Broome Nurse Practitioners
SKINCARE

Patient Intake Form

Date:_____
Patient Name: _____
(As it appears on your insurance cards)

Date of Birth: _____ **Gender:** Male/Female

Mailing Address: _____
Street

_____ _____ _____
City State Zip Code

Telephone Numbers: _____ (Home/Cell/Work)
_____ (Home/Cell/Work)

Email Address: _____

Race: ☐ White ☐ Black African American ☐ Other _____ ☐ Patient Declined/Unknown

Ethnicity: ☐ Spanish/Hispanic ☐ Not of Spanish/Hispanic origin ☐ Patient Declined/Unknown

Languages: ☐ English ☐ Spanish ☐ Other ☐ Patient Declined/Unknown

Employment Status: ☐ Retired ☐ Full Time ☐ Part Time

Occupation:_____**Employer:**_____
Address: _____
Phone#: _____

Student Status: ☐ Full Time ☐ Part Time

Referring Physician: _____ **Telephone:** _____

Primary Care Physician:_____ **Telephone:** _____

How did you hear about us? _____

Pharmacy Name: _____ **Address:** _____

Mail order pharmacy: _____

Primary Insurance Information:

Insurance Company: _____
Subscriber's Name: _____ Date of birth: _____
Subscriber's Gender☐ Male ☐ Female
Relationship of subscriber to patient: _____

Insurance identification number: _____
(including any prefix or suffix)
Effective date: _____

Secondary Insurance Information:

Insurance Company: _____
Subscriber's Name: _____ Date of birth: _____
Subscriber's Gender☐ Male☐ Female
Relationship of subscriber to patient: _____

Insurance identification number: _____
(including any prefix or suffix)
Effective date: _____

Tertiary Insurance Information:

Insurance Company: _____
Subscriber's Name: _____ Date of birth: _____
Subscriber's Gender☐ Male ☐ Female
Relationship of subscriber to patient: _____

Insurance identification number: _____
(including any prefix or suffix)
Effective date: _____

Specimen Lab Processing Policy

If your insurance plan requires your specimens be processed by a particular laboratory to avoid out-of-network charges, please identify the laboratory._____

If no laboratory is identified, your specimen will be sent to **Cayuga Medical Center Laboratory** and their associates and you will be responsible for any copays, coinsurances or deductibles that result in the processing of your specimen by this laboratory.

_____ _____
Signature of patient or guardian Date

HIPAA

May we leave appointment information on? (check all that apply)

□ **Home Telephone** □ **Cell Phone** □ **Work Telephone**

May we leave medical information on? (check all that apply)

□ **Answering Machine** □ **Cell Phone**

□ **Work Voicemail** □ **Send through mail**

□ **Send through secure email** □ **With another person**

I hereby give my permission to release information regarding my care and protected health information to the following individuals: (Parent, other family members, friends, or others who need to know about your health care).

Name	Relationship	Contact Phone Number
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ I have received and reviewed the HIPAA statement.

_____ _____
Signature of patient or guardian Date

I _____give consent to the providers of Broome Family Nurse Practitioners to use and retrieve my medication history for Surescripts.

_____
Patient/Guardian Signature

SIGNATURE ON FILE AUTHORIZATION

Statement to Permit Payment of Medicare or Any Other Health Insurance Benefits to Supplier, Physician, or Patient:

I request that payment of authorized Medicare or any other health insurance benefits be made either to me or on my behalf to above noted physician/supplier for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable to related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If item 9 of the HCFA-1500 claim form is completed, my signature authorizes release of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance, and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____

Patient or Guardian Signature Date

ACCOUNT RESPONSIBILITY

Who is responsible for this account? SELF OTHER (circle one)

If other please identify person responsible: _____

Relationship to patient: _____

Mailing Address: _____

City: _____ State: _____

Cell Phone: _____ Home Phone: _____

Date of Birth: _____

Authorization For Treatment and Responsibility of Account

Thank you for choosing us as your health care provider. We are committed to providing quality medical care. Please understand that payment of your bill is considered part of your care plan. We ask that you read and sign this Financial Policy prior to any treatment. You may be asked to sign this page again as it is updated. Please let us know if you have any questions.

· We will verify your insurance coverage at every visit. It is the patient's responsibility to supply all current insurance cards. ·

· If you do not have insurance, or cannot provide proof of insurance at the time of service, you will be treated as self pay and payment in full will be required at time of service.

· We accept cash, checks, and credit cards. A $25 fee will be assessed for returned checks.

· No-show appointments/cancellations less than 24 hours in advance may be charged a $25 fee.

· If your insurance requires a referral from your Primary Care Provider (PCP) to see another physician, it is your responsibility to obtain a referral/authorization prior to your appointment. Any unauthorized charges will be your responsibility.

· The adult accompanying a minor to a visit and the legal parents/guardians are responsible for any payments due at time of service. We will not be involved in negotiating between parents in custody disputes.

· If you are here for multiple procedures, the provider will determine whether or not to perform all these procedures during the same office visit or to schedule them at a future date. We cannot guarantee multiple procedures on the same day of service. Your insurance company may have one co-payment for the office visit and a second co-payment for the actual procedure. In addition, if we provide a non-covered service during the same visit as a medical dermatology encounter, then you will have two separate charges.

·All procedures (such as biopsies, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately Initials _____ and are not included in the office visit.

As a courtesy to our patients, we will submit claims to your insurance carrier for you. For those plans that we participate in, we will also submit secondary and/or tertiary claims. Insurance plans vary considerably, and we cannot predict or guarantee what part of our services will or will not be covered by your particular plan. Patients are responsible for knowing the details/rules of their health plan(s), as we cannot change our coding in an attempt to obtain payment.

I hereby authorize Broome Family Nurse Practitioners to release any medical information required in the course of examination and treatment and permit payment directly to them any benefits due for their services rendered. I recognize and accept responsibility for services rendered regardless of insurance coverage. This includes, but is not limited to, co-payment, co-insurance, deductible, and non-covered services.

I have read, understood, and agree to the Financial Policy (above)

_____ _____

Name of Patient or Responsible Party (Please Print) Date

_____ _____

Signature of Patient or Responsible Party Relationship to Patient

Dermatology Medcial History Form

Name:_____ Age: _____ Date of birth: _____

Height: _____ Weight: _____

Please circle any medical conditions that apply:

Pacemaker
Defibrillator
Asthma
Hay Fever
Seasonal Allergies
Eczema
Psoriasis
Diabetes controlled by (circle)
Diet Medication Insulin
High Cholesterol
High Blood Pressure
Stroke
Heart Attack
Congestive Heart failure
Heart Murmur
Heart Valve Problem
Acne
Thyroid Disorder
Kidney problems
Arthritis
Artificial Joints
Appendix Removed
HIV or AIDS
Hepatitis A B C (please circle)
Liver Cirrhosis
Liver Problems Type_____
Bleeding disorder
Anxiety
Depression
Gallbladder Removed
Pregnant
Breast Feeding
Planning Pregnancy
Hysterectomy: Total or Partial
Tubal Ligation
Prone to Yeast Infections with Antibiotics

Have you ever been told to take antibiotics before dental procedures due to a heart murmur, heart valve or artificial joint?
Yes No (please circle)

Melanoma: If yes, where and when? _____
Basal Cell: If yes, where and when? _____
Squamous Cell: If yes, where and when? _____
Blistering sunburn: if yes, number of times and where? _____
Skin type: If first exposure to the sun, without sunscreen would you (please circle)
Always Burn Sometimes Burn Never Burn Always tan

Surgeries:_____ **Date:**_____ **Hospitalized:** Y/N
_____ _____ Y/N
_____ _____ Y/N

Please list any other surgeries or medical problems: _____

SOCIAL HISTORY

Do you smoke or use tobacco? YES NO (circle one)
If yes, what type? _____ How many per day? _____ Are you a former smoker? YES NO (circle one)

Do you drink alcohol? YES NO (circle one) How many per week?_____

Family History: Circle any condition affecting a blood relative. Specify which family member.
Melanoma_____ Breast Cancer_____
Psoriasis_____ Acne_____
Allergies_____ Asthma_____
Basal cell or Squamous Cell Skin Cancer_____

Medications

Please list your current medications, supplements and vitamins:
Please include dose and frequency.

Allergies

Please list all allergies: