Levy Dermatology, P.C.
1125 Schilling Blvd E Ste 105
Collierville, TN 38017
P: (901) 624-3333 F: (901) 457-7407

Please print and answer all questions in full.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Email Address: _____ Date of Birth: _____ SS#: _____

Marital Status: Single Married Divorced Widowed **Sex:** Male Female

Occupation: _____ Employer: _____

Insurance Responsibility Is Insurance Policy Holder the patient? **No Yes**
If yes, move onto next section. If no, please answer the following questions.

First Name: _____ **Middle Initial:** _____ **Last Name:** _____

Address: _____ City: _____ Zip: _____

Contact Number: _____ Date of Birth: _____

Employer: _____ Sex: Male Female

Referring Physician Information (If applicable)

Referring Physician: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

Office Policy

Please remember that insurance is considered a method of reimbursing the patient for fees paid to Levy Dermatology, P.C. and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. In order to control the cost of billings, we request that out office visit charges be paid at the conclusion of each visit. I am aware that my insurance ***copay, deductible, and/or coinsurance*** is to be paid at each date of service. If my insurance plan requires an authorization for this visit and any follow up visits, it is my responsibility to ensure that the ***referral*** is current and on file with Levy Dermatology, P.C. ***IT IS MY RESPONSIBILITY TO PAY ANY COPAY, DEDUCTIBLE, COINSURANCE, AND/OR OTHER BALANCES NOT PAID BY MY INSURANCE COMPANY.*** I am aware that if Levy Dermatology, P.C. does not participate with my plan or if I have no insurance, payment in full must be made on the date of service.

Patient/Legal Guardian Signature: _____ **Date:** _____

Levy Dermatology

Patient History

Name: _____ Age: ____ Today's Date: ____/____/_____ Date of Birth: ____/____/_____

Current Medications (including over-the-counter):

_____

_____

_____

_____

Drug Allergies (please describe reaction): _____

_____

Are you allergic to latex? Yes ☐ No ☐

Have you ever had a reaction to Lidocaine? Yes ☐ No ☐

Are you pregnant or planning a pregnancy? Yes ☐ No ☐

Are you nursing? Yes ☐ No ☐

Do you drink alcohol? Yes ☐ No ☐ Drinks per week? _____

Do you smoke tobacco? Yes ☐ No ☐ Packs per day? _____

Have you smoked in the Past? Yes ☐ No ☐ How long? _____

Reason for visit today: _____

_____

Past medical conditions and surgeries (please list all):

_____

_____

_____

_____

Family history (illnesses running in your family including skin cancer):

_____

_____

_____

Dermatology:

Skin Lesions: Yes ☐ No ☐

Change in Moles: Yes ☐ No ☐

History of Skin Cancer: Yes ☐ No ☐

If yes, what type was it? _____

Where was it located? _____

How was it treated? Topical ☐ ED&C ☐ Excision ☐ MOHS ☐

REVIEW OF SYMPTONS (Do you have any of the symptoms below? Please check Yes or No).

1. Constitutional

Fever/ Chills	Yes ☐	No ☐
Feeling Poorly	Yes ☐	No ☐
Weight Loss without Dieting	Yes ☐	No ☐

2. Eyes

Visual Problems	Yes ☐	No ☐
Itchy Eyelids	Yes ☐	No ☐
Redness of Eyes	Yes ☐	No ☐

3. ENT

Sore Throat	Yes ☐	No ☐
Sinus Problems	Yes ☐	No ☐
Nosebleeds	Yes ☐	No ☐

4. Cardiovascular

Heart Attack	Yes ☐	No ☐
High Blood Pressure	Yes ☐	No ☐
Artificial Heart Valve	Yes ☐	No ☐
Pacemaker/Defibrillator	Yes ☐	No ☐
Irregular Heart Beat	Yes ☐	No ☐

5. Respiratory

Asthma	Yes ☐	No ☐
Cough	Yes ☐	No ☐
Shortness of Breath	Yes ☐	No ☐

6. Gastrointestinal

Nausea/Vomiting	Yes ☐	No ☐
Abdominal Pain	Yes ☐	No ☐
History of Liver Problems	Yes ☐	No ☐
Hepatitis B or C (circle one)	Yes ☐	No ☐

7. Genitourinary

Vaginal/Penile Discharge	Yes ☐	No ☐
Painful Urination	Yes ☐	No ☐

8. Musculoskeletal

Joint Pain	Yes ☐	No ☐
Artificial Joints	Yes ☐	No ☐
Swollen Joints	Yes ☐	No ☐

9. Neurological

Headache	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Numbness	Yes ☐	No ☐
Dizziness	Yes ☐	No ☐

10. Psychiatric

Anxiety	Yes ☐	No ☐
Depression	Yes ☐	No ☐

11. Endocrine

Diabetes	Yes ☐	No ☐
Thyroid Problems	Yes ☐	No ☐

12. Hematology/Lymph

Swollen Glands	Yes ☐	No ☐
Taking Blood Thinners	Yes ☐	No ☐
Easy Bruising	Yes ☐	No ☐

13. Immunologic

HIV/AIDS	Yes ☐	No ☐
Lupus	Yes ☐	No ☐

14. Gynecological (Women Only)

Irregular Periods	Yes ☐	No ☐

Signature: _____

Completed by: Patient ☐ Parent/Guardian ☐

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Notice of Privacy Practices and Patient Consent For Use and Disclosure of Protected Health Information

PATIENT NAME _____ **DATE** _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Levy Dermatology, PC may use or disclose my protected health information for treatment, payment or health care operations—which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Levy Dermatology, PC has a detailed document called the ***'Notice of Privacy Practices'***. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the *'Notice'* before signing this agreement. If I ask, Levy Dermatology, PC will provide me with the most current *Notice of Privacy Practices.*

My signature below indicates that I have been given the chance to review such copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Levy Dermatology, PC to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Levy Dermatology, PC has taken action relying on this consent.

SIGNATURE (Patient or Legal Custodian/Authorized Representative) _____ **DATE** _____

Relationship to Patient if signed by another party _____ **DATE** _____

You may obtain a copy of our *Notice of Privacy Practices*, including any revisions of our *'Notice'* at any time by contacting: Levy Dermatology, PC 1125 Schilling Blvd East Ste 105 Collierville, TN 38017 Phone: (901) 624-3333 Fax: (901) 457-7407.

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FORM Us

Levy Dermatology, P.C.
Patient Financial Policy

In order to provide understanding between our patients and the practice, we have implemented the following financial policy. If you have any questions about the policy, please ask to speak with something in our billing department. We are committed to providing you the best possible care and your complete understanding of your responsibilities are a key element in providing that service. For questions regarding your insurance coverage please contact your insurance company prior to your appointment.
It is always best to ask questions about your insurance coverage PRIOR to having services performed.

A driver's license is required to be shown at your visit to verify that we are providing services to the appropriate person and protect our patients from identity theft.

- For all services rendered to minor patients, we will hold the parent or legal guardian accompanying the minor on the first visit responsible for the expenses occurred.
- If you fail to notify us of an insurance change you will be **fully responsible** for any amount not paid by your insurance company.
- You will be responsible for any charges associated with collection costs if your account goes to a collection agency due to an unpaid overdue balance.
- Commonly, in this practice, we perform surgical procedures that require lab work. The laboratory company will bill your insurance and a ***separate statement*** will be sent to you for their services.

Patients with Insurance we participate in:

- Co-pays, deductibles, and coinsurances are required at the time of service. We accept cash, credit, debit, and care credit.
- You are responsible for any services that your insurance does not cover at the time of service.
- As a courtesy, we will file an insurance claim with your insurance company. If your insurance company has not paid the claim within 45 days you will be responsible for payment.
- Your insurance policy is a contract between you and your insurance company in which the doctor is not involved.
- Note: Even though a service is "covered" by your insurance policy, this does not necessarily mean that your insurance will pay for the service. If you are unsure of your responsibility, please contact your insurance company *prior* to your visit or having any procedures done.
- If any claim is not covered after processing through your insurance company, you are responsible for the unpaid balance.

Patients with Insurances we DO NOT participate with and/or Self-Pay Patients:

- Payment in full is required at the time of service. We accept cash, credit, debit, or care credit.
- If you have received authorization for services from our practice that are not normally covered by your plan, please note that payment is still due at time of service and we will file a courtesy claim for you.

Out of courtesy to others, we ask that you kindly give at least a 24-hour notice for cancelling an appointment. A **$35 charge** for general appointments and an **$80 charge** for surgeries and/or cosmetics will apply for no-show visits or cancellations less than 24-hour notice.

I have read and understand the financial policy of Levy Dermatology, P.C. and agree to its terms. I understand that such terms may be amended by the practice at any time.

Patient Signature or Responsible Party if Minor **Date**

Printed Name of Patient: _____

Levy Dermatology
Medical/Surgical/Cosmetic Skin Care Specialists

Patient Name: _____ Date of Birth: _____

CONSENT FOR CARE
I hereby give by consent for treatment at Levy Dermatology, P.C.

AUTHORIZATION TO RELEASE INFORMATION
I hereby authorize Levy Dermatology, P.C. to release any information acquired during my examination or treatment to third-party payors for payment of the charges. I authorize the release of any information necessary to expedite insurance claims.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY
I have received a copy of the Notice of Privacy Practices as required by HIPAA Privacy Regulations, developed 2013.

ELECTRONIC PRESCRIBING
I authorize Levy Dermatology, P.C., it employees or agents, to release Medical Information to share and/or receive prescription information electronically via SureScripts for my treatment medications.

Please place a check mark in EACH BOX indicating your consent:

Authorization to Leave Messages

_____ I hereby authorize Levy Dermatology, P.C. to leave a voicemail regarding appointments, tests, or other information at my residence or cell phone.

_____ I hereby authorize Levy Dermatology, P.C. to send appointment reminders or other information via text message.

_____ I hereby authorize Levy Dermatology, P.C. to send me information via email.

Please provide a list of anyone besides yourself who has permission to receive information regarding any of the contents of your medical record.

Name _____ Relationship _____

Name _____ Relationship _____

By signing below, I understand that I may revoke this authorization at any time by notifying the clinic in writing. The revocation will only be effective from the date it is received in this office and will not apply retroactively.

Patient or Parent Signature **Relationship** **Date**