NEW PATIENT INFORMATION FORM

Provider you are seeing: ☐ Dr. Jeffrey C. Houin, Jr. ☐ Dr. Bradley N. Greenhaw Date: _____
☐ Dr. Ira D. Harber ☐ Jennifer H. Stone, PA-C ☐ Hannah N. Savely, PA-C

Referring Physician: _____ Phone#: (___)_____

PATIENT INFORMATION *(please print clearly with full detail)*

Patient's Last Name: _____ Patient's First Name: _____

Patient's Preferred Name: _____ Middle Initial: _____

Date of Birth: _____ Sex: ☐Male ☐Female ☐Social Security #:_____

Address: _____ City: _____ State: _____ Zip:_____

Home Phone#: (___)_____ Work#: (___)_____ Cell Phone#: (___)_____

How would you like us to contact you: ☐Home ☐Work ☐Cell ☐Leave message on voicemail? Yes No

Email Address: _____ Marital Status: ☐Child ☐Single ☐Married ☐Divorced ☐Other

Ethnicity: ☐Hispanic ☐Non-Hispanic ☐Decline Preferred Language: _____ Race:_____

Patient's Employer: _____ ☐Full Time ☐Part Time ☐Unemployed ☐Retired

Emergency Contact: _____ Phone#: (___)_____ Relationship: _____

Pharmacy Name:_____ Phone#: (___)_____

IF PATIENT IS A MINOR

Parent's Last Name: _____ Parent's First Name: _____ Middle Initial: _____

Address (If Different): _____ City: _____ State: _____ Zip: _____

Date of Birth: _____ Social Security #: _____

Phone#: _____ Relation to Patient: ☐Mother ☐Father ☐Guardian

Parent's Employer: _____ ☐Full Time ☐Part Time ☐Unemployed ☐Retired

INSURANCE INFORMATION

Name of Policy Holder: _____ Secondary Policy Holder: _____

Primary Policy Date of Birth: _____ Secondary Policy Date of Birth:_____

Relation to Policy Holder: ☐Child ☐Spouse ☐Other Relation to Secondary: ☐Child ☐Spouse ☐Other

Insurance: _____ Secondary Insurance: _____

Policy ID #: _____ Policy ID #: _____

Group ID #: _____ Group ID #: _____

HEALTH HISTORY

Last Name: _____ First Name: _____ M.I.: _____

Height _____ Weight _____

	Name (of Medication)	Dosage	Frequency
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

(if you need additional space, please provide on separate sheet of paper)

Medication Allergies (Please list reaction): _____

Do you smoke? ☐Yes ☐No Do you drink alcohol? ☐Yes ☐No Do you use sunscreen? ☐Yes ☐No

Family History of Melanoma? ☐Yes ☐No Are you Pregnant? ☐Yes ☐No

Do you have a Pacemaker? ☐Yes ☐No

Major Medical Surgeries: _____

Medical Condition History (Please check any of the following conditions you have or have had in the past):

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular Heartbeat)
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Chronic Obstructive Pulmonary Disease)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stages
- ☐ GERD
- ☐ Other _____
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Renal Disease
- ☐ Seizures
- ☐ Stroke

Skin Disease History (Please check any of the following conditions you have or have had in the past):

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Basal Cell Carcinoma
- ☐ Dry Skin/Eczema
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma

FINANCIAL POLICY FORM

Welcome

Thank you for choosing ***Dermatology Center of North MS, P.A.*** for your dermatology needs. We are committed to providing you with quality medical care, our professional fees have been determined through careful consideration, and we believe these fees are reasonable and reflect other area physician's charges. We are pleased to discuss with you any questions you may have concerning your bill. Providing quality care is our primary concern.

Regarding Insurance

Private Insurance Policies: ***Dermatology Center of North MS, P.A.*** will file claims directly with your insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee your insurance will pay for services. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

Contracted Managed Care Plans (HMO, PPO etc): Each time you make an appointment with a ***Dermatology of North MS, P.A.*** physician, it is your responsibility to make sure the physician is currently under contract with your plan and you have obtained the necessary referrals when needed. Verification of your plan benefits/coverage is required. Often this verification requires us to share the reason for your visit with a managed care plan. Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service.

We allow 45 days from the date a claim was filed by our office for the insurance company to pay. If the Insurance Carrier has not paid within this time, you are responsible for the entire balance. We will not become involved with disputes between you and your insurance company regarding deductibles, non-covered services, co-insurance, co-payments, coordination of benefits, pre-existing conditions or "reasonable and customary" charges other than to supply factual information when necessary. You are responsible for the timely payment of your account.

Medicare/Tricare/Champus: ***Dermatology Center of North MS, P.A.*** will accept assignment of Medicare/Tricare/Champus benefits. You may be asked to sign a waiver to acknowledge your understanding of your responsibility to pay for services not covered by Medicare/Tricare/Champus.

Medicaid: ***Dermatology Center of North MS, P.A.*** is not a contracted provider for services for Medicaid only.

Medical/Surgical Procedures: I understand that the pricing that is given by the staff of ***Dermatology Center of North MS, P.A.*** is an estimate and that there could be additional cost once the claim has been processed by my Insurance Carrier. If processed and is less, a credit will be issued to the account or refunded when requested.

Method of Payment: For your convenience, ***Dermatology Center of North MS, P.A.*** will be happy to accept your personal check, cash, Visa, and MasterCard for payment of your medical services. A $35.00 fee will be accessed to your account for all returned checks.

Minors: The parent(s) or guardian(s) of a minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. ***Unaccompanied minors must have authorization for medical treatment signed by a parent or guardian and is responsible for current insurance information for self and/or payment in full for services provided.***

I have read and understand the above terms and conditions and will verify so by giving my signature.

Signature Date

Insurance Assignment and Authorization to Release Information

I request payment of authorized insurance company benefits be made on my behalf to ***Dermatology Center of North MS, P.A.*** for any services furnished me by that party who accepts assignment/physician.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carriers any information needed for this or a related Medicare/Other Insurance Company claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the above mentioned party who accepts assignment. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment.

Signature Date

DERMATOLOGY CENTER
OF NORTH MISSISSIPPI, P.A.

516 Pegram Drive • Tupelo, Mississippi 38801
(662) 844-6272 • Fax: (662) 844-1603
100 Norman Road • Corinth, Mississippi 38834
(662) 205-4762 • Fax: (662) 594-1620

Acknowledgment of Review of

Notice of Privacy Practices (HIPAA)

I, _____ (*if minor*, Parent/Guardian's name) _____
Patient's Name (*if minor*, Parent/Guardian's name)

have received a copy of ***Dermatology Center of North MS, P.A.'s*** Notice of Privacy Practices for review which explains how my medical information will be used, disclosed and protected.

Signature of Patient (or Parent/Guardian): _____ Date: _____

HIPAA Compliance Officer: C. Gambrel, Practice Administrator
HIPAA Compliance Officer's Signature: C. Gambrel

I do / do not (circle one) authorize ***Dermatology Center of North MS, P.A.*** and its designated representatives to release my medical information to my spouse, parent, guardian, or other. **If authorized, please provide name**:

_____

I do / do not (circle one) authorize ***Dermatology Center of North MS, P.A.*** and its designated representatives to release my medical information to my primary care physician. **If authorized, please provide name of Physician**:

_____

Patient Record Disclosures
Contact Permission: The HIPAA Privacy Rules give individuals the right to request a restriction on uses and disclosures of their protected health information. In the event that ***Dermatology Center of North MS, P.A.*** needs to contact you (the patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

Yes **No** (circle one) Leave a message on an answering machine.
Yes **No** (circle one) Speak with authorized entities listed above.

Signature of Patient (Parent or Guardian): _____ Date: _____