APEX SKIN
MEDICAL / SURGICAL / AESTHETIC
Dermatology and Skin Surgery Center

MEDICAL HISTORY INFORMATION

Patient:_____ **DOB:**_____/_____/_____

Reason for visit:_____ **Appointment Date:**_____/_____/_____

Did a doctor's office send you to us for a specific problem? ■ Yes ■ No

If Yes, list the name of referring provider _____

List all medications (herbal supplements and or vitamins you are currently taking) ■ Not currently taking Medications

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

Are you allergic to any medications/anesthetics? ■ Yes ■ No *(If YES, please list):*

_____ _____ _____ _____ _____

Please list major surgeries/hospitalizations:

_____ Date:_____ _____ Date: _____

_____ Date: _____ _____ Date: _____

Preferred Pharmacy: _____ City: _____ Phone: _____

May we leave a message regarding biopsy results on your answering machine/voicemail? ■ Yes ■ No

Does your insurance require a specific Lab? ■ Yes ■ No / Name of preferred Lab:_____

Have you had the flu vaccine? ■ Yes ■ No / If YES, when? _____/_____/_____

Have you had the pneumonia vaccine? *(patients over 65 years old)* ■ Yes ■ No / If YES, when? _____/_____/_____

Smoking Status: ■ Current ■ Non Smoker Do you drink Alcoholic Beverages? ■ Yes ■ No

Female patients *(check all that apply):* I am ■ pregnant ■ nursing ■ planning to become pregnant ■ not pregnant

List of IMMEDIATE FAMILY whom have had the following: (mother, father, maternal or paternal grandparent)

Melanoma: _____ _____ _____

Other Skin Cancers:(Basal cell, Squamous Cell, etc.) _____ _____ _____

Do you have, or have you had any of the following? *(If YES, please check)* ■ None

■ Acne
■ Artificial heart valve
■ Artificial joints or metal implant
■ Atopic Dermatitis
■ Atypical moles
■ Autoimmune disease (lupus, rheumatoid arthritis)
■ Bleeding disorder
■ Blood clots
■ Cold sores/herpes
■ Depression
■ Diabetes
■ Heartburn/Reflux
■ HIV
■ High blood pressure/Hypertension
■ Keloids or scarring problems
■ Kidney disease
■ Liver disease or hepatitis
■ Lung disease
■ Psoriasis
■ Seasonal allergies/asthma
■ Skin Cancer
■ Skin Pre-Cancers (actinic keratoses)
■ Thyroid trouble
■ Ulcers (stomach)
■ Other conditions, please list:

_____

_____

Do you wear sunscreen ■ Yes ■ No

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How did you find us?

- ○ Family/Friend- Name:_____
- ○ Insurance Provider List
- ○ Internet Search
- ○ Facebook/Social Media
- ○ Physician-Name: _____
- ○ Other: _____

(Please print)

PATIENT INFORMATION

Legal Name:(Last) _____ (First) _____ (MI)_____

Preferred Name (if different from above): _____ Patient Date of Birth:___/___/___ SS#:___-___-___

Marital Status: ☐ Single ☐ Married ☐ Partner ☐ Divorced ☐ Widowed Gender: ☐ Male ☐ Female ☐ Choose not to disclose

Address:_____

City, State, Zip: _____

Home Phone: _____Cell:_____Work:_____

E-Mail Address:_____

PCP Doctor: _____ Referring Doctor: _____

Do you have an Advanced Directive (Living Will or HealthCare Power of Attorney) regarding your healthcare wishes? ☐ Yes ☐ No

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk at check-in. ☐ SELF PAY

POLICY HOLDER INFORMATION: (if not patient, complete below)

Policy Holder Full Name: _____ DOB Required: _____/_____/_____ SS#: _____-_____-_____

Relation:_____ Address: _____ City:_____ State: _____ Zip: _____

RESPONSIBLE PARTY INFORMATION (Information used for patient balance-responsible for payment)

Responsible party: ☐ Other Source ☐ Guarantor ☐ Self ☐ Check here if address and telephone information is same as patient

Responsible party Name:(Last)_____(First)_____(MI)_____

Responsible party DOB: _____/_____/_____ Responsible Party Social Security Number: _____-_____-_____ Sex: ☐ Female ☐ Male

Address: _____ City: _____ State: _____ Zip: _____

MEDICAL RELEASE INFORMATION (Please list any persons to whom your protected health information can be disclosed (i.e. spouse, parent, etc.)

Name: _____ **Relation:** _____ **#:** _____

Name: _____ **Relation:** _____ **#:** _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relation:** _____ **#:** _____

APEX DERMATOLOGY PATIENT INFORMATION PACKET

The documents listed below are provided to patients in the normal course of business for Apex Dermatology, and I have been informed that additional copies and/or updates will be provided to me at my request.
I have received, read, and understand the following documents: 1. Consent for Medical Treatment, Administration or Local Anesthesia and Performance of Surgery and/or Procedures Necessary to the Practice of Dermatology 2. Insurance Coverage and Our Patient Form 3. Notice of Privacy Practices.

RETURN POLICY: All sales are final. If you experience an adverse reaction to a product, a gift certificate may be offered at the manager's or aesthetician's discretion for used products returned within 2 weeks of original purchase date. All services are non-refundable, unless an adverse reaction has occurred after the first treatment. All deposits must be used within 90 days. All purchased services including packages must be used within one calendar year of purchase date

NO SHOW AND CANCELLATION POLICY: We understand that situations arise that may require you to cancel your scheduled appointment. As a courtesy to other patients and our medical staff, we require that you provide our office with a minimum of 24 hours' notice of cancellation. Patients who fail to keep their scheduled appointment and who do not provide 24-hour notice of cancellation will be considered as NO SHOW. Patients who have two (2) documented NO SHOW appointments will only be able to schedule "SAME DAY" appts for all services with Apex Dermatology providers and staff for a six (6) month period from the date of the last NO SHOW appointment.

SPOT CHECK PATIENTS ONLY: I UNDERSTAND THAT TODAY'S VISIT IS A LIMITED EXAM SPECIFIC TO ONE SPOT OF CONCERN. _____(Initial)

SIGNATURE: _____ (Patient or Guardian) DATE: _____

If the patient is under the age of 18 years or unable to provide authorization

Signature of personal representative: _____Date: _____

Printed name of personal representative: _____Relationship to patient: _____

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Patient Financial Policy

Thank you for choosing Apex Skin as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Your clear understanding of our Patient Financial Policy is important to our professional relationship. Please understand that payment for services is a part of that relationship. Please ask if you have any questions about our fees, our policies, or your responsibilities. ***It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, etc).***

Co-pays

The patient is expected to present an insurance card at each visit. ***All co-payments and past due balances are due at time of check-in unless previous arrangements have been made with a billing coordinator.*** The co-pay cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We accept cash, check or credit cards. Absolutely no post-dated checks will be accepted. Payments are also accepted by phone. **Self-Pay Patients** Payment is due at the time of service. _____(initial)

Outstanding Balance Policy

All outstanding balances must be brought current within the first 30 days of receiving your statement. If payment is not made on the account a hold will be placed on the account and no appointments can be made until account is brought current. _____ (initial)

Collections

It is our office policy that accounts 60 days past due be sent to collections. If payment is not made a single phone call will be made to set up payment arrangements. If no resolution can be made, the account will be sent to collections. _____ (initial)

Insurance Claims

Insurance is a contract between you and your insurance company. In most cases, we are NOT a party of this contract. We will bill your primary insurance company as a courtesy to you. In order to properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete insurance information may result in patient responsibility for the entire bill. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility and benefits. If your insurance company is not contracted with us, you agree to pay any portion of the charges not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forward the payment to us immediately. _____ (initial)

Apex Lab

When a procedure is performed, and a specimen obtained, it is sent to our Apex's Lab in Parma for processing. Currently at Apex we bill for the Technical component, which is the preparation of tissue on a slide. An independent outside laboratory is used to evaluate and diagnose the tissue on the slide and interpret the result. Laboratory charges are billed separately by the Laboratory providing the services. If your insurance company requires the use of a specific Laboratory, please notify our staff prior to the procedure. Failure to notify the staff may result in your financial responsibility for all lab charges. _____ (initial)

_____

Signature Date

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Notice of Information Practices

Apex Dermatology and Skin Surgery Center, LLC may use and disclose personal health information for treatment, payment, and healthcare operations.

- Examples of treatment include, but are not limited to, information sent to other physicians treating you, your insurance company, labs, x-ray facilities, hospitals, or to agencies providing therapy services.
- Examples for payment include insurance companies, coordination of benefits between payers, and collection agencies.
- Examples of healthcare operations include quality control audits and coding audits. You are not required to consent to these uses of your personal health information. However, if you refuse, we are not required to accept you as our patient. We are permitted or required to disclose information without the patient's consent in certain circumstances. Examples include court orders and public health requirements.

Apex Dermatology and Skin Surgery Center, LLC will not make any other use or disclosure for your health information without your written consent. You may revoke this consent at any time, but this must be in writing.
We may at times contact you to remind you of appointments or to give you information about your treatment alternatives or other health-related benefits and services that may be of interest to you.

Apex Dermatology and Skin Surgery Center, LLC will abide by the terms of this notice or the updated notice in effect at the time of any information disclosure. We reserve the right to update the terms of this notice and to make new notice provisions effective for all personal health information that we maintain. We will provide each patient with a copy of revisions of our Notice of Information Practice at the time of their next visit. We may send a copy of the revised Notice via mail if we need to release information in a way covered by revisions to the Notice. Copies may also be obtained at any time.

Any person or patient may file a complaint about these practices to the Secretary of Health and Human Services if they believe their privacy rights have been violated. They may also file a complaint with our Privacy Officer at Apex Dermatology and Skin Surgery Center, LLC 7580 Auburn Road, Suite 301, Concord, OH 44077, or by phone at 440-352-7546. All complaints will be addressed, and results will be reported to the President of the practice and to the Compliance Committee. It is our policy that no retaliatory action will be taken against someone submitting a complaint.

PATIENT CONSENT

I acknowledge that I received the Notice of Information Practices of Apex Dermatology and Skin Surgery Center, LLC.

I hereby consent to the release of confidential information maintained about me by Apex Dermatology and Skin Surgery Center, LLC to third parties for the purposes of treatment, obtaining payment or for healthcare operations. I also consent to the release of personal health information for other purposes specified by Health Insurance Portability and Accountability Act of 1996. ("HIPAA")

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CONSENT FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND PERFORMANCE OF SURGERY AND/OR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY

1. I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intra-lesional kenalog (cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by Jorge Garcia-Zuazaga, MD, or by any physician, nurse practitioner, physician assistant, or appropriately trained and/or licensed health care personnel on the staff of Apex Dermatology and Skin Surgery Center, for or upon me or my minor child.

2. I further consent to the examination for diagnostic and/or investigational purposes, and the disposal, by the authorities of the above named medical facility or its designates herein, of any tissue or parts which may be removed.

3. I understand that the skin biopsy involves removal of a piece of skin, and that such removal may result in a permanent scar or in discoloration of the skin at the site of the biopsy. I further understand that more than one biopsy may occur during this visit.

4. I understand that all specimens removed are sent for dermatopathologic analysis and that the charges for dermatopathology will be billed to my insurance. However, I understand that in certain cases, I may be responsible for a portion or all the charges as determined by my insurance carrier.

5. I understand that the destruction with liquid nitrogen of precancerous lesions, which are also known as actinic keratoses or solar keratoses, may be deemed necessary by a member of the medical staff, to prevent the risk that these lesions evolving into squamous cell carcinomas (skin cancer).

6. I understand that the destruction by liquid nitrogen of warts or molluscum may be advised, but these types of lesions are not cancerous and do not necessarily have to be treated. I recognize that because they may be contagious, they should be treated. Should Dr. Jorge Garcia-Zuazaga or a member of the Apex medical staff recommend destruction of these lesions by liquid nitrogen, I consent based on that advice. I am aware that these lesions may require more than a single treatment.

7. I understand that the injection of triamcinolone (cortisone) for the treatment of scars, cysts, acne, and inflammatory conditions like psoriasis, atopic dermatitis, and alopecia areata, may be deemed necessary, advisable, or desirable by Dr. Jorge Garcia-Zuazaga or a member of the Apex medical staff.

8. I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to, permanent scarring, permanent discoloration of the skin at the treatment site, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness or temporary or permanent loss of function of certain muscles (paralysis).

9. I understand that no guarantees or assurances have been made as to the effectiveness of treatments or procedures which I may receive from Dr. Jorge Garcia-Zuazaga or a member of the Apex medical staff. I acknowledge that no guarantees or assurances have been made to me concerning the results of treatments and/or procedures.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD, AND RECEIVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLANANTONS REGARDING THE PROVIDED INFORMATION.

Signature of Patient_____ Date: _____

If patient is under 18 years of age or unable to authorize consent.
Signature of Parent or Legal Guardian _____Date: _____

CONSENT TO TREAT A MINOR

Date: _____

Patient Name: _____

Date of Birth: _____

Address: _____

Responsible Party's Name: _____

Phone: _____

The undersigned hereby requests and authorizes _____ to perform diagnostic tests, procedures and render treatment to _____, a minor child. This authorization extends to all Apex Dermatology doctors and staff members. As of the date above, the undersigned states and vows to have the legal right to select and authorize health care services for the minor child named above. If applicable, under the terms and conditions of divorce, separation or other legal authorization, the consent of a spouse, former spouse, or other parent is not required. If authority to select and authorize the care should be revoked or modified in any way, the undersigned does hereby agree to notify Apex Dermatology as soon as possible.

Signature of Person Authorized to Sign for Patient: _____

Printed Name of Person Authorized to Sign for Patient: _____