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Dr. Anita Henderson, MD
Elizabeth DiPaola, FNP-BC
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Stephanie Morgan, RN

medical & aesthetic Dermatology

Phone/Fax: 443-542-0505/0506
www.ColumbiaSkinMD.com

9256 Bendix Road
Suite 200A
Columbia, MD 21045

3416 Olandwood Ct
Suite 201
Olney, MD 20832

PATIENT INFORMATION

Patient's Name: ______________________________ Date of Birth: _____/_____/_____ Sex: ________

Patient's Address: ______________________________ City: ______________ Zip code: ____________

Patient's Email: ______________________________ Patient's Phone #: ______________________

Patient's Relationship to Insured: O Self O Spouse O Child O Other: ______________

Insured's Name: ______________________________ Date of Birth: _____/_____/_____ Sex: ________

Insured's Address: ______________________________ City: ______________ Zip code: ____________

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits and any/all medical benefits to Medical & Aesthetic Dermatology.

______________________________ _________/_________/_________

Signature of Patient or Parent/Guardian if Minor **Date**

PATIENT ACKNOWLEDGMENT OF OFFICE POLICIES

Insurance: I authorize this practice to submit a claim and, if needed, medical documentation to my insurance company, attorney or other financially responsible entity on my behalf. I agree to provide accurate information at the time of EACH visit. If inaccurate, inactive or no information is provided at the time of service I agree to pay the full balance of the account for the services provided. I understand I am financially responsible for any amounts not covered by my insurance including but not limited to co-pays, coinsurances and or deductibles.

Referrals: I understand that I am responsible to provide a referral from another physician if one is required by my insurance to be seen by this practice. If a claim is denied by my insurance company because a referral was not provided at the time of service I agree to be financially responsible for the full balance for the services provided. Note: If you do not know if a referral is required please call your insurance. The name of the practice is Medical and Aesthetic Dermatology and the NPI# is 1720364227 and Tax ID # is 45-1330815. I understand that in some instances my primary care physician may approve a retro referral. I will be responsible for contacting my primary care physician after my visit and requesting a retro referral be sent to the provider's office via fax at 443-542-0506. I understand that my insurance carrier determines if they will consider a retro referral valid for them to process my claim. I agree that if my insurance carrier determines my retro referral to be invalid, I will be financially responsible for all charges that are not covered. I will only be allowed to sign 1 referral waiver; any subsequent visits will be billed at the self-pay rate until a valid referral is obtained.

Delinquent balances: An account is considered delinquent if an invalid mailing address is provided and/or the age of the balance reaches 90 or more days after the balance becomes the patient's responsibility. I understand and agree to be financially responsible for any additional charges or fees associated with delinquent balances. Returned checks will be subject to a $35.00 fee.

Cancellation/No Show Policy: I agree to notify the practice at least 24 hours in advance of a scheduled appointment in order to cancel or reschedule the appointment. I agree that if I do not notify the practice 24 hours in advance or I fail to arrive for an appointment by the scheduled time I may be responsible for a $50 fee for medical visits and/or a $100 fee for cosmetic or surgical appointments. The practice holds the right to discharge a patient after a total of three no show or cancelled appointments.

Late Policy: We strive to respect your time as much as you respect ours. While we appreciate a call ahead of time to let us know you are running late, this will not alter our policy. If you arrive late to your appointment, we will do our best to accommodate you, but we cannot guarantee you will be able to be seen. If you arrive past your appointment time, you will likely have to reschedule for another day or time.

Cosmetic Consultation Policy: I understand that Cosmetic Consultations are charged a fee of $200.00 per consultation. I also acknowledge that if I come in for a treatment and the appointment is changed to a consultation, I am still responsible for the consultation fee.

Maryland Law (Section 18-338.3 et. seq.): I agree that if, during the course of care, a health provider/worker may be directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B, C or AIDS, for the protection and wellbeing of the health care provider/worker, it is important that a test be made on my blood without charge to me to determine whether I am carrying the viruses and that under Maryland law I am deemed to have consented to said test(s) and to the release of the test results to the exposed health care provider/worker. I also understand that health care providers/workers are deemed to consent to tests and the release of the results to me, should I be similarly exposed.

I agree to the terms of this agreement: ______________________________ **Date:** ________________

Signature of Patient or Parent/Guardian if Minor

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No Show/Late Cancellation Agreement

- I understand/agree that appointments must be canceled with 24 hours' notice and that I will be financially responsible for all appointments that are not canceled 24 hours prior to the scheduled appointment time.
- I understand that I may receive a courtesy reminder email or phone call, but ultimately, I am responsible for keeping track of my scheduled appointments.
- I understand that first no shows or late cancellations may be waived, but subsequent no shows or late cancellations will be charged. A $50 fee will be incurred for each missed medical appointment, and a $100 fee will be incurred for each missed surgical appointment or cosmetic procedure.
- As a result of three missed appointments, I will be required to have a credit card on file that will automatically be charged at the time of any future missed appointment.
  ***If you have an active balance on your account, you may be asked to pay towards your balance.**
- I understand that after three missed appointments, I am in jeopardy of being asked to leave the practice.
- I understand/accept that if I cancel my appointment without proper notice, I will not receive special accommodations to reschedule.
- I understand that missing an appointment may result in delays of requests, such as medication refills, paperwork, etc.
- I understand if my child's school is closed or closed early it does not mean my appointment fee will be waived if I have a no show or late cancellation.

By signing below, I agree to follow the terms of this agreement and authorize Medical & Aesthetic Dermatology to process the card on file for any/all charges resulting from a missed appointment. Any questions or concerns regarding this agreement have been addressed.

____
Printed Name of Patient

____
Signature of Patient or Parent/Guardian if Minor

____
Date

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GENERAL INFORMATION

Patient Name: ______________________________

Patient DOB: _________/__________/__________

Phone No: _________________________________

E-Mail: ___________________________________

○ I do NOT wish to be contacted for promotional material

Pharmacy: _________________________________
Please list pharmacy name, street address, and city

How did you hear about us?

○ Family ○ Friend ○ Google

○ Primary Care Physician: ________________
Please write PCP name

○ Insurance ○ Facebook ○ Instagram

Other (Please specify): ______________________

____

PAST MEDICAL HISTORY

Please mark all that apply. If none apply, mark "none".

○ Acne
○ Asthma
○ Atypical Moles
○ Cancer, skin
○ Diabetes
○ Eczema
○ Excessive Sweating
○ Flushing
○ Glaucoma
○ Hair Loss
○ Hay Fever
○ Headaches
○ Heart Disease/Attack
○ Hepatitis B
○ Hepatitis C
○ Herpes Simplex
○ High Blood Pressure
○ HIV/AIDS
○ Itching
○ Joint Aches
○ Kidney Disease
○ Lupus
○ Melanoma
○ Psoriasis
○ Thyroid Disease
○ None

Other: ____________________________________

FAMILY HISTORY

Has anyone in your immediate family (parents, grandparents, siblings) had:

○ Allergies ○ Eczema ○ Melanoma

○ Non-Melanoma Skin Cancer

PEDIATRIC PATIENTS (UNDER 19Y/O)

Height: ____________ Weight: ___________

SURGICAL HISTORY

Do you need to take antibiotics prior to any surgical and/or dental work? ○ Yes ○ No

SKIN HISTORY

Do you have a problem with skin or wound healing? ○ Yes ○ No

Do you develop keloids or thick scars after surgery? ○ Yes ○ No

Do you bleed easily? ○ Yes ○ No

Regular tanning bed usage, past or present? ○ Yes ○ No

Any blistering sunburns past or present? ○ Yes ○ No

WOMEN ONLY

Irregular periods ○ Yes ○ No

Trying to get pregnant ○ Yes ○ No

Birth Control ○ Yes ○ No

Currently Pregnant/Nursing ○ Yes ○ No

SOCIAL HISTORY

Do you smoke? ○ Yes ○ No

Do you drink alcohol? ○ Yes ○ No

GENERAL

Medications (please list) ○ None

____

____

____

Allergies (please list) ○ None

____

____

____

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PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:
- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices, and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

Who else may we discuss your Personal Medical Information with:

- ○ **Parent** (Authorized by default if patient is minor): Name: ____________________________________
- ○ **Spouse**: Name: ____
- ○ **Other**: Name: ________________________________ Relationship to Patient: _________________
- ★ **Valid Until** (If blank, 3 years is assumed): Date: __________/__________/__________

By signing your name below, you agree that this is valid as your signature.

____
Signature of Patient or Parent/Guardian if Minor

____
Relationship to Patient (If Other Than Patient):

_______/_______/_______
Date