Patient Information Record
Please PRINT All Information

HORIZON
— DERMATOLOGY —

PATIENT INFORMATION

PATIENT'S NAME (LAST, FIRST, MI)			SOCIAL SECURITY NUMBER
ADDRESS	CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	
EMAIL ADDRESS			

GENDER ☐ Male ☐ Female ☐ Other: _____	MARTIAL STATUS ☐ Married ☐ Legally Separated ☐ Single ☐ Widowed ☐ Divorces	AGE	DATE OF BIRTH	HAVE BEEN TO THIS OFFICE BEFORE: ☐ Yes ☐ No IF YES, WHEN?

OCCUPATION	EMPLOYER
WORK ADDRESS	
SPOUSE'S NAME (LAST, FIRST, MI) [If not applicable please fill in N/A]	SPOUSE'S DATE OF BIRTH
PRIMARY CARE PHYSICIAN / REFERRING PROVIDER	

PERSON RESPONSIBLE FOR PAYMENT IF OTHER PATIENT

NAME	DATE OF BIRTH	RELATIONSHIP
ADDRESS		
OCCUPATION	EMPLOYER	PHONE
EMPLOYER ADDRESS		WORK PHONE

POLICY HOLDER INFORMATION

1. INSURANCE COMPANY	1. NAME OF POLICY HOLDER	
1. GROUP #	1. CERTIFICATE/POLICY/ID#	1. POLICY HOLDER'S DATE OF BIRTH
1. MEDICARE #	1. MEDICAID #	1. POLICY HOLDER'S SOCIAL SECURITY

IF ADDITONAL INSURANCE

2. INSURANCE COMPANY	2. NAME OF POLICY HOLDER	
2. GROUP #	2. CERTIFICATE/POLICY/ID#	2. POLICY HOLDER'S DATE OF BIRTH
2. MEDICARE #	2. MEDICAID #	2. POLICY HOLDER'S SOCIAL SECURITY

Assignment of Benefits:

I hereby assign/authorize my insurance carrier including Medicare, other government sponsored insurances of which I may be covered and/or all commercial payers to make payments on my behalf directly to Horizon Dermatology and Skin Surgery Center. I also assign any Medigap benefits to be paid directly to my provider. I permit a copy of this autorotation to be used in place of the original.

Signed _____ **Date** _____

Payment Policy	All copayments, deductibles, patient responsibility amounts, and any outstanding balances are due at the time of check-in. We accept cash, check, VISA, and MasterCard. A valid credit card is required to be kept on file for all patients. Once your insurance claim has been processed, any remaining balance will be automatically charged to the card on file 14 days after adjudication, up to a maximum of $500. If your balance exceeds $500, we will charge $500 to your card, and you will be responsible for paying any remaining balance. You will receive an email notification 14 days prior to any charge being processed. If you need to update your payment method, please contact our billing office at (954-852-3604) before the 14-day period ends.
Referrals & Authorizations	If your insurance plan requires a referral, authorization, or pre-authorization, it is your responsibility to ensure it is obtained prior to your appointment. Please contact your primary care physician or insurance provider to confirm. If authorization has not been received before your scheduled appointment, your visit will be rescheduled. Failure to obtain the required authorization may result in reduced or denied insurance coverage, and the full balance will become the patient's responsibility.
No-Show & Cancellation Policy	We require at least 24 hours' notice for appointment cancellations or changes. **Failure to provide adequate notice will result in the following fees:** **Standard appointment: $25** **Excision procedure: $75** **MOHS procedure: $100** **Aesthetician services: 50% of the scheduled service cost**
Returned Checks	Returned checks are subject to a $40 non-sufficient funds (NSF) fee. Patients with returned checks will be required to use electronic forms of payment for future visits.
Insurance Policy	Insurance is a contract between you and your insurance provider. While we will bill your primary insurance as a courtesy, you are ultimately responsible for all charges incurred. To ensure accurate billing, you must provide complete and up-to-date insurance information, including primary and secondary coverage. Failure to provide accurate information may result in the full balance being your responsibility.
****Important Notice****	**Insurance estimates are not guarantees of payment.** Your insurance provider determines final coverage, eligibility, and benefits. If we are out-of-network, you are responsible for any charges not covered, including amounts above usual and customary allowances. If your insurance pays you directly, you are responsible for forwarding payment to us promptly. We accept most major insurance plans; however, due to frequent changes, we strongly recommend contacting your insurance provider prior to your appointment to confirm that we are in-network.
Financial Responsibility	It is your responsibility to verify that our physicians and practice are participating providers under your insurance plan. Your employer or insurance provider can supply a current provider directory. You are responsible for maintaining a current account balance, including all copays, deductibles, non-covered services, and any remaining balances reflected in your Explanation of Benefits (EOB) or billing statements. All outstanding balances must be paid in full prior to your next appointment. Failure to receive a billing statement does not waive your responsibility for payment.

ACKNOWLEDGMENT

Patient Name**(print)**: _____ Date: _____

Patient Signature: _____

MEDICAL INTAKE		
MEDICATION ALLERGIES		
PHARMACY NAME/CITY		PHARMACY PHONE #
PATIENT	Ht	Wt

MEDICAL HISTORY (PLEASE CHECK ALL THAT APPLY)		
☐Anxiety ☐ Arthritis ☐ Asthma ☐ Atrial Fib ☐ Cancer: Type(s)_____ _____ ☐ Crohn's Disease ☐ Depression ☐ Diabetes ☐ Dialysis ☐ GERD (Acid Reflux)	☐ Heart Disease ☐ Hearing Loss ☐ Hepatitis ☐ High Blood Pressure ☐ HIV/AIDS ☐ High Cholesterol ☐ Immunosuppression ☐ Kidney Disease ☐ Liver Diseases ☐ Lung Diseases (COPD, emphysema, other) ☐ Lupus	☐ Radiation Treatment ☐ Seizures ☐ Stroke ☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcerative Colitis ☐ None ☐ OTHER _____ _____ _____

PAST SURGICAL HISTORY
Please list all post surgeries with approximate dates: (including joint replacement, organ transplant, etc)
Please list current medications, and include dose and frequency for each (If you brought a list, the front desk can make copy)

Skin Disease History: (Please check all that apply)		
☐Acne ☐Blistering Sunburns ☐Dry Skin ☐Eczema ☐Excessive sun exposure	☐Flaking or Itchy Scalp ☐Lupus ☐Psoriasis ☐Actinic Keratosis (precancerous lesions)	☐Atypical (dysplastic) moles ☐Basal Cell Carcinoma ☐Melanoma ☐Squamous Cell Cancer ☐Other: _____

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

Do you currently use a tanning bed? ☐ Yes ☐No

Have you ever used a tanning bed in past? ☐ Yes ☐No

Do you have a family history of Melanoma? ☐ Yes ☐No If yes, which relative(s)? _____

Social History	
Smoking Status: (Please mark one)	**Alcohol Status (Please mark one)**
Current Smoker ☐	None ☐
Former Smoker ☐	Occasional/Social ☐
Never Smoker ☐	1-2 drinks per day ☐
	3 or more drinks per day ☐

Occupation (Important for exposures/allergens): _____

Immunizations: Have you had the following immunizations?			
Vaccine	**Date of Vaccincation (can be approximate if unsure)**		
Influenza (flu)		HPV	
Pneumonia		COVID-19	
Varicella (Shingles)		Hepatitis B	

Review of Systems: Have you recently experiences or are you currently experiencing any of the following?					
Changing mole	☐ Yes	☐No	**Seizures**	☐ Yes	☐No
Rash	☐ Yes	☐No	**Cough**	☐ Yes	☐No
Hair Loss	☐ Yes	☐No	**Nauses/Vomiting**	☐ Yes	☐No
Fever or chills	☐ Yes	☐No	**Diarrhea**	☐ Yes	☐No
Depression	☐ Yes	☐No	**Fatigue**	☐ Yes	☐No
Anxiety	☐ Yes	☐No	**Wheezing**	☐ Yes	☐No
Acne	☐ Yes	☐No	**Pacemaker**	☐ Yes	☐No
Problems with healing	☐ Yes	☐No	**Defibrillator**	☐ Yes	☐No
Problems with bleeding	☐ Yes	☐No	**Blood thinners**	☐ Yes	☐No
Problems scarring (thick or keloid)	☐ Yes	☐No	**GI upset with antibiotics**	☐ Yes	☐No
Immunosuppression	☐ Yes	☐No	**Allergy with adhesive**	☐ Yes	☐No
Night sweats	☐ Yes	☐No	**Allergy to lidocaine**	☐ Yes	☐No
Unintentional weight loss	☐ Yes	☐No	**Allergy to topical antibiotics (Neosporin)**	☐ Yes	☐No
Thyroid problems	☐ Yes	☐No	**Artificial heart valve**	☐ Yes	☐No
Sore throat	☐ Yes	☐No	**Artificial joint within the past 2 years**	☐ Yes	☐No
Abdominal pain	☐ Yes	☐No	**MRSA**	☐ Yes	☐No
Joint aches	☐ Yes	☐No	**Premedication prior to procedures**	☐ Yes	☐No
Muscle weakness	☐ Yes	☐No	**Rapid heartbeat with epinephrine**	☐ Yes	☐No
Vision problems	☐ Yes	☐No	**Pregnancy or planning a pregnancy**	☐ Yes	☐No
Headaches	☐ Yes	☐No	**Breastfeeding**	☐ Yes	☐No

Family History: (please check all that apply)								
Acne	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Arthritis	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Asthma	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Atypical (dysplastic) moles	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Diabetes	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Eczema	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Hay Fever/Allergies	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Lupus	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Psoriasis	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None
Non-Melanoma Skin Cancers	☐ Mother	☐ Father	☐ Sister	☐Brother	☐Daughter	☐ Son	☐ Other	☐ None

Authorization for Release of Health Information

I authorize Horizon Dermatology and Skin Surgery Center (HDSSC) to use and disclose my health information for purposes of **treatment, payment, and healthcare operations**.

My health information may be disclosed to any individual or entity responsible for payment on my behalf in order to verify coverage, process claims, or address payment-related inquiries. Additionally, information may be released to my employer's designated representative when services are related to a **workers' compensation claim**.

If I am covered by **Medicare or Medicaid**, I authorize the release of my health information to the Social Security Administration, its intermediaries or carriers, or the appropriate state agency as necessary for claim processing and payment. This information may include, but is not limited to, medical history, physical examinations, laboratory results, operative reports, physician notes, nursing notes, and consultation records.

I understand that federal and state laws may allow this practice to participate in healthcare information-sharing organizations with other providers, insurers, and authorized subcontractors. These organizations may share my health information for purposes including, but not limited to:

- Improving the accuracy and availability of my medical records
- Reducing the time required to access my health information
- Supporting quality improvement and care coordination efforts
- Other purposes permitted by law

I acknowledge that this practice may participate in one or more such organizations.

This authorization includes the disclosure of sensitive health information, including but not limited to:

- Psychological and psychiatric conditions
- Intellectual or developmental disabilities
- Genetic information
- Substance use or chemical dependency
- Infectious diseases, including bloodborne illnesses such as HIV/AIDS
- Substance use or chemical dependency

Disclosure to Family and Friends

I authorize Horizon Dermatology and Skin Surgery Center to disclose my Protected Health Information (PHI), including medical results, findings, and care decisions, to the family members or individuals listed below.

NAME	RELATIONSHIP	CONTACT NUMBER (If applicable)
1.		
2.		
3.		
4.		
5.		

Patient/Representative may revoke or modify this specific authorization and that revocation or must be submitted in writing.

I agree to the items as outlined in this agreement.

Disclaimer: By typing your name below, you are singing this form electronically. You agree that your electronic signature is the legal equivalent of your manual signature on this form

ACKNOWLEDGMENT

Patient Name**(print)**: _____ Date: _____

Patient Signature: _____

HORIZON
— DERMATOLOGY —

General Consent / Agreement for Outpatient Services

CATEGORY	DETAILS	PATIENT ACKNOWLEDGMENT
Consent to Treatment	I consent to medical and/or cosmetic services including evaluation, cryosurgery, biopsies, diagnostic procedures, and lab services. I authorize examination, treatment, and handling of specimens. No guarantees of results are made.	Initials
Photography & Documentation	I authorize photographs, video, and digital imaging for identification, treatment, documentation, and payment purposes.	Initials
Infectious Disease Testing	I understand testing (including HIV where applicable) may occur and I may opt out when permitted. Additional consent may be required for exposure incidents.	Initials
Financial Responsibility	I agree to pay all copays, deductibles, and non-covered services. I will forward insurance payments if sent to me. Payment may be required before services.	Initials
Insurance & Authorizations	I am responsible if referrals/authorizations are not obtained, services are out-of-network, or I elect self-pay. HDSSC may act on my behalf for claims/appeals (ERISA if applicable).	Initials
Dermatopathology Services	Specimens may be sent to third-party labs. Services may result in separate billing and may be out-of-network. I accept financial responsibility.	Initials
Missed Appointments	**$25 no-show fee may apply. Repeated cancellations may result in additional fees.**	Initials
Use of Health Information (HIPPA)	I authorize use/disclosure of my PHI for treatment, payment, and operations, including sharing across locations and with insurers/agencies.	Initials
Sensitive Information	This may include mental health, genetic data, substance use, and infectious diseases (including HIV/AIDS).	Initials
Care Correlation	HDSSC may share information through health information exchanges to improve care coordination.	Initials
Communication Consent (TCPA)	I consent to be contacted via phone, voicemail, text, and email for appointments, care, billing, feedback, and optional marketing. I understand that: • Message and data rates may apply based on my mobile carrier • Providing a phone number is not a condition of receiving treatment • I may opt out of certain communications (such as marketing texts/emails) at any time by following provided instructions or submitting a written request	**Please see "**" below:**
Automated Communications	Messages may be sent using automated systems. Message/data rates may apply. Consent is not required for treatment.	Initials
Opt-Out Rights	I may opt out of communications at any time via instructions or written request.	Initials
Revocation	I may revoke or modify this authorization at any time in writing (applies to future actions only).	Initials
Privacy Policy	I acknowledge receipt/review of the Notice of Privacy Practices.	Initials

**This consent applies to all future communications unless I revoke or modify it in writing. **

Home Phone: _____ **Cell Phone:** _____

Authorized email address: _____

OR

☐ I decline to receive communication via text. **(Initial)** _____

☐ I decline to receive communication via email. **(Initial)** _____

Revocation

☐ I hereby revoke my request for future communication via email and/or text.

☐ I hereby revoke my request to receive any future appointment reminders, feedback, marketing and general health via text

Disclosure to Family and Friends

I authorize Horizon Dermatology and Skin Surgery Center (HDSSC) to disclose my Protected Health Information (PHI), including results, findings, and care decisions, to the individuals listed below:

NAME	RELATIONSHIP	CONTACT NUMBER (If applicable)
1.		
2.		
3.		
4.		

I hereby revoke my request to receive any future appointment reminder, feedback, marketing, and general health via email.
NOTE: This revocation only applies to communication from this practice.

Patient Name: _____

Patient/Patient Representative Signature: _____

Date: _____

Notice of Privacy Practices Acknowledgment

I acknowledge that I have received and/or reviewed Horizon Dermatology and Skin Surgery Center's Notice of Privacy Practices.

I understand that this notice describes how my medical information may be used and disclosed, as well as how I can access my information. I further understand that I may contact the Privacy Officer with any questions or concerns regarding this notice or my privacy rights.

To the extent permitted by law, I consent to the use and disclosure of my health information as outlined in the Notice of Privacy Practices.

I understand and acknowledge that any medical records, information, or data previously created, maintained, or collected under any prior or affiliated business entity name associated with this practice may be retained, accessed, and used by Horizon Dermatology and Skin Surgery Center for purposes of treatment, payment, and healthcare operations, in accordance with applicable laws and the Notice of Privacy Practices.

ACKNOWLEDGMENT

I hereby agree to the items as outlined in the agreement.

Patient Name**(print)**: _____ Date: _____

Patient Signature: _____

Relationship to Patient: _____

Consent to Treat a Minor

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

Patient Name: _____ **Date of Birth:** _____

I, the undersigned parent or legal guardian of the above-named minor patient, hereby authorize the physicians, physician assistants, and nurse practitioners at any Horizon Dermatology and Skin Surgery Center (HDSSC) location to provide healthcare services as outlined in the General Consent for Outpatient Services.

These services may include, but are not limited to, evaluation, assessment, diagnosis, treatment planning, and medical treatment under the supervision of a physician licensed in the state where care is provided.

In the event of a medical emergency, I authorize HDSSC providers to render emergency care, initiate treatment, and/or arrange hospital referral as deemed necessary in their professional judgment.

Authorization for Treatment When Accompanied by Another Adult

I, the undersigned parent or legal guardian, authorize Horizon Dermatology and Skin Surgery Center to provide medical care and treatment to the above-named minor when accompanied by any of the following authorized adult(s), age 18 or older:

Adult's Name: _____ **Relationship to the child:** _____
(print)
Adult's Name: _____ **Relationship to the child:** _____
(print)
Adult's Name: _____ **Relationship to the child:** _____
(print)

☐ I authorize my adolescent child to be treated at the office visit(s) if I am unable to attend.

This authorization is valid:

☐ For any and all medical treatment

☐ For today only.

☐ For these specific problems () or a specific date range. Please specify: _____

- This consent will be valid until revoked in writing by me from the date signed unless other specified in writing.

ACKNOWLEDGMENT

I hereby agree to the items as outlined in the agreement.

Parent or legal guardian **(print):** _____ Date: _____

Parent or legal guardian Signature: _____

Witness **(print):** _____ Signature: _____

HORIZON
— DERMATOLOGY —

Patient Portal Access

Please share your email address with us so you can access these great features:

- Communicate with your provider via email
- View your visit notes
- Update your medication list
- Update your medical history
- View patient education material
- Add your favorite pharmacy for electronic Rx

*Within 24 hours you will receive an email stating "A request was made to activate your patient portal with Horizon Dermatology and Skin Surgery Center."

*Please follow the links in the email to set up your patient portal. The link will expire in exactly 24 hours after receiving the email. Please contact our office at 423-712-8301 if your link expires before you active your account.

*The email will come from Modernizing Medicine which is our electronic medical software

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Patient Portal Consent

Last Name _____ First Name _____

Date of Birth _____ Email Address: _____

☐ Please do not send me occasional announcements and offers from Horizon Dermatology and Skin Surgery Center

☐ Please check if you wish to decline the patient portal.

Signature: _____ Date: _____

HORIZON
— DERMATOLOGY —

MIPS Questionnaire

PATIENT QUESTIONNAIRE	DATE
1. Are you a tobacco smoker? ☐ **Current** ☐ **Former** ☐ **Never**	
2. Have you received an Influenza Vaccine during the flu season **(August 2020-March-2021 or August 2021-March-2022)?**	If NO, select reason why: ☐ **Refused** ☐ **Allergy**
FOR PATIENTS 65 YEARS AND OLDER	
3. Have you ever had a Pneumonia Vaccine (Prevnar 13 and/or Pneumovax 23)? ☐**Yes** ☐ **No**	
4. Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐**Yes** ☐ **No**	
5. Do you have a living will? ☐**Yes** ☐ **No**	

Patient Name**(print)**: _____ Date: _____

Patient Signature: _____

Primary Care Physician: _____