Dermatology Patient Information Form

Date: _____

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

Address:_____**City**:_____**State:**____ **Zip:**_____

Primary phone number: _____ **Cell phone number**: _____

Email: _____

Is it okay to leave a message with medication information/test results? **Y** or **N**

Is it okay to text you regarding outstanding balances? **Y** or **N**

Gender: M or F **Status**: Single □ Married □ Divorced □ Widowed □

Parent / Guardian (if patient is under 18): _____

Language: English □ Spanish □ Other_____

Name of person that we may discuss your medical condition with: _____
Contact Number: _____ **Relationship**: _____

Emergency Contact: _____ **Contact phone**: _____

Relationship: _____

Insurance Information*:*

Primary Insurance:	Secondary Insurance:
Subscriber's Name:	Subscriber's Name:
Subscriber's DOB:	Subscriber's DOB:
Relationship to Patient:	Relationship to Patient:
Address of Subscriber (if different than patient):	

Primary Care Physician (if applicable): _____
Referring doctor's name: _____ **Phone:** _____

Pharmacy name / location: _____

Patient name: _____ **Date of birth:**_____

Melanoma History: **Y** or **N** If yes, please complete the following:

Year(s)	Location(s)	Treatment(s)

Skin Cancer History: (other than melanoma) **Y** or **N** If yes, please complete the following:

	Location(s)
□ Basal cell carcinoma	
□ Squamous cell carcinoma	
□ Other _____	

Personal History: Do you currently or have you ever had:

Actinic keratosis	Y	N	Autoimmune disease	Y	N
Eczema / Psoriasis (circle one)	Y	N	Hepatitis	Y	N
Abnormal mole diagnosed from a biopsy	Y	N	HIV / AIDS	Y	N
Seasonal allergies, asthma, or hayfever	Y	N	Pacemaker / defibrillator	Y	N
Cancer (other than skin cancer)	Y	N	Allergy to adhesive/latex/iodine (circle which)	Y	N
Diabetes	Y	N	Difficulty with anesthesia	Y	N
Difficulty with scars or keloids	Y	N	Difficulty with bleeding or clotting (circle one)	Y	N
Mental health conditions	Y	N	Seizures	Y	N
Artificial heart valves or joints	Y	N			

If you have answered yes to any of the above, please explain: _____

_____

_____

Please list any other medical conditions that we should know about: _____

_____

_____

Please list any major surgeries or hospitalizations: _____

_____

_____

*Females: Are you currently pregnant? **Y** or **N** Are you currently nursing? **Y** or **N**

Family History: If anyone in your family has/had the following, please specify which blood relative:

Eczema	Y	N	
Psoriasis	Y	N	
Melanoma	Y	N	
Skin cancer other than melanoma	Y	N	
Other skin disorder	Y	N	

Patient name: _____ **Date of birth:**_____

Medications: Please list all current medications including topical creams and over the counter medications. **If you brought a list of your medications you can leave section blank and attach list**

_____

_____

Allergies: Please list all known allergies (and reactions)

_____

_____

Social History:

What is your occupation / employer? _____

Where did you grow up (city / state)? _____

Have you traveled outside the U.S. in the past 3 months? (If yes, specify which continent)_____

Do you wear sunscreen? Everyday □ Sometimes □ When at the beach/outdoors □ Never □

If so, what SPF? _____

Have you ever used a tanning booth? **Y** or **N** If yes, explain: _____

Do you have a history of blistering sunburns? **Y** or **N**

Do you drink alcohol? **Y** or **N** If yes, how much weekly: _____

Have you ever used tobacco? (cigarettes, e-cigarettes, nicotine gum, chew, snuff, etc) **Y** or **N**

Type:_____ How much over how many years: _____

_____

Patient or guardian signature Date

(Office Use Only) Reviewed by:

_____

Renewal Dermatology & MedSpa

How did you hear about us? (Please circle)

Bull Run Observer Ad Renewal MedSpa PW OB/GYN Friend
Family Website Primary Care Physician Other

Consent for Examination

It is recommended that everyone have a complete skin examination at least yearly for melanoma and non-melanoma skin cancer. The purpose of the skin exam is to look for the presence of atypical moles, skin cancers, and signs of internal disease or genetic illness. If your primary reason for your appointment today is for something other than a full body exam, **please schedule one at your next visit.**

Signing below indicates that we recommend you receive a full body exam at least once a year.

Patient/Guardian Signature _____ Date: _____

Have you ever tested positive for the following: Yes ☐ No ☐

☐ HIV/ AIDS ☐ Hepatitis B ☐ Hepatitis C

Consent for Testing

I understand that if, during the course of care, a health care provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B, C or AIDS, for the protection and well-being of the health care provider, it is important that a test be made on my blood (without charge) to determine whether I am carrying the virus and that under Virginia Law (Section 32.1 – 45.1 et.seq.) Lab testing must be done within 72 hours of the exposure. I am deemed to have consented to the said test(s) and the release of the test results to the exposed health care provider. I also understand that health care providers are deemed to consent to tests and the release of results to me should I be similarly exposed.

Patient/Guardian Signature _____ Date: _____

RENEWAL DERMATOLOGY & MEDSPA

IMPORTANT SUMMARY OF THE PRIVACY OF YOUR HEALTH INFORMATION

Your privacy is extremely important to us. The information that we record about you and

your medical history is to help us provide quality medical care. We are committed to protecting this information. The *Notice of Privacy Practices* describes your rights with regards to your health information and our responsibility to protect that information. This is just a summary, but a detailed description of your rights is posted in the waiting area. We would also be happy to provide you with a detailed copy to take with you.

Your rights include:

- The right to amend your health information
- The right to request restrictions on what information we use or how we disclose your health information
- The right to see an account of certain disclosures we have made of your health information
- The right to obtain access to your health information with limited exceptions (a written or notarized request, an appointment for access, appropriate advance notice, and a cost-based fee for expenses delineated by law)
- The right to receive a paper copy of our *Notice of Privacy Practices*
- **We may use your health information and/or records to:**
- Plan for your care and help your health care providers communicate and work together for your overall medical benefit
- Submit medical bills for reimbursement for the care provided to you
- Help health care payers or medical insurance companies verify that services were provided to you
- Help improve the quality of your health care
- Disclose information to certain officials or organizations as requested by law

If you would like to receive promotional emails from our practice regarding product and service specials, please fill in your email below:

Email:_____

Everyone working for Renewal Dermatology & MedSpa who has access to your information is bound by law to uphold all privacy standards.

We encourage you to read the *Notice of Privacy Practices* and to please ask if you need further information.

Your signature below confirms that you have read and understand your rights to privacy, and that you have been given access to all information pertaining to those rights.

Patient/Guardian: _____ Date: _____

Renewal Dermatology and MedSpa
Assignment of Benefits & Financial Policy

ASSIGNMENT OF BENEFITS

If you have no insurance:
I agree to pay my medical expenses, in full, when I am seen by the physician/physician assistant. If for any reason there is a balance owed on my account, I agree to pay promptly upon receipt of my monthly statement.

If you have Medicare:
I request that payment of authorized Medicare benefits be made on my behalf to the rendering physician for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services. I agree to pay any portion of my charges that my Medicare carrier determines to be my responsibility. (ex. my annual deductible and 20% co-payment). I understand that I may be asked to sign an advanced notice/waiver for certain procedures or services.

If you have HMO, PPO, commercial or government insurance:
I authorize any holder of medical information about me to release to my insurance company or its agents any information (including HIV, alcohol, and mental health) needed to determine benefits payable for related services. I agree to comply with the terms of my insurance coverage, including payment of my co-payment at the time of service rendered and payment of any portion of charges that my insurance carrier determines to be my responsibility, upon receipt of my monthly statement.

If you have Medigap insurance (Medicare Supplement):
I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering physician for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my Medigap carrier any information (including HIV, alcohol, and mental health) needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature of Responsible Party Date

STATEMENT OF FINANCIAL RESPONSIBILITY

Payment Policy- February 2026 Version

Thank you for choosing us for your skin care needs. We are committed to providing you with quality and affordable health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. We warmly welcome self-pay patients; payment in full is required at each visit.

2. **Insurance:** We participate in most insurance plans, including Medicare. If you are not insured by a plan that we participate with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. An updated copy of your insurance card is required yearly, unless a change happens prior to that. It is the patients responsibility to update our office with any insurance changes at the time of the visit.

3. **Co-payments, co-insurance and deductibles:** All co-payments, co-insurance and deductibles must be paid at the time of service. This arrangement is part of your contract and our contract with your insurance company. It is a violation of our contract if we do not collect your co-pay. Please help us in upholding the law by paying your co-payment at each visit.

4. **Non-covered services:** Please be aware that some – and perhaps all- of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. <u>You must pay for these services in full at the time of the visit.</u> **In addition to our charge for the visit and/or procedure, if you have a biopsy, surgical specimen, or culture swab taken at any visit, you or your insurance will be billed separately by the pathologist or lab for their analysis of the specimen. We will provide your billing and insurance information to the lab or pathologist.**

5. **Proof of insurance**: All patients must complete our patient information form before being seen. We must obtain a copy of your driver's license and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

6. **Claims submission**: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Your account must be paid in full from any prior visits that have settled with your insurance company before any additional medical services can be rendered.

7. **Coverage changes**: If your insurance changes, you must notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If our practice is not notified of an insurance change, you will be responsible for all visit fees. If your insurance company does not pay your claim in 60 days, the balance will automatically be billed to you.

8. **Nonpayment**: If you have an account balance that remains more than 90 days after the date of your medical visit, a $25.00 Administrative Fee may be assessed, and your account will be placed in our internal collections list. During that time, no further medical appointments can be made, prescription refills will not be authorized, and medical forms will not be filled out until the balance is paid in full (unless a payment plan has been established with our office and is being upheld by you). Please be aware that if a balance remains unpaid after 120 days, we may refer your account to a collection agency and you may be discharged from this practice. If this is to occur, you will be notified by regular mail as well as by email that you have 30 days to find alternative medical care.

9. **Missed/No Show Policy:** These charges will be your responsibility and billed directly to you. Please help us serve you better by keeping your regularly scheduled appointment.
    a. **Missed office visit: $50.00** (if there is no notification within 24 hours)
    b. **Missed Surgery Appointment: $50.00** (if there is no notification within 24 hours)

10. **Returned checks are subject to a $35.00 administrative fee:** Any accounts turned over to our collection agency/attorney will be subject to collection fees and you may be dismissed from our practice.

11. **Fee for completion of Letter/Forms:** Our practice charges a $15.00 fee for any forms or requested letters that need to be completed by our practice.

All insurance forms processed by this office, prior to payment in full, are assigned to this practice. Your cooperation in complying with the terms of this assignment is appreciated.

I, the UNDERSIGNED, have read the above and realize that all medical and surgical charges incurred by me, or my dependents, for services rendered by providers at Renewal Dermatology & MedSpa are my financial responsibility. All court fees, attorney fees, or other fees necessary to collect this account, should it become delinquent, are payable by me.

If your insurance requires you to have a written referral from your primary care physician, this is your responsibility to know this and obtain the appropriate referral for each visit. Otherwise, you will be responsible for payment in full.

_____ _____

Signature of patient or responsible party Date