COSULICH DERMATOLOGY

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PATIENT DEMOGRAPHIC FORM

TODAY'S DATE:_____

Please complete this form to ensure proper billing of your services.

Name:_____ Date of Birth: _____
First Last

Age:_____Gender:_____Email (for your patient portal): _____

Street Address:_____ City, State, Zip:_____

Preferred Phone #: _____ ○ HOME ○ MOBILE Alternate Phone #:_____ ○ HOME ○ MOBILE ○ WORK

Emergency Contact Information

Emergency Contact Name:_____ Relationship to You: _____

Best Contact # for Emergencies: _____

Primary Care Information

Primary Care Physician: _____
Address (street): _____
City, State, Zip: _____
Telephone #: _____

Ref. Physician (if different): _____
Address (street): _____
City, State, Zip: _____
Telephone: _____

Send diagnostic letters to Primary/Referring Physician, if necessary?: ☐ Yes ☐ No

Insurance Information

Policy Holder's Name: _____

Your Relationship to Policy holder (or write SELF): _____

Policy Holder's Date of Birth: _____

PRIMARY Insurance Carrier: _____ **SECONDARY** Insurance Carrier: _____

Member ID #:_____ Member ID #: _____

COSULICH DERMATOLOGY, LLC

PATIENT DEMOGRAPHIC FORM

Electronic Communications

Patient Portal: For your convenience, our practice offers secure electronic communications between you and your office via the Patient Portal. Secure messages and information can be read only by someone who knows your password to log in to the Portal site. The communications are automatically encrypted and, for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

☐ Yes, I want to participate using my email provided on Page 1.

☐ No, I do not wish to participate at this time and decline online access to my clinical notes, results, and the ability to exchange messages via the portal.

Appointment Reminders: As an added convenience, we offer appointment reminder phone calls and texts via an automated service. The reminders are sent using a software service and cannot be used as a way for you to communicate back to us. Should you need to reach us, please call our main number (732−280−1200). If at any time you change your mind about reminders, please let us know or simply opt out by following the prompts in the voice calls or texts.

I understand under the Telephone Consumer Protection Act, that in order for the practice to contact me for services related to my medical care, Cosulich Dermatology, LLC and/or its agents may contact me by phone, including my cell phone, which may result in charges to me. Methods of contact may include prerecorded/artificial voice messages and/or use of an automated dialing device, as applicable.

☐ Yes, I want to participate. Phone #: _____

☐ No, I do not wish to participate at this time and decline any reminders for my future appointments.

Patient Signature:_____Date: _____

Additional Information

Which category best describes your racial background?

☐ American Indian or Alaska Native
☐ Asian
☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander
☐ White
☐ Unreported/Refuse to Report

Ethnicity: How would you describe your ethnicity, such as your family background or ancestry?

☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unreported/Refuse to Report

Preferred language: What language do you usually speak at home?

☐ English ☐ Spanish ☐ Other _____

Whom can we thank for referring you to our practice?

☐ Health Insurance ☐ Social Media ☐ Google/Other Search Engine ☐ ER/Hospital/Doctor

☐ Newspaper/Magazine ☐ Other Patient _____ ☐ Other _____ _

COSULICH DERMATOLOGY, LLC

HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

We are required by law to maintain the privacy of protected health information and provide individuals with this Notice of our legal duties and privacy practices with respect to protected health information. By signing below, patient acknowledges that he/she has been given the option of receiving a copy or been afforded an opportunity to review this Notice of Cosulich Dermatology's HIPAA Notice of Privacy Practices.

Print Name	Patient Signature	DOB	Today's Date

Patient Contact Information

Preferred #: (Telephone) _____ Alternate #: (Telephone) _____

I authorize messages with medical information to be left on voicemail at (check all that apply):

☐ Preferred # ☐ Alternate # ☐ None, please do not leave voice messages

I authorize brief message details: ☐ Preferred # ☐ Alternate #

I authorize extended message details: ☐ Preferred # ☐ Alternate #

Restrictions/Instructions: _____

Release of Medical History, Treatment, and Billing Information

I authorize the following individual(s) to receive information regarding any medical history, treatment, billing issues and to act on my behalf:

Name: _____ Relationship: _____ DOB: _____ Phone #: _____

Name: _____ Relationship: _____ DOB: _____ Phone #: _____

Restrictions/Instructions: _____

Patient Acknowledgement

In accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996, I understand that:

1. I may revoke this authorization at any time, except to the extent where action has already been taken in accordance to the original authorization for disclosure. My revocation must be in writing, signed by me or on my behalf, and delivered to your office. My revocation will be effective once received by Cosulich Dermatology, LLC.
2. A copy of this authorization may be used with the same effectiveness as the original.

This authorization replaces any prior written authorization I have made regarding the use, release, and disclosure of my medical information.

Print Name	Patient Signature	Date

COSULICH DERMATOLOGY, LLC

FINANCIAL POLICY

Welcome to Cosulich Dermatology, LLC, where we are fully committed to giving you the best care possible. We thank you for choosing our practice as your dermatology specialist. Please continue reading and sign below to acknowledge your understanding of our authorization for treatment, payment, and patient financial policies.

Authorization for Treatment and Payment of Medical Benefits

I give permission to Cosulich Dermatology, LLC to provide medical services for diagnosis and treatment. I authorize the release of medical information necessary to process any claims for services rendered and for payment from my insurance company to be made directly to the practice.

Use of Photography

I agree that any photo identification and photos of spot and lesion sites taken at the time of my appointment will be considered a part of my medical record and will be used solely for the purpose of my treatment and medical care.

e-Prescription Consent for Medication History

We may request and use your prescription medication history information from your pharmacy using our e−prescription feature. This is only for informational purposes so that an up−to−date record of your medication is available for your treatment and safety.

- ◯ Yes, I consent to obtain my medication history using the e−Prescribing feature.
- ◯ No, I do not consent. I understand that my medication information may not be complete when making treatment decisions.

Patient Financial Responsibilities

- I (or patient's guardian) understand that I am ultimately responsible for the payment of my treatment and care, including Lab/Pathology fees, which are separate from normal Practice fees.
- Cosulich Dermatology will assist me by billing my contracted insurers. However, I understand that I am required to provide the office with the most correct and updated information for my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated. I understand that if I need a referral, it is my responsibility to contact my primary doctor for the referral prior to my Cosulich Dermatology appointment. I understand that any bills resulting from not obtaining the required referral are my responsibility as the patient.
- I understand that I am responsible for the payment of copays, coinsurance, deductibles, and all other procedures or treatment not covered by my insurance plan. I understand payment is due at the time of service, payable by cash, check, and most major credit cards, including HSA and FSA cards.
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include, but are not limited to:
    - Charge for returned checks
    - Charge for the copying and distribution of patient medical records
    - Charge for forms the practice fills out on your behalf
    - Charge for missed appointments

Patient Authorizations

I hereby authorize Cosulich Dermatology, LLC to release medical and other information to the necessary insurance companies and third party payers required for payment of rendered health services. I hereby authorize assignment of financial benefits directly to Cosulich Dermatology, LLC. I understand that I am financially responsible for charges not covered or denied, in full or in part, by my insurance plans.

Print Name:_____ Signature:_____ Date: _____

COSULICH DERMATOLOGY, LLC

HEALTH ASSESSMENT FORM - 2023

In accordance with CMS government guidelines (PQRS − Physician Quality Reporting System), we are required to obtain *annual* overall health assessments on our patients.

Print Name:_____DOB: _____ Today's Date:_____

Fall Risk Assessment

Have you had any falls in the past year? ◯ No ◯ Yes

If yes, how many falls in the past year?

If yes, were you injured? ◯ No ◯ Yes

If injured, describe injury below:

☐ I do not wish to discuss this matter

Vaccination Screening

Have you had a flu vaccine this season? ◯ No ◯ Yes

If yes, date of vaccination (MM/YY): __ __ /__ __

If no, reason:

☐ Recommended but not administered

☐ Refused − Do not want vaccine

☐ Allergic to flu vaccine

If you are **over** 65 years of age, have you ever had the pneumococcal vaccination? ◯ No ◯ Yes _____ (YYYY)

☐ I do not wish to discuss this matter

Diabetic Patient Screening

Are you diabetic? ◯ No ◯ Yes

If yes, what is your Hemoglobin A1C? ◯ Less than 7 ◯ Between 7 and 9 ◯ Greater than 9 ◯ Unsure

☐ I do not wish to discuss this matter

Advance Directive (Living Will)

If you are 65 or over, do you have an advance directive (living will)? ◯ No ◯ Yes

If yes, please write the name of your Proxy (individual authorized to make medical decisions on your behalf − usually a spouse or child): _____

If no, would you like more information? ◯ No ◯ Yes ◯ I do not wish to discuss this matter