REDDY DERMATOLOGY, SC

MEDICAL • SURGICAL • LASER • COSMETIC

LALITHA REDDY, MD

Date		DOB	_____/_____/_____
Patient Name		Gender	Male/Female
Address		City, State, Zip	

Spouses Name: _____DOB_____

Pharmacy Name: _____

City: _____ Cross Street(s): _____

Referring Physician: _____

City: _____Clinic Name: _____

Primary Care Physician: _____

City: _____ Phone: _____ Fax: _____

SKIN DISEASE HISTORY:

HAVE YOU HAD ANY OF THE FOLLOWING?

☐ Actinic Keratoses

☐ Basal Cell Skin Cancer Site/Year: _____

☐ Squamous Cell Skin Cancer Site/Year: _____

☐ Melanoma Site/Year: _____

☐ Abnormal moles Site/Year: _____

☐ Eczema: _____

☐ Psoriasis: _____

Family history of skin cancer: (If yes, please specify who and type): _____

_____

Do you wear sunscreen: ☐ Yes ☐ No **History of sunburns in your past?:** ☐ Yes ☐ No

NAME: _____ DOB: _____/_____/_____

PAST MEDICAL HISTORY:
LIST ANY MEDICAL CONDITIONS YOU CURRENTLY HAVE/HAVE HAD:

_____

_____

PAST SURGICAL HISTORY:
HAVE YOU HAD ANY SURGERIES? IF SO, PLEASE LIST WITH YEAR:

_____

MEDICATIONS:

_____

_____

ALLERGIES:

_____

_____

SMOKING STATUS: (choose one)
- ☐ Current every day smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

ALCOHOL INTAKE: (choose one)
- ☐ None
- ☐ 1 or less per day
- ☐ 1 – 2 per day
- ☐ 3 or more per day

COSMETIC QUESTIONNAIRE (Optional to fill out):

Other than the medical services we will provide for you, what additional services would you be interested in learning about? Please check all that apply.

- ☐ Topical skin care products
- ☐ Skin Discoloration
- ☐ Facial Redness
- ☐ Brown spots/Age spots
- ☐ Red spots
- ☐ Non-invasive body contouring
- ☐ Scars (Acne or surgical)
- ☐ Chemical peels
- ☐ Facial fine lines/wrinkles
- ☐ Aging hands
- ☐ Other: _____

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OFFICE POLICIES

CONSENT FOR CARE AND TREATMENT

I, the undersigned, do hereby agree and give my consent for the above stated to furnish medical care and treatment as considered necessary and proper for diagnosis and treatment. This includes cryotherapy, cautery, biopsies, excisions and other procedures deemed medically necessary by the medical health care provider. This may also include photography. I understand that the medical health care provider will discuss with me prior to any procedure or treatment and this will be documented in my medical record. This shall be valid throughout all treatment for this condition and/or disease process.

PATHOLOGY/LAB SERVICES

Reddy Dermatology uses third parties for our Laboratory work and pathology services. You/your insurance will receive an additional bill from the lab service provider (Quest, LabCorp, Dermpath Diagnostics). We are unable to adjust these charges as they are provided by a separate entity.

REFERRALS

Your insurance plan may require a referral to be completed before seeing a specialist. It is your responsibility to obtain the proper referral in order to be seen for your appointment. If you don't have a referral at your appointment time, your appointment may be re-scheduled.

MEDICARE

Our physician is a Medicare Provider and we do accept assignment on covered services. All Medicare patients are responsible for their 20% co-insurance and annual deductible and these are due at the time of service.

PRESCRIPTION POLICY

Please call for refills during regular office hours and leave the patient's name, DOB, phone number, medication, and the pharmacy requested. Some Prescriptions may be delayed due to completing a PRIOR AUTHORIZATION form set forth by the insurance companies. For oral medications, biologics, and some topical medications, the patient needs to be evaluated every 6 months. We cannot refill a prescription if the patient has not been evaluated within 12 months.

MINOR POLICY

All minor patients (less than 18 years of age) must be accompanied by their parent, grandparent, or legal guardian on their first visit. If under the age of 16, the patient may only be seen with a parent, legal guardian, or grandparent present. Surgical or laser procedures as well as any Accutane related visits must have a legal guardian present if the patient is under the age of 18.

_____ _____

Signature of Patient or Legal Representative **Date**

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Thank you for choosing Reddy Dermatology for your skin care needs. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential element of your care. With healthcare costs shifting to patient responsibility, it is essential you understand your deductible and details of your plan. To help you in this, we provide an estimated cost of our most common procedures, available upon request.

Please read carefully and sign at the bottom to confirm your understanding.

1) Insurance: your visit is filed with the carrier for whom our practice has a valid contract with. It is the responsibility of the patient to provide *accurate insurance and personal information* including any preferred laboratory cards. If your insurance requires a referral, it is your responsibility to provide the referral *prior to your visit*. You will be responsible at the time of service for the payment of copays, unpaid deductibles, and past due balances.

2) Self-pay and cosmetic: Payment is expected in full at the time of services.

3) Cancellation and Missed Appointments: We understand that unexpected events, illnesses, etc occur. When this happens, call our office as soon possible to inform us of such issues. In the case of missed appointments or cancellations within 24 hours of the appointment:

    a) Office Visit- I understand that it is my responsibility to cancel my appointment 24 hours in advance of my appointment time and date, otherwise a $50 fee will be billed to my account which is not covered by my insurance plan.

    b) Surgical/cosmetic procedure appointments- I understand it is my responsibility to cancel or change my appointment at least 24 hours prior to my appointment time and date, otherwise a $200 fee will be charged to my account which is not covered by my insurance plan.

4) Requests for Medical Records/forms (FMLA, Cancer policies): available at a fee dependent upon chart volume. Medical records may be sent to another provider at no charge. FMLA, medical and other such policy forms to be filled out will be charged $10 fee.

5) Methods of payment accept are: Cash, Visa, Mastercard and Discover and personal checks with proper identification (valid Driver's license or photo ID). A $30.00 overdraft charge will be added to the insufficient funds amount of any returned checks.

6) I have read the above financial policies and understand my financial responsibilities as a patient. I understand that failure to make payment when due is the basis for legal action and agree to pay all costs of collection.

7) Recent changes in healthcare markets have altered insurance coverages to shift more of the cost of care to our patients. *Many policies have higher deductibles, which means, even if a procedure is covered by insurance, you may still receive a bill*. These external factors make it necessary for Reddy Dermatology to maintain a credit card on file for all commercially insured patients. The card information is stored with security--the same HIPAA compliant software that protects your confidential medical information. Should you have a balance after your visit, we will mail out two statements, if no payment is received after 60 days we will bill the card on file. By signing this form you authorize Reddy Dermatology to bill your card on file. Receipt of any transaction will be forwarded to the home address in our records.

_____ _____

Signature of Patient or Legal Representative **Date**

ACKNOWLEDGEMENT OF RECEIPT OF REDDY DERMATOLOGY PRIVACY NOTICE

I have received a copy of Reddy Dermatology's Notice of Privacy Practices, detailing how my protected health information may be used and disclosed as permitted under federal and state law. The Notice contains a section describing my rights under the law. I have the right to review the Notice before signing this acknowledgement. The terms of the notice may change. If the Notice is revised, I may obtain a revised copy at the office.

I have the right to request restrictions on how protected health information is used or disclosed. The practice is not obligated to agree to such restrictions, but if the practice agrees to any restrictions, it will honor the agreement.

A confidential message may be left on your voicemail and answering machine at the preferred number(s) indicated below or with a friend or family member who answers the telephone at one of the preferred numbers or at your residence and who can verify your address and date of birth. Such message may include, without limitation, reminders of upcoming scheduled appointments information regarding your pathology or laboratory tests, billing information or answers to medical questions you may have inquired about to our staff.

I request the following restriction(s) concerning the use of my personal protected health information and also include preferred phone number and email address:

_____

Preferred Phone Number: _____

Preferred Email Address: _____

Signature: _____ **Date:** _____

Patient Name: _____ **DOB:** _____

If not signed by patient, please indicate relationship to patient: _____
