Renew Family Dermatology

MD CD KW LR KS HS COS

Please answer the following questions:

REASON FOR TODAY'S VISIT: _____

Name_____ DOB: _____DATE: _____

Mailing Address_____City_____State_____Zip_____

Home Phone_____ Cell phone_____ Social Security #_____

Email: _____ Primary physician _____

Preferred pharmacy_____

Insurance: _____ Policy/ID number: _____

Policy holder name: _____ DOB: _____

Secondary Insurance: _____ Policy/ID number: _____

Responsible Party (Guarantor): (if minor, parent's information)

Responsible party's name_____ Telephone number_____

Responsible party's date of birth_____ Social Security Number_____

Emergency contact (name and number) _____

Patient's Medical health

Please circle all that apply: ARTIFICIAL JOINTS PACEMAKER/DEFIB ANTIBIOTICS PRIOR TO SURGERY PREGNANT

Are you allergic to: ☐Lidocaine ☐Epinephrine ☐Adhesives ☐Latex

Are you subject to excessive prolonged bleeding? Yes No Are you on blood thinners? YES NO

Check all that apply:

☐ Arthritis	☐ Diabetes	☐ Seizures
☐ Asthma	☐ Chronic Heart Failure	☐ Stroke hx
☐ Anemia	☐ High blood pressure	☐ Tuberculosis (TB)
☐ Autoimmune Disorder	☐ HIV/AIDS	☐ Liver disease (fatty or hepatitis)
☐ Cancer : _____	☐ Thyroid Disorder (Hypo or Hyper)	☐ Kidney disease
☐ Celiac Disease	☐ Chrohns or UC	☐ Depression/Anxiety

☐ Actinic Keratoses (precancer)	☐ Lupus	☐ Other_____
☐ Basal Cell Carcinoma	☐ Squamous Cell Carcinoma	☐ Other_____
☐ Hay fever/allergies	☐ Melanoma	☐ Other_____
☐ Psoriasis	☐ Tanning bed use (past or present)	☐ Other_____
☐ Atopic Dermatitis/Eczema	☐ other_____	☐ Other_____

Family history of Melanoma? Yes No Which family member? _____

PLEASE LIST MEDICATIONS ON BACK

List all medications (include otc and vitamins):_____

_____

_____

_____

_____

_____

_____

MEDICATION ALLERGIES: _____

*To better serve you, we must be able to import your medications from your pharmacy, so our records are up to date. By submitting this paperwork, you are consenting to letting us access your medications when necessary for your care.

Please answer the following questions:

Smoking status (includes vaping)? Never, current, former Year quit? _____

Alcohol status? None, less than 1 drink per day, 1-2 drinks per day, 3-6 drinks per day, 7+ drinks per day

Please answer the following questions:

1) **During the past month, have you often been bothered by feeling down, depressed, or hopeless? YES NO**
2) **During the past month, have you often been bothered by little interest or pleasure in doing things? YES NO**

Do you have an advanced directive? YES NO

HIPAA Authorization Form

Patient Name: _____ Date of Birth: _____

CHOOSE ONE:

☐ I DO NOT authorize Renew Family Dermatology to release my medical and billing information to anyone other than myself. (**Caution**: We will not be able to share personal info with anyone without a signed revision of this form.)

OR

☐ I authorize Renew Family Dermatology to release my medical and billing information to the individuals listed below:
(If you are the parent/guardian/spouse filling out this form, please include your own information as well.)

Name	Relationship	Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I authorize Renew Family Dermatology to leave detailed messages on my voicemail:

Home #: **Yes** or **No** Cell #: **Yes** or **No**

I authorize Renew Family Dermatology to text appointment reminders to cell #: **YES or NO**

The HIPAA privacy rule permits health care providers to communicate with patients regarding their healthcare, including protected health information (PHI) and billing information. This includes communicating with the patient through mail, phone, fax, or another manner.

I understand that Renew Family Dermatology (RFD) is permitted by the HIPAA privacy rule to leave information regarding my appointment, including the date and time, on any phone number(s) provided. RFD may request a return phone call to our office by leaving a message or when speaking to any individual who answers the phone. If I only want confidential communication between myself and RFD, I must provide written notice to RFD.
I understand that it is my responsibility to keep RFD informed of any changes to this information and that I may revoke this authorization at any time by written notice.

Patient Name (Print) _____

Responsible Party Signature_____ Date_____

PLEASE SEE BACK PAGE FOR ADDITIONAL INFORMATION

Financial, Insurance, and Billing Waiver

- ❖ All copays, deductibles, and balances are due at the time of service. We accept cash, check, and VISA, MC, Discover. CareCredit is an option for those not able to pay all at once.
- ❖ Patients will be required to pay ALL fees that Renew Family Dermatology incurs due to any returned check(s).
- ❖ No refunds for any cosmetic products purchased in the clinic. Credit may be transferred to other cosmetic products depending on practice discretion.
- It is your responsibility to make sure that we have all your billing information up to date in our system. If you fail to provide complete and accurate insurance information on the date of service, you will be responsible for whatever is not covered by your insurance(s).
- If for some reason your insurance has determined that we are an out of network provider or the insurance plan does not provide appropriate coverage for the provider being seen, you will be responsible for whatever is not covered by your insurance(s).
- It is your responsibility for any denied or non-covered services, services declared not medically necessary by your insurance, any copayments, deductibles, and coinsurance. You are also responsible for any claims denied due to lack of patient information.
- Self-pay patients are required to pay all of the services rendered at time of visit.
- We will send monthly statements for charges that are deemed your responsibility and may require you to pay all fees prior to being seen at future appointments.
- I have read and understand my responsibilities that Renew Family Dermatology LLC has outlined for me and all my responsible parties. I authorize the release of necessary information in order for Renew Family Dermatology LLC and staff to receive payment for services.

Signature of patient/Authorized

Representative_____ Date_____

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

RENEW FAMILY DERMATOLOGY

There should be a copy of the Notice of Privacy Practices included with your paperwork or on our website if you are printing the paperwork. If not, please inform the front desk attendants and they can provide you with a copy. We can also print and give you a personal copy upon request.

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Renew Family Dermatology's Notice of Privacy Practices with respect to the patient.

I am a patient of Dr. Michael S. Digby, M.D., Cassandra Digby, NP-C, Laci Robertson, NP-C, Kendra Wright, NP-C, or Katie Sewell, NP-C. I hereby acknowledge receipt of Renew Family Dermatology's Notice of Privacy Practices.

Signature of patient/Authorized

Representative_____ Date_____