermatology Center(s) may call my home or other designated location and leave a message on voice mail 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 at this time authorize the Dermatology Center to discuss my account both verbally and in writing with the following people.____

This authorization is good for medical_________ and/or financial___________ and will remain in effect until I rescind the authorization in writing.(Check those that apply)

With my consent, The Dermatology Center(s) 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.

I have the right to request that The Dermatology Center(s) 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 The Dermatology Center's 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,
The Dermatology Center(s) may decline to provide treatment to me.

____
Signature of Patient or Legal Guardian

______________________________ ______________________
Patient's Name Date

____
Print Name of Patient or Legal Guardian

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