Integrated Dermatology of Granville

Midwest Dermatology Centre, LLC
Melinda Woofter, MD
1959 Newark-Granville Rd. Granville, OH 43023
740-587-0778 Phone 740-587-0601 Fax

Patient Information: ☐*New Patient* ☐*Name Change* ☐*Address Change* ☐Insurance Change

Please present your insurance card(s) and a photo ID to the receptionist along with this completed form.

Name _____
Last *First* *M.I.*

Date of Birth: ____/____/____ Age: _____ Sex: ☐Male ☐Female **S.S #** _____

ADDRESS: _____
Street *City* *State* *Zip*

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Referring Doctor Name & Address _____

How did you hear about us: _____

Approval to send you information on products and services Y N E-Mail _____

PARENT, SPOUSE, OR RESPONSIBLE PARTY *(if different from patient)*

Name: _____ Date of Birth: ____/____/____
Last *First* *M.I.*

Address: _____
Street *City* *State* *Zip*

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Coverage - PRIMARY:

Insurance Co. Name: _____ Occupation: _____
Name (Insured): _____ Policy Holder (Insured) DOB: ___/___/___
Policy #: _____ Group Name or #: _____
If patient is child, check relationship to insured: ☐Mother ☐Father ☐Other _____

Medical History (Circle ONE)

Arthritis or Rheumatism	Y N	Do you smoke?	Y N
AIDS/HIV	Y N	Do you drink alcohol	Y N
Diabetes	Y N	Have you had Cancer?	Y N
Glaucoma	Y N	explain: _____	
Heart Problems	Y N	Have you had skin Cancer	Y N
Hepatitis	Y N	explain: _____	
High Blood Pressure	Y N	Approximate # of sunburns in your life: _____	
Kidney Disease	Y N	**Females:**	
Liver Problems	Y N	Are you pregnant?	Y N
Peptic Ulcer Disease	Y N	breastfeeding	Y N
Seizures	Y N	taking birth control pills?	Y N

OTHER SERIOUS DISEASES: _____

LIST ANY MAJOR SURGERIES: _____

CURRENT MEDICATIONS: _____

ALLERGIES TO MEDICINES: _____

PREFERRED PHARMACY: _____

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE

I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance 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.

Date: ____/____/____ **Signature:** _____

INTEGRATED DERMATOLOGY GROUP

MIDWEST DERMATOLOGY CENTRE, LLC
MELINDA J. WOOFTER,M.D.

HIPAA
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 Practice and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- 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 receipt of treatment upon the execution of this Consent.

This Consent was signed by: _____
Printed Name – Patient or Representative

X _____ __/__/__
Signature Date

Relationship to Patient
(if other than patient): _____

Witness:

_____
Printed Name – Practice Representative

X _____ __/__/__
Signature Date

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Financial Policy

Thank you for choosing **Midwest Dermatology Centre, LLC**. as your health care provider. We are committed to your treatment being successful. Please understand that *payment of your bill is considered part of your treatment*. The following is a statement of our Financial Policy, which **we require you read**, **initial by each paragraph and sign at the bottom**. We hope that this will help to avoid any possible misunderstandings in the future.

Initials_____

Payment is due at the time of service if we do not have a contract with your insurance.
We accept **Cash**, **Check**, **Visa**, or **MasterCard**. Initials_____

Regarding Insurance
It is your responsibility to provide our office with the **correct** information, and keep us updated with any changes. We may have a contract with your insurance to accept assignment of benefits. If this is the case, and your insurance requires co-pay, you will be responsible for that amount at the time of service. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. It is your responsibility to know any policy exclusions or limitations, and any requirements of your policy such as a referral from your primary care physician. In the event that your insurance fails to make payment for your services you are financially responsible. Please understand that Midwest Dermatology Centre is not a lending institution and therefore will not extend credit. Any/all balances deemed your responsibility by your insurance are due in full upon receipt of your first statement from our office. Dr Woofter does not participate in any Affordable Care Act plans, otherwise known as Obama Care or Marketplace.

Initials_____

Missed Appointments
Unless cancelled, at least 24 hours in advance, our policy is to charge a missed Office appointment fee of $50; for missed Surgical appointment fee of $75 and $100 fee for missed Cosmetic appointments. Please keep in mind that this charge is not covered by insurance. Please help us serve you better by keeping scheduled appointments.

Initials_____

Rebilling Fee
If we must send more than one bill in order to collect payment you will be assessed a rebilling fee in the amount of five ($5.00) dollars for each additional billing required. Initials_____

Returned Check Fee
All returned checks will be subject to a fee of *forty-five ($45.00)* dollars. Initials_____

Delinquent Account Fee
If your account is turned over to collections there will be a collection fee of ten dollars ($10.00) added to your balance. You may also be dismissed from our practice. Initials_____

NOTE: All prescription refills **must** be faxed to us by your pharmacy. **NO** phone calls for prescription refills.

Initials_____

I have read and understand this Financial Policy:

Signature: _____ Relationship: _____ Date: _____
Signature of Patient or Responsible Party Relationship to Patient Date

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Permission To Release Form

Do we have permission:

Leave a message on your answering machine: Y N

Please list any other person that we may discuss your medical information with:

_____

_____

_____

_____

_____ _____

Signature **Date**

This policy will be enforced until we receive written documentation from you.
Thank you for choosing Midwest Dermatology Centre/Integrated Dermatology of Granville

Medicare Patients Only

This office is required to keep your signature of the following file authorizing us to file claims to Medicare for you and to release information th 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 Health Care Financing Administration 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 **Date**