

Appalachian Spring Dermatology -10

Cosmetic and Laser Surgery Center

BETH SANTMYIRE-ROSENBERGER MD PHD

GENERAL INFORMATION

PATIENT'S NAME (FIRST, MIDDLE, LAST)		
BIRTH DATE	AGE	SEX
SOCIAL SECURITY #	MARITAL STATUS	SPOUSE NAME
HOME PHONE	WORK PHONE	CELL PHONE

HOME ADDRESS (STREET, CITY, ZIP CODE)

EMAIL ADDRESS

IF PATIENT IS UNDER AGE 18, WHO IS THE LEGAL PARENT/GUARDIAN?

EMPLOYER/OCCUPATION/SCHOOL

PRIMARY CARE PHYSICIAN NAME

PREFERRED PHARMACY (NAME and LOCATION)

INSURANCE INFORMATION - IF DIFFERENT FROM PATIENT INFORMATION

	PRIMARY INSURANCE	SECONDARY INSURANCE
INSURED NAME		
INSURED BIRTH DATE		
INSURED SS#		
INSURED ADDRESS		
INSURED PHONE NUMBER		

COMMUNICATION OF PROTECTED HEALTH INFORMATION (PHI)

AT WHICH NUMBER SHOULD WE ATTEMPT TO CONTACT YOU FIRST?

AT WHICH NUMBER MAY WE LEAVE A MESSAGE/APPOINTMENT REMINDER FOR YOU?

AT WHAT MAILING ADDRESS CAN WE SEND INFORMATION TO YOU?

WHICH FAMILY MEMBERS CAN WE SPEAK TO ON YOUR BEHALF?

WHAT QUESTION CAN WE ASK THIS FAMILY MEMBER TO VERIFY THEIR IDENTITY?

ANY OTHER LIMITATIONS IN CONTACT OR RESTRICTION ON RELEASE OF YOUR PHI?

EMERGENCY CONTACT (CLOSEST PERSON NOT LIVING WITH YOU. IF UNDER AGE 18, PARENTS' NAME)

EMERGENCY CONTACT (NAME)

RELATIONSHIP TO PATIENT		PHONE NUMBER
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PAST MEDICAL HISTORY

PLEASE LIST ALL CURRENT MEDICAL PROBLEMS	PLEASE LIST ALL PRIOR SURGERIES

PLEASE LIST ALL DOCTORS YOU HAVE SEEN IN THE PAST YEAR

MEDICATIONS (YOU CAN BRING YOUR OWN LIST IF IT IS LONG & WE WILL COPY IT)

PLEASE LIST ANY MEDICATIONS, VITAMINS OR HERBAL SUPPLEMENTS THAT YOU TAKE ON A REGULAR BASIS?

WHICH MEDICATIONS DO YOU TAKE AS NEEDED (For joint pain, headaches, etc.)?

ARE YOU CURRENTLY PREGNANT OR BREASTFEEDING?

ALLERGIES - ARE YOU ALLERGIC TO ANY MEDICATIONS OR FOODS? LATEX?

Signature Date

Please mark, yes or no, and explain where needed beside the question

PLEASE NOTE – WE WILL USE A COMPUTER SCANNER TO RECORD SOME OF THIS INFORMATION.
IT IS VERY IMPORTANT THAT YOU FILL IN THE CIRCLES AS DEMONSTRATED. Yes No

Social History If Yes, Please Explain

- Are you currently working outside the home? If yes, please indicate occupation. Yes No
- Have you traveled outside of the US in the past three months? If yes, where? Yes No
- Do you drink alcoholic beverages? If yes, how often. Yes No
- Do you use tobacco products? If yes, how often and how much? Yes No
- Do you currently use recreational drugs? Yes No
- Do you exercise on a regular basis? Yes No
- Have you, or are you currently using a tanning salon? Yes No
- Have you had at least one blistering sunburn in your life? Yes No

Family History (Please answer even if Family Member is Deceased)

- Does/Did your mother have any medical problems? If yes, list Yes No
- Does/Did your father have any major medical problems? If yes, list. Yes No
- Is there any family history of melanoma? If yes, please list which relatives. Yes No
- Do/Did your siblings have any major medical problems? If yes, list. Yes No

Past Medical History (Have you ever had any of the following?) If Yes, Body Location

- Melanoma Yes No
- Basal Cell Carcinoma Yes No
- Squamous Cell Carcinoma Yes No
- Dysplastic Nevus Yes No
- History of keloid / abnormal scarring Yes No

Review of Systems (Have you ever had any of the following?) If Yes, Please Explain

- | | | | |
|------------------|------------------------|---------------------------|--------------------------|
| INFECTIOUS | Tuberculosis | <input type="radio"/> Yes | <input type="radio"/> No |
| | HIV/AIDS | <input type="radio"/> Yes | <input type="radio"/> No |
| | Hepatitis B or C | <input type="radio"/> Yes | <input type="radio"/> No |
| | Herpes | <input type="radio"/> Yes | <input type="radio"/> No |
| | Cold Sores | <input type="radio"/> Yes | <input type="radio"/> No |
| | Warts | <input type="radio"/> Yes | <input type="radio"/> No |
| GASTROINTESTINAL | Hepatitis | <input type="radio"/> Yes | <input type="radio"/> No |
| | Stomach Ulcers | <input type="radio"/> Yes | <input type="radio"/> No |
| | Liver Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| RENAL | Kidney Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| | Dialysis | <input type="radio"/> Yes | <input type="radio"/> No |
| PULMONARY | Asthma | <input type="radio"/> Yes | <input type="radio"/> No |
| | Shortness of Breath | <input type="radio"/> Yes | <input type="radio"/> No |
| | Bronchitis | <input type="radio"/> Yes | <input type="radio"/> No |
| | Sarcoidosis | <input type="radio"/> Yes | <input type="radio"/> No |
| ENDOCRINE | Diabetes | <input type="radio"/> Yes | <input type="radio"/> No |
| | Thyroid Disease | <input type="radio"/> Yes | <input type="radio"/> No |
| HEMATOLOGIC | Anemia | <input type="radio"/> Yes | <input type="radio"/> No |
| | Low White Blood Cells | <input type="radio"/> Yes | <input type="radio"/> No |
| | Low Platelets | <input type="radio"/> Yes | <input type="radio"/> No |
| | Bruise or Bleed Easily | <input type="radio"/> Yes | <input type="radio"/> No |

PATIENT NAME _____ DATE _____

HEMATOLOGIC	Blood Clots	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Lymphoma/Leukemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sickle Cell Anemia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
CARDIOVASCULAR	Heart Murmur	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Heart Valve	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pacemaker	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hypertension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Varicose Veins	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Coronary Artery Disease	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hypotension	<input type="checkbox"/> Yes	<input type="checkbox"/> No
MUSCULOSKELETAL/RHEUMATOLOGIC	Artificial Joints/Implants	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Arthritis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Joint Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Muscle Pain	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Gout	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Lupus	<input type="checkbox"/> Yes	<input type="checkbox"/> No
PSYCHIATRIC	Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Anxiety	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Phobia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Bulimia/Anorexia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Chemical Dependency	<input type="checkbox"/> Yes	<input type="checkbox"/> No
GYNECOLOGIC (female patients only)	Irregular Menstrual Cycles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Menopause	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Pregnancy	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Excessive Bleeding	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Endometriosis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	EENT	Glaucoma	<input type="checkbox"/> Yes
Sinus Infection		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Cataracts		<input type="checkbox"/> Yes	<input type="checkbox"/> No
NEUROLOGIC	Seizures	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Fainting	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Headaches	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Stroke	<input type="checkbox"/> Yes	<input type="checkbox"/> No
DERMATOLOGIC	Hives	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Skin Ulcers	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Itching	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Skin Cancer	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Acne	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Eczema	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Psoriasis	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Hair Loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Nail Problems	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Sun Sensitivity	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Reaction to Jewelry	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Rosacea	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PATIENT NAME _____ DATE _____

BETH SANTMYIRE-ROSENBERGER MD PhD

Our Office Policy Regarding Patient Financial Responsibility

We are committed to providing you with the best possible medical care, regardless of whether or not you have health insurance. In order to achieve this goal, we need your assistance and your understanding of our financial policy.

Payment for services is due at the time services are rendered, unless we participate with your insurance. As a courtesy, we will bill to insurances with which we are a participating provider on the patient's behalf. Your co-pay, any deductible, or any amount not covered by your insurance is due at the time of your visit. All cosmetic procedure and consultation fees must be paid in full before the procedure or consult is performed. The fees that we charge are within the usual range for our area and specialty.

If Appalachian Spring Dermatology does not receive payment from your insurance company within ninety days, you will be responsible for the entire outstanding unpaid balance regardless of the reason for the denial.

If we are not a participating provider with your insurance or if you do not have insurance, you will be expected to pay the entire fee, in full, at the time of the visit. If we do not participate with your insurance, we can provide you with information for you to submit to your insurance carrier. Depending on the type of plan you have, you may be reimbursed directly. Please consult with your insurance carrier.

Prior to seeing Dr. Rosenberger, a staff member may call you to discuss the costs involved in your visit/procedure(s) and review your financial responsibility. We will gladly discuss any questions you have regarding our billing and your insurance. However, you must realize that your insurance is a contract between you, your employer, and the insurance company. It is your full responsibility to know the rules and regulations of your insurance carrier and operate within your insurance carrier's benefit guidelines. It is also your responsibility to seek medical care with physicians participating in your plan when possible. You are ultimately responsible for your bill, for deductibles, co-pays and services not covered by your insurance. If your insurance requires a deductible to be met, it is your responsibility to know what that deductible is and provide documentation if you have already met your deductible. Remember that insurance may not cover all fees. To be fully aware of your benefit limitations, please read your insurance policy thoroughly or talk with your insurance representative prior to your visit.

Please sign to acknowledge that you have been advised of your financial responsibility.

Signature _____ **Date** _____

Medicare Patients: We bill Medicare directly for you. However, you are responsible for charges applied to your deductible, any co-insurance, or charges not covered by Medicare. Some Medicare secondary insurances are known as Medigap policies, for these policies Medicare automatically forwards your claim to your secondary insurance carrier if they have a contract with the carrier. This is known as a “crossover” or “medigap”. Some newer policies such as Advantra combine PEIA and Medicare. These newer policies have a copay unlike the traditional medicare plans. Your copay can vary with the amount and types of procedures done.

Participating Insurance: Appalachian Spring Dermatology is a participating provider for a variety of commercial insurance carriers (See Attached List) and we bill them directly as a courtesy to you. Prior to your visit, you will be informed whether or not we are a provider for your insurance plan. We accept payment for covered services from these insurance plans in accordance with our contracts. You are responsible for applicable co-insurance and deductible amounts as well as payment for services that are not covered by insurance such as cosmetic procedures. **We currently do not participate with Medicaid or the Health Plan.** We are currently a participating provider with the following insurance companies as well as many others: 4 Most, Acordia/PEIA, Advantra, Aetna, Blue Cross/Blue Shield, Carelink/Coventry, Choice Care Network (CCN), Cigna, Direct Care of America, First Health, Health Care Coalition Partners, Medicare, Multiplan, National Capitol PPO, Private Health Care Systems (PCHS), Tricare and United. **If you do not see your plan listed here, please call us about this prior to your visit.**

Non-participating Insurance: If we are not a provider for your insurance carrier and you wish to see Dr. Rosenberger, you are responsible for payment of all charges at the time of service. You are then responsible for submitting the claim to your insurance company for reimbursement.

Uninsured: All charges are to be paid in full at the time of service.

Labs and Biopsies: In addition to our fees, you will receive a separate bill for lab processing and reading your biopsy. Our office will provide the lab with your insurance information on your behalf. Some insurance plans require biopsies and lab specimens to be sent to specific labs. Please call your insurance company to determine which lab your specimen needs to go to prior to your appointment.

Cancellation Policy: We require at least 24 hours notice for cancellations. If you do not come to your scheduled appointment or you cancel with less than 24 hours notice, you may be charged a \$25 cancellation fee. You may be required to pay the \$25 cancellation fee prior to scheduling another appointment.

We accept check, cash, Visa, MasterCard, Discover and American Express.

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

I understand that I have financial responsibility for payment of medical services provided by Dr. Santmyire-Rosenberger. I hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office. I have read and understand this financial policy and agree to accept responsibility as described.

Patient Name _____ **Date** _____

Patient, legal guardian or responsible party signature _____

THIS IS A LIFETIME AUTHORIZATION UNLESS REVOKED IN WRITING.

CONSENT TO ACCESS PAST MEDICATION HISTORY

With our electronic medical record, we can access a list of medications that you have filled in the past. This list includes medications that were paid for/prescribed under your insurance pharmacy benefits. This function is not available to all patients (or all insurance plans), but using it can be valuable when a patient can not remember their medications.

Signing below allows us to access your medication history when needed.

Signature _____ **Date** _____

MEDICARE PATIENTS ONLY

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card

_____ **Date** _____

If you have a supplemental policy and it is MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Medigap Card

_____ **Date** _____

THIS IS A LIFETIME AUTHORIZATION UNLESS REVOKED IN WRITING.

LACK OF MEDICARE SECONDARY

Patient Name: _____

Your initials and signature below signifies that you clearly understand and agree that:

You currently do not have a Medicare Secondary. _____

You are personally responsible for the portion not covered by Medicare at the time of service. _____

For example, if a standard office visit costs \$100, Medicare will cover 80% or \$80. If your secondary insurance does not crossover, you will be responsible for the remaining 20% or \$20 at the time of service

We will do our best to estimate your portion at the time of your visit. However, the FINAL DETERMINATION of what YOU OWE is DETERMINED BY MEDICARE. Therefore, you may owe MORE or LESS than the estimate you receive. _____

I understand all of the above and still want to receive services from Dr Rosenberger today.

Signature of patient: _____ Date _____

Amount to be paid TODAY based on Estimate of Charges _____

BETH SANTMYIRE-ROSENBERGER MD PhD

PHOTOGRAPHY CONSENT FORM

At Appalachian Spring Dermatology you will be asked to have your photograph taken for your medical record. At your first visit, we would like to take a picture of you (or scan your license picture), so we can put a face with your name during phone conversations, etc. You also may be asked to have photographs taken of the area of concern or treatment at each visit.

Please read and initial each statement below and circle YES or NO.

PLEASE NOTE... Photography is required for ALL biopsies, cosmetic procedures and surgical procedures.

___ YES NO I understand that photographic documentation is an integral part of the dermatologic medical record.

___ YES NO I consent to be photographed and to have the photographs kept with my medical record.

___ YES NO I consent to my photos being used for insurance documentation.

___ YES NO I consent to my photos being used in patient brochures.

___ YES NO I consent to my photos being used in educational lectures.

___ YES NO **I consent to my photos being used in the office photo album for patient education.**

___ YES NO I consent to have my biopsy area photographed before, after and/or during therapy.

___ YES NO I consent to have my surgical treatment area photographed before, after and/or during therapy.

___ YES NO I consent to have my cosmetic treatment area photographed before, after and/or during therapy.

Patient Name _____

Patient Signature _____

Signature of Patient Representative _____

Patient is Unable to Consent Because: _____

Relation to Patient _____

Date and Time _____

Physician Name - Beth Santmyire-Rosenberger MD PhD

Physician Signature _____

Witness Print - _____

Witness Signature _____

To allow us to better serve you, please bring the following information to your appointment:

- Your Drivers License (or other photo ID. We need this to verify your identity).
- Your insurance cards and your prescription cards.
- **Due to new FTC Identity/Credit protection laws, you cannot be seen without presenting your current insurance cards and photo ID at EVERY APPOINTMENT.**
- Any referral or paperwork required by your insurance company.
- Your medications (including herbs, vitamins and over the counter). Please bring the bottle for oral medications and the tubes or jars for any soaps, creams, shampoos or cosmetics used in the area in question.
- Completed and signed (enclosed) registration form, medical history form, financial policy form, photography consent form and any other additional enclosed forms. This will greatly speed up your first appointment wait time.
- Credit Card or other preferred method of payment. (Please see Financial Policy)

We understand that the forms are lengthy. Please realize that these forms and the list above reflect Dr. Rosenberger's very thorough approach to your skin health care.

Directions to Our Office: 100 Village Drive Suite 201 Fairmont is LOCATED JUST ONE MILE OFF INTERSTATE 79.

From Morgantown. Traveling on I-79 South. Exit 132 South Fairmont. Turn left on US 250 South. After 0.66 mile turn right at second light on Middletown Road (Route 73). Proceed 0.62 mile and turn left on Dylan Drive at the green sign for Village Center Professional Building. Head uphill 0.09 mile and turn right into the parking lot.

From Clarksburg. Traveling on I-79 North. Exit 132 South Fairmont. Turn right on US 250 South. After 0.30 mile turn right at first light on Middletown Road (Route 73). Proceed 0.62 mile and turn left on Dylan Drive at the green sign for Village Center Professional Building. Head uphill 0.09 mile and turn right into the parking lot.

PLEASE NOTE: On many maps including the computer generated map below, Dylan Drive is mislabeled as Old Hickory Drive. The street sign says DYLAN DRIVE.

WE REQUIRE 24 HOURS NOTICE FOR CANCELLATION. IF YOU CANCEL WITH LESS THAN 24 HOURS NOTICE YOU WILL BE REQUIRED TO PAY A \$25 FEE.

We look forward to seeing you on _____ at _____.
If you have any questions or need to reschedule this appointment, please call us at (304) 368 0111.