Brett D. Krasner, M.D.
Lindsay L. Kidd, M.D.
Victor A. Teran, M.D.
215 Wayles Lane, Suite 150
Charlottesville, VA 22911
(434) 964-9500

Deemed Consent for Designated Blood Borne Pathogens

Virginia law requires health care providers to notify you that Hepatitis B and C or HIV (Aids) Virus testing on a sample of your blood may be done if a health care worker is exposed to your blood or body fluids. This following notice is to advise you that this is in effect at this facility.

As a health care provider under the Virginia Acts of Assembly Section 32.1-45.1, whenever any healthcare worker associated with or working for Family Dermatology of Albemarle PLC is directly exposed to body fluids of a patient in a manner which, according to the guidelines of the Centers for Disease Control, may transmit Human Immunodeficiency Virus (Aids) or Hepatitis B and C, Family Dermatology of Albemarle PLC will proceed to test the patient through his or her physician and to the health care worker(s) who was/were exposed.

When a person is tested, we automatically test for HIV and Hepatitis B and C for the safety of all concerned. This policy protects you as a patient, should you be exposed.

Consent to Medical Care

I voluntarily consent to medical care at Family Dermatology of Albemarle which may include examinations, tests, photographs, and treatments performed by our doctors and staff. No promises have been made to me as to the results of treatment or examinations.

Parental Consent for Child Under 18 Years of Age

I am present with my child _____ today and I give my consent for the doctor(s) at Family Dermatology of Albemarle to see and treat my child as indicated. I give my permission for continued follow-up care which may include changes to the treatment plan in my absence. (No invasive procedures will be performed without direct notification to the parent.)

Consent to the Use and Disclosure of Health Information for Treatment, payment or Healthcare Operations

A copy of Family Dermatology of Albemarle's Notice of Privacy Practices is available upon request. I acknowledge I declined a copy or was provided a copy upon my request.

Signature: ✕ _____ **Date:** _____

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Conditions of Registration and Financial Policy

Patient Name: _____ Date of Birth:_____

The following are our conditions of registration as well as our policies with respect to the billing and collections of your account. By signing below, you are agreeing to be bound by these terms.

1. **BASIC POLICY** Payment is due in full at the time service is provided in our office.
1. **FOR PATIENTS WITH MEDICARE** We will bill Medicare on your behalf. As a courtesy, we will also bill secondary insurance carriers on your behalf. You are responsible for all co-insurance payments.
2. **FOR PATIENTS WITH INSURANCE** All co-payments are due at the time of service. We will bill insurance carriers on your behalf if we have a current contract with the carrier. We will submit a courtesy claim on your behalf to insurance carriers with which we do not participate. Please be advised that your agreement with your insurance carrier is a private one and that ultimately, you are responsible for payment. We do not keep track of patient's individual deductibles or co-insurance portions. Keep in mind that all office visits and treatments (often considered surgical procedures) of any kind are subject to deductibles and co-insurance. If an insurance carrier has not paid a claim within 60 days of billing, our fees are due and payable from you.
3. **INSURANCE AUTHORIZATIONS** You are responsible for ensuring that if your insurance requires a valid referral that one is in place before being seen. You will be financially responsible for any services performed without a valid referral.
4. **NONCOVERED SERVICES** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or immediately upon notice of insurance claim denial.
5. **MISSED APPOINTMENTS** In fairness to other patients and the doctor, we require at least 24 hours notice to cancel an appointment. You may be charged $50.00 for each appointment that was missed or not cancelled with 24 hours notice. If you miss an excision you will be required to put a $150.00 deposit down to reschedule. Missing more than two appointments without providing 24 hours notice is grounds for discharge from the practice.
6. **RETURNED CHECKS** In the event that a check is returned for insufficient funds, the account will be debited by an ACH transaction once the funds become available. Furthermore, you are subject to up to a $50 fee that will also be automatically debited from your account as provided in Section 8.01-27.1 of the code of Virginia.
7. **COLLECTION FEES** Should this account become delinquent and collection becomes necessary, the undersigned agrees to be responsible for attorney's fees of 33 1/3%, interest at 18% per annum from the last date of payment and any and all court costs.

MEDICARE PATIENTS: SIGNATURE ON FILE. I request and authorize payments of Medicare benefits be made to Family Dermatology of Albemarle, PLC for any services furnished me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Service and its agents any information needed to adjudicate these benefits for services. I understand my signature requests that payment be made and authorizes release of all information necessary to adjudicate the claim. If "other health insurance" is indicated, my signature authorizes the release of all information to the insurer or agency that is necessary to adjudicate the claim. In Medicare assigned cases, the provider or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and that I am responsible for the deductible, co-insurance, and any non-covered services.

Signature:✕_____ Date: _____

ASSIGNMENT OF INSURANCE BENEFITS: I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to Family Dermatology of Albemarle, PLC for any services furnished me by the provider. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorized said assignee to release all information necessary to adjudicate all claims and secure payment for services rendered.

Signature:✕_____ Date: _____

I have read, understood, and agree to be bound by the terms of this financial policy.

Signature: ✕_____ Date: _____

Printed Name:_____Relationship: _____

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FAMILY DERMATOLOGY of ALBEMARLE

Date of Visit: _____

Name: _____ **DOB:** _____

Today's visit is for: _____

Do you require premedication with antibiotics before surgical/dental procedures? ❑ **Yes** ❑ **No**

CURRENT MEDICATIONS (INCLUDE VITAMINS, SUPPLEMENTS, AND OVER THE COUNTER MEDS)			
Medication	**Dose**	**Route**	**Frequency**
1.			
2.			
3.			
4.			
5.			

Primary Care Provider: _____

How did you learn about us?

- ❑ Primary Care Physician (PCP): _____
- ❑ Another Dermatologist: _____
- ❑ Family/Friend/Co-Worker: _____
- ❑ The Embarq Yellow Pages
- ❑ Other (Specify): _____

May we have access to patient's prescription history? ☐ Yes ☐ No

MEDICAL HISTORY: PLEASE CHECK OR FILL IN ALL PHYSICIAN DIAGNOSED MEDICAL CONDITIONS

- ❑ ***Skin Cancer:***
  - o Melanoma (Date: _____)
    Location: _____
  - o Squamous Cell Carcinoma
  - o Basal Cell Carcinoma
  - o Actinic Keratosis (pre-skin cancer)
  - o Other: _____
- ❑ ***Dermatological Disease:***
  - o Herpes/Cold sores
  - o Psoriasis
  - o Eczema
  - o Acne
  - o Rosacea
  - o Blistering Disorder: _____
  - o Healing problems (slow, keloid, bruising)
- ❑ ***Immunological Disease:***
  - o Immune Deficiency
  - o HIV / AIDS
  - o Lupus or Scleroderma
- ❑ ***Hematology / Oncology:***
  - o Cancer (Type: _____)
  - o Bleeding Problems
- ❑ ***Rheumatological Disease:***
  - o Osteoarthritis
  - o Rheumatoid Arthritis
  - o Gout
- ❑ ***Psychological / Emotional Disease:***
  - o Depression
  - o Obsessive – Compulsive
- ❑ ***Gastrointestinal Disease*:**
  - o Crohn's Disease, Ulcerative Colitis
  - o Esophageal Reflux
  - o Peptic ulcer
  - o Esophagitis
- ❑ ***Cardiovascular Disease:***
  - o High Blood Pressure
  - o Heart Problems: _____
  - o Heart Attack (Date: _____)
  - o Pacemaker / AICD
  - o Irregular heartbeat
  - o High Cholesterol
- ❑ ***Endocrine Disease:***
  - o Diabetes
  - o Hyperthyroid / Hypothyroid
- ❑ ***Neurological Disease:***
  - o Stroke / Aneurysm
  - o Seizure / Epilepsy
  - o Alzheimer's
  - o Fainting
- ❑ ***Liver Disease:***
  - o Hepatitis (Type: _____)
  - o Jaundice
- ❑ ***Lung Disease:***
  - o Asthma
  - o COPD
  - o Tuberculosis
- ❑ ***Kidney Disease:***
  - o Poorly functioning kidneys
  - o Dialysis (Type: _____)
- ❑ ***For Female Patients:***
  - o Are you Pregnant/ Planning Pregnancy
  - o Polycystic ovarian disease (PCOS)
  - o Breastfeeding
- ❑ ***Other / Not Listed:***
  - o _____
  - o _____
  - o _____
  - o _____

MEDICATION ALLERGIES

NAME OF MEDICATION	TYPE OF REACTION
	❑ rash ❑ difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑ difficulty breathing ❑ stomach pain/vomiting ❑ other:
	❑ rash ❑ difficulty breathing ❑ stomach pain/vomiting ❑ other:

Last Name: _____
DOB: _____

Surgeries	
Date	*Type*

Hospitalizations	
Date	*Reason*

FAMILY MEDICAL HISTORY (PLEASE ADD ANY OTHERS NOT LISTED)	
Conditions/Problems	*Family Members affected and exact nature of problems*
❑ Melanoma	
❑ Non-Melanoma Skin Cancer	
❑ Blistering Disorder	
❑ Psoriasis	

SOCIAL HISTORY / HABITS

- Occupation: _____ ❑ Retired
- ❑ Non-smoker ❑ Smoker: ___ cigarettes/day ❑ Quit smoking in _____
- Are you interested in receiving information on smoking cessation? ❑ Yes ❑ No
- Smokeless Tobacco: ❑ Yes ❑ No
- Alcohol use: ❑ Yes (drinks/week: _____) ❑ No
- Recreational Drug use: ❑ No ❑ Yes _____
- Sunscreen use: ❑ Regularly ❑ Rarely ❑ Never
- Have you traveled outside the US in the past 3 months? ❑ Yes ❑ No

TANNING / SUN EXPOSURE

Do you:
- ❑ Always burn, never tan
- ❑ Usually burn, tan w/ difficulty
- ❑ Sometimes burn, usually tan
- ❑ Rarely burn, tan easily

Have you had:
- ❑ At least 1 blistering sunburn

Do you:
- ❑ Utilize a tanning bed

REVIEW OF SYSTEMS: Please mark the symptoms you've been having recently.

GENERAL
- ❑ weight gain / loss
- ❑ loss of appetite
- ❑ fever / chills
- ❑ weakness
- ❑ night sweats

SKIN
- ❑ rash
- ❑ lumps
- ❑ dry/sensitive skin
- ❑ hives
- ❑ suspicious moles
- ❑ suspicious lesions
- ❑ jaundice
- ❑ acne
- ❑ itching
- ❑ hair loss

EAR/NOSE/THROAT
- ❑ congestion
- ❑ nosebleed
- ❑ change in voice
- ❑ sore throat
- ❑ difficulty swallowing

ALLERGY
- ❑ runny nose
- ❑ scratchy throat
- ❑ itchy eyes
- ❑ sinus congestion
- ❑ sneezing

CARDIOLOGY
- ❑ chest pain
- ❑ palpitations
- ❑ leg swelling

MUSCULOSKELETAL
- ❑ joint stiffness
- ❑ leg cramps
- ❑ joint pain
- ❑ joint swelling
- ❑ back pain
- ❑ neck pain
- ❑ muscle aches

RESPIRATORY
- ❑ shortness of breath
- ❑ chest tightness
- ❑ cough
- ❑ wheezing
- ❑ congestion

PSYCHOLOGY
- ❑ depression
- ❑ high stress level
- ❑ suicidal thinking
- ❑ eating disorder
- ❑ mental or physical abuse
- ❑ mood swings
- ❑ obsessive - compulsive tendencies

ENDOCRINE
- ❑ excessive sweating
- ❑ excessive thirst
- ❑ excessive urination
- ❑ heat intolerance
- ❑ cold intolerance

BLOOD/LYMPH
- ❑ swollen glands
- ❑ fatigue
- ❑ varicose veins
- ❑ easy bruising

EYES
- ❑ decreased vision
- ❑ eye irritation
- ❑ eye drainage
- ❑ blurry vision

NEUROLOGY
- ❑ headache
- ❑ tingling/numbness
- ❑ seizures
- ❑ dizziness

GASTROENTEROLOGY
- ❑ nausea
- ❑ vomiting
- ❑ heartburn
- ❑ abdominal pain
- ❑ change in bowel habits

UROLOGY
- ❑ difficulty urinating
- ❑ blood in urine
- ❑ leaking urine

✕ _____ _____ _____ _____

Patient's Signature **Date** **Physician's Signature** **Date**

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As a new patient, please complete these forms and bring them with you.
Please arrive 15 minutes prior to this scheduled time for your first appointment.

Preferred Pharmacy
Name:
Address:
City, State, Zip:
Phone Number:
Fax:

Patient Information:

Name: _____ **DOB:** ____ / ____ / _____ **SSN:** _____ - _____ - _____

Address: _____ **Phone (H):** (_____) _____ - _____ **Gender:** _____

City/State/Zip: _____ **Phone (C):** (_____) _____ - _____ **Race:** _____

Employer: _____ **Phone (W):** (_____) _____ - _____

Occupation: _____ **Marital Status:** ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other

May we leave messages with personal health information on voicemail of above phones: **Home:** ☐ Yes ☐ No
Cell: ☐ Yes ☐ No
Work: ☐ Yes ☐ No

Email Address: _____
Your email address will be used to register for portal and for reminders regarding appointments and statements

Do you have an advance directive? ☐ Yes ☐ No ☐ Declines to discuss

If yes, check all that apply: ☐ Do Not Intubate ☐ Do Not Resuscitate ☐ Living Will ☐ Power of Attorney
☐ Surrogate Decision Maker ☐ No Blood Transfusions ☐ Other: _____

Insurance Information

(The receptionist will copy your insurance card.)

Primary Insurance Name: _____
Insured Name: _____
Insured DOB: ____ / ____ / _____
Relationship to Patient: _____
ID#: _____
Group#: _____

Secondary Insurance Name: _____
Insured Name: _____
Insured DOB: ____ / ____ / _____
Relationship to Patient: _____
ID#: _____
Group#: _____

Responsible Party: (Complete only if patient is a minor OR otherwise not financially responsible)

Name: _____ **Relationship:** _____

Address: _____ **DOB:** ____ / ____ / _____ **Phone (H):** (____) ____ - _____

City/State/Zip: _____ **SSN:** ____ - ____ - _____ **Phone (C):** (____) ____ - _____

Employer/Occupation: _____ **Phone (W):** (____) ____ - _____

PLEASE NOTE THAT THERE WILL BE A CHARGE OF $50.00 FOR MISSED APPOINTMENTS.

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Sharing Information with Family and Friends

Family Dermatology of Albemarle, PLC has a Notice of Privacy Practices which describes how we may use and disclose, and how you may access your protected health information. At times spouses, children or others may call on your behalf. If you would like us to share your protected health information with others, please indicate to whom we may disclose this information. If you do not let us know who we may speak to, we will NOT discuss your protected health information with them.

I, _____, (date of birth ____/____/_____), give my permission to Family Dermatology of Albemarle, PLC to discuss my medical care and/or to leave messages with the following people:

_____	_____	_____-_____-_____
Name	Relationship	Phone Number
_____	_____	_____-_____-_____
Name	Relationship	Phone Number
_____	_____	_____-_____-_____
Name	Relationship	Phone Number
_____	_____	_____-_____-_____
Name	Relationship	Phone Number

OR

_____ Do NOT disclose my information without signed authorization first.
(Initial)

Patient Signature: _____ Date: ____/____/_____