FRANKLIN DERMATOLOGY / LATOUR SKIN CARE **Today's Date:**

REVIEW THE ENTIRE FORM, CORRECT ANY INCORRECT OR OUTDATED INFORMATION. PLEASE PRINT.

PATIENT INFORMATION

Patient name:

Address:

City/ST/Zip:

Gender: ❑ F ❑ M **Date of Birth:** **Marital Status**: ❑ Single ❑ Married ❑ Divorced ❑Widow Spouse:

Phone (H): **Phone (W):** **Phone (C):** **Email address:**

Social Security #:_____ What is your **preferred method of contact**? ❑Cell Phone ❑Home Phone ❑ Work Phone

Primary Care Physician: **Referring Physician:**

Emergency Contact: **Emer. Contact Phone:**

Race: ❑ White ❑ Black/African American ❑ American Indian ❑ Hispanic ❑ Asian ❑ Native Hawaiian /Other Pacific Islander

Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino

Preferred Language:

Primary Health Insurance

Primary Insurance Company:

Insured Name: **Patient Relation to Insured:**

Insured Date of Birth: **Insured Gender:**

Insured ID Number: **Insurance Group Number:**

Leave ID and Group number blank if card presented at check-in.

Secondary Health Insurance (if applicable)

Primary Insurance Company:

Insured Name: **Patient Relation to Insured:**

Insured Date of Birth: **Insured Gender:**

Insured ID Number: **Insurance Group Number:**

Leave ID and Group number blank if card presented at check-in.

RESPONSIBILITY PARTY INFORMATION - Complete ONLY IF patient is under 18 or has Power of Attorney

Name: **DOB:**

Relationship to Patient: **Phone:**

Address: **City:** **State:** **Zip:**

By signing below, I acknowledge the above information provided is true & correct.

Signature of Patient or Guardian: Date:

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Franklin Dermatology Group
740 Cool Springs Blvd.#200 Franklin, TN 37067-2696
ph: (615) 771-1881 **fx**: (615) 771-0050
www.franklinderm.net

HEALTH QUESTIONNAIRE

First Name: _____ Middle: _____ Last: _____

Patient Birthdate: _____ Today's Date: _____

Preferred Pharmacy/Location: _____ Pharmacy Phone #: _____

Past Medical History					
YES	**NO**		**YES**	**NO**	
❑		Patient denies any past medical history			
❑	❑	Acid reflux	❑	❑	GI/Stomach ulcers
❑	❑	ADD/ ADHD	❑	❑	Heart disease/Heart attack
❑	❑	Anemia	❑	❑	Heart murmur
❑	❑	Anxiety	❑	❑	High blood pressure
❑	❑	Arthritis	❑	❑	Insomnia
❑	❑	Asthma	❑	❑	Irritable bowel syndrome
❑	❑	Atrial fibrillation/irregular heartbeat	❑	❑	Kidney disorder
❑	❑	Bipolar disorder	❑	❑	Leukemia/Lymphoma
❑	❑	Bleeding disorder	❑	❑	Liver disorder
❑	❑	Blood transfusion	❑	❑	Lupus
❑	❑	BPH (enlarged prostate)	❑	❑	Migraine headaches
❑	❑	Breast cancer	❑	❑	Other internal cancer
❑	❑	Celiac disease	❑	❑	Overactive bladder
❑	❑	Clotting disorder	❑	❑	Pulmonary embolus
❑	❑	Chemotherapy or radiation treatments	❑	❑	Raynaud's
❑	❑	Colon cancer	❑	❑	Sarcoidosis
❑	❑	COPD/ Emphysema	❑	❑	Scleroderma
❑	❑	Crohn's Disease/ Ulcerative Colitis	❑	❑	Seasonal Allergies
❑	❑	Deep venous thrombosis	❑	❑	Seizures/epilepsy
❑	❑	Depression	❑	❑	Sexually transmitted disease
❑	❑	Dermatomyositis	❑	❑	Stroke
❑	❑	Diabetes	❑	❑	Thyroid disorder
❑	❑	Elevated cholesterol/lipids	❑	❑	Tuberculosis
❑	❑	Fibromyalgia	❑	❑	Vitamin B12 deficiency
❑	❑	Food allergies	❑	❑	Vitamin D deficiency
❑	❑	GI bleed	❑	❑	Yeast infection with antibiotics
❑	Other:				

	Past surgeries/hospitalizations (EXCLUDING skin surgeries) *Write NONE if no previous surgeries*		
	Surgery	**Date**	**Notes**
1			
2			
3			
4			
5			

	Current Medications (if none, please write none)			
	Medication Name	Dosage	# of times daily	Notes
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

	Allergies (if none, please write none)	
	Causative Agent	**Reaction**
1		
2		
3		
4		
5		

YES	NO	Other Medical History	Notes
❑	❑	Hepatitis B	
❑	❑	Hepatitis C	
❑	❑	HIV/AIDS	
❑	❑	Pacemaker	
❑	❑	Defibrillator	
❑	❑	Artificial joints	
❑	❑	Artificial Heart valves	
❑	❑	Antibiotics prior to dental procedures	
		**If yes, please list name of antibiotic you typically take	
❑	❑	Organ transplant or stem cell transplant	
❑	❑	Oxygen use	
❑	❑	Mitral valve prolapse	
❑	❑	Other Electrical Stimulator	
❑	❑	Do you get lightheaded or faint with procedures?	

YES	NO	FEMALE ONLY QUESTIONS	Notes
❑	❑	Are you currently pregnant?	
		**If yes, when is your due date?	
❑	❑	Are you currently breastfeeding?	
❑	❑	Are you currently planning a pregnancy?	
❑	❑	Have you had a hysterectomy?	
❑	❑	Have you had a tubal ligation?	
❑	❑	Are you currently on contraception? (birth control)	
❑	❑	Are your periods irregular?	
❑	❑	Are you post-menopausal?	

YES	NO	Family history	Affected family member	Notes
❑		*No Contributing Family History		
❑	❑	Adopted		
❑	❑	Alopecia (hair loss)		
❑	❑	Asthma/Seasonal allergies		
❑	❑	Autoimmune Disorders (lupus, etc.)		
❑	❑	Diabetes		
❑	❑	Dysplastic Nevi		
❑	❑	Eczema/ sensitive skin		
❑	❑	Malignant Melanoma		
❑	❑	Non-melanoma Skin Cancer		
❑	❑	Psoriasis		
❑	❑	Other Cancer (Breast/Colon)		
❑	❑	Other		

Additional comments:

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HEALTH QUESTIONNAIRE

Personal History		Social History	
Alcohol Use:	❑ Never drink alcohol ❑ Occasionally drink alcohol ❑ Drink alcohol daily How many drinks do you have in a typical day? _____	Relationship Status:	❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Domestic partner
Tobacco Use:	❑ Never smoker ❑ Former smoker ❑ Current every day smoker ❑ Current occasional smoker ❑ Chewing tobacco/ dip ❑ Unknown if ever smoked Date Started: _____ Date Ended: _____	Occupation:	
		Hobbies:	
		Number of Children:	

YES	NO	Past Skin History	Year	Notes
❑		*No significant skin history		
❑	❑	Acne		
❑	❑	Actinic Keratosis		
❑	❑	Basal Cell Carcinoma		
❑	❑	Dysplastic Nevi (pre-cancerous mole)		
❑	❑	Eczema		
❑	❑	Herpes (cold sores/fever blisters)		
❑	❑	Keloids		
❑	❑	Malignant Melanoma		
❑	❑	MRSA/Staph infection		
❑	❑	Psoriasis		
❑	❑	Rosacea		
❑	❑	Seborrheic Dermatitis		
❑	❑	Sensitive Skin/Allergies		
❑	❑	Squamous Cell Carcinoma		
❑	❑	Urticaria (hives)		
❑	❑	OTHER: _____		

Sun Exposure History (In your lifetime)					
	BLISTERING SUNBURNS		**SUNSCREEN USE**		**TANNING BOOTH USE**
❑	0	❑	Never use sunscreen	❑	Never used tanning beds
❑	1-3	❑	Sometimes use sunscreen	❑	Previous use of tanning beds
❑	>3	❑	Always wear sunscreen	❑	Currently use tanning beds

YES	NO	Other Sun Exposure History
❑	❑	Did you sunbathe regularly
❑	❑	Did you grow up in a sunny location? (If yes, Where?)
❑	❑	Have you had an outdoor profession?

Franklin Dermatology Group

HIPAA AUTHORIZATION

Patient Name: _____DOB: _____/_____/_____
(Please Print)

CHOOSE ONE:

☐ **I DO NOT authorize Franklin Dermatology Group to release my medical and billing information to anyone other than myself.**

OR

☐ **I authorize Franklin Dermatology Group to release my medical and billing information to the individuals listed below:**

RELATIONSHIP		NAME OF DESIGNATED PERSON	PHONE
SPOUSE	☐ YES ☐ NO	_____ Please Print	_____
CHILDREN	☐ YES ☐ NO	_____ Please Print	_____
IN-LAWS	☐ YES ☐ NO	_____ Please Print	_____
CAREGIVERS	☐ YES ☐ NO	_____ Please Print	_____
PARENTS	☐ YES ☐ NO	_____ Please Print	_____
OTHERS:		_____ Please Print	_____

I authorize Franklin Dermatology Group to leave information on my voicemail:

HOME: ☐ YES ☐ NO CELL: ☐ YES ☐ NO WORK: ☐ YES ☐ NO

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

I understand that FDG is permitted by the HIPAA privacy rule to leave information regarding my appointment, including, the date and time, on any phone number(s) provided. FDG may request a return phone call to our office by leaving a message or when speaking to any individual that answers the phone. If I only want confidential communication between myself and FDG I must provide written notice to FDG on a form provided upon my request.

I understand that it is my responsibility to keep FDG informed of any changes to this information and that I may revoke this authorization at any time by written notice to FDG on a form provided upon my request.

_____ _____
Signature of Patient or Personal Representative (Legal Guardian) Date

_____ _____
MINOR Patient ONLY - Print Name of Personal Representative (Legal Guardian) Date

Continue to back of form →

Franklin Dermatology Group

Notice of Privacy Practices Acknowledgement

Patient Name: _____DOB: _____/_____/_____
(Please Print)

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in the treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

A copy of the Franklin Dermatology Group *Notice of Privacy Practices* was made available to me. It contains a more complete description of the uses and disclosures of my PHI. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact Franklin Dermatology Group at any time to obtain a current copy of the *Notice of Privacy Practices*.

_____ _____

Signature of Patient or Personal representative **Date**

FRANKLIN DERMATOLOGY GROUP USE ONLY

I attempted to obtain the patient's signature in acknowledgement of the *Notice of Privacy Practices* Acknowledgement but was unable to do so as documented below:

Date:	Initials:	Reason:

Insurance, Copayments, Deductibles

Franklin Dermatology Group will submit all insurance claims to insurance companies for payment. Patients are responsible for presenting accurate and current insurance coverage information at the time of check in. Failure to present accurate insurance information could lead the insurance company to deny payment of claims and therefore payment will be the responsibility of the patient. Copayments, deductible payments, cosmetic charges, and past due payments will be due at the time of service. Cosmetic services will not be submitted to my insurance company and full payment will be due at the time services are rendered.

Patients who have not met their insurance plan deductible will be required to make a payment of no less than $100 at the time of service and this fee will be applied toward payment of the services rendered.

Please note that skin cancer screenings are not considered a "preventive service" in the U.S. Preventive Task Force's Guide to Clinical Preventive Services as part of the Affordable Care Act legislation. Because the guidelines do not recommend skin cancer screening as a "preventive service," dermatologists cannot submit claims as preventive visits or wellness exams, even if the screening is for malignant neoplasms. Our providers are happy to see you for an exam; however, we are unable to submit claims for preventive skin screenings to your insurance as a "no cost" benefit under the Affordable Care Act.

For further information on this subject, please visit https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4187299/pdf/phr12900526a.pdf

Self-Pay/Out-of-Network Insurance

Regarding patients without insurance coverage or those who are covered by an insurance policy which is out-of-network with the providers of Franklin Dermatology Group, full payment of services rendered will be due at time of service.

Payment/Returned Check Fees

Franklin Dermatology and The Aesthetics Center of FDG accept payment in the form of cash, check, or credit card (American Express, Visa, Mastercard, Discover). There is a fee of $35.00 for all checks returned for insufficient funds. Post-dated checks will not be accepted.

Past-Due Accounts

Outstanding balances over 60 days duration will be subject to the account being turned over to a collection agency and could result in the dismissal from the practice. Patients whose accounts are turned over to a collection agency will be responsible for the 45% collection fee charged by the collection agency. If Franklin Dermatology Group must refer collection of the balance to an attorney, the patient will be responsible for all attorney's fees incurred including court costs. In the case of a resulting lawsuit, the venue shall be Williamson County, TN.

Cancellation/No-Show Fee

Appointments cancelled less than two business days in advance from the scheduled appointment date may be subject to a $50 cancellation fee. Patients who no-show for their scheduled appointment may be charged a $50 no-show fee as well. This fee will not be submitted to insurance and will be the full responsibility of the patient. After three total cancellations and/or no-show appointments, Franklin Dermatology Group reserves the right to terminate the physician-patient relationship.

I hereby authorize and request that payment by an authorized insurance company be made payable to Franklin Dermatology Group on my behalf for the services furnished to me by the physician(s)/practitioner(s) of Franklin Dermatology Group. I understand that I am responsible for charges generated by referral to another physician or laboratory by any physician/practitioner of Franklin Dermatology Group. Refusal to sign the financial policy could lead to potential termination of my patient/provider relationship with Franklin Dermatology Group and The Aesthetic Center of FDG.

Print Patient Name: _____ _____

Patient Signature: _____ Date: _____