the Dermatology Clinic PLLC
Dr. Angela Wingfield • Dr. Joshua Ortego

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6510 Hwy 90, Suite C | Gautier, MS 39553 228-372-8559
116 Menge Ave., Suite A | Pass Christian, MS 39571 228-586-9565
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3109 Shortcut Road | Pascagoula, MS 39567 228-202-5182
TheDermClinic.net 228-864-3333

Chart # _____

We welcome you and thank you for selecting The Dermatology Clinic, PLLC for your healthcare needs. We are dedicated to providing you with the best possible healthcare. To help us, please fill out this form completely in ink. If you have any questions, please ask us. We will be happy to assist you.

1. Personal Information

Patients' Name (Mr. / Mrs. / Ms. / Dr.) _____

Date of Birth _____ / _____ / _____

Patient Mailing Address _____

City / State / Zip _____

☐ Male ☐ Female Social Security # _____ - _____ - _____

Race _____ Ethnicity _____ Preferred Language _____

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Employer _____ Occupation _____

Email _____

2. Telephone Information

Home Phone _____ Work Phone _____ Cellular Phone _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Phone _____

3. Responsible Party (If not Patient)

Who is Responsible for the Account? _____

Address / City / State / Zip _____

_____

Relationship to Patient _____ Social Security # _____ - _____ - _____

Date of Birth _____ / _____ / _____

Employer _____ Occupation _____

Work Phone _____ Home Phone _____

4. Insurance Information

Primary Insurance

Name of Insured _____

Relationship to Patient _____

Insured's Birth date _____ / _____ / _____

Social Security # _____ - _____ - _____

Employer _____

Insurance Co. _____

Employee I.D. / Cert. # _____

Group # _____

Secondary Insurance

Name of Insured _____

Relationship to Patient _____

Insured's Birth date _____ / _____ / _____

Social Security # _____ - _____ - _____

Employer _____

Insurance Co. _____

Employee I.D. / Cert. # _____

Group # _____

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Patient Questionnaire

Please answer the following questions (please print)

Name _____ DOB ____ /_____ /_____ Today's Date ____ /_____ /_____
Reason for today's visit _____
_____
How long have you had this problem? _____
List any previous treatment for the problem _____
Please list all allergies (medication or other) _____
List all **medications** you are currently taking (over-the-counter meds; vitamins and herbals / dosage and frequency)
_____
_____
_____
Have you ever had dental anesthesia (Novocaine)? ☐ Yes ☐ No Any bad reaction? ☐ Yes ☐ No
Do you have a pacemaker / defibrillator? ☐ Yes ☐ No
List all surgical procedures and year performed (within the last 10 years) _____
_____
Do you smoke? ☐ Yes ☐ Never ☐ Former Start Date ____ /_____ /_____ End Date ____ /_____ /_____
Do you drink alcohol? ☐ Never ☐ Occasionally ☐ Frequently
Are you pregnant? ☐ Yes ☐ No Breastfeeding? ☐ Yes ☐ No
What is your occupation (or past occupation if retired)? _____

Please check any of the following problems **you** might have or had:

Skin
- ☐ Keloids
- ☐ Poor healing
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne
- ☐ Other _____

Hematologic / Lymphatic
- ☐ Anemia
- ☐ Bleeding problems
- ☐ Enlarged lymph nodes
- ☐ Blood clots / DVT

General Symptoms
- ☐ Weight loss
- ☐ Fever
- ☐ Weak, tired
- ☐ Nausea, vomiting, diarrhea (when taking antibiotics)

Ears / Eyes / Nose / Throat
- ☐ Glaucoma
- ☐ Hearing aid
- ☐ Cosmetic surgery
- ☐ Other _____

Urinary
- ☐ Kidney disease
- ☐ Kidney failure/dialysis

Cardiovascular
- ☐ Angina, heart attacks
- ☐ Heart valve problems
- ☐ High blood pressure
- ☐ Allergies

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Other lung problems

Gastrointestinal
- ☐ Stomach ulcers
- ☐ Other GI problems
- ☐ Other _____

Musculoskeletal
- ☐ Arthritis
- ☐ Artificial joints
- ☐ Aching joints

Neurological
- ☐ Stroke
- ☐ Seizures
- ☐ Other _____

Psychiatric
- ☐ Depression
- ☐ Anxiety attacks
- ☐ Other _____

Endocrine
- ☐ Diabetes
- ☐ Thyroid problems
- ☐ Other _____

Infections
- ☐ Hepatitis ____ Type / treatment
- ☐ Urinary tract
- ☐ HIV / AIDS ☐ Staph ☐ TB

Please check if **family member** has had any of these diseases and list family member.
- ☐ Melanoma (skin cancer); Family member _____
- ☐ Other skin cancer; Family member _____
- ☐ Seasonal allergies; Family member _____
- ☐ Psoriasis; Family member _____
- ☐ Eczema; Family member _____
- ☐ Acne; Family member _____
- ☐ Other _____

Have you had extensive sun exposure? (even as a child) ☐ Yes ☐ No
Have you had blistering sunburns? (even as a child) ☐ Yes ☐ No
Do you have a history of skin cancer? ☐ Yes ☐ No Type _____
If yes, please list **site, date, treatment and doctor** _____
Please list any other cancers or malignancies _____

Primary Care Physician _____
Do we have your consent to communicate with your primary care physician? ☐ Yes ☐ No

Preferred Pharmacy _____

Patient Signature _____

Signed by Physician _____ **Reviewed by** _____

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Financial Policy

Patient Name _____ Date of Birth _____ / _____ / _____

Your clear understanding of our financial policy is important to our professional relationship.

1. Payment for Services

- Our financial policy requires that payment in full be collected on the day that services are rendered unless the service is covered by insurance.
- If you have valid health insurance coverage with one of the insurance carriers that we contract with, we will collect co-pays at the time of service(s) being rendered. The co-pay requirement cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier.
- You are also responsible for any co-insurance, deductibles or non-covered services as required by your insurance.
- After payment is received from your insurance carrier(s), any balance that remains on the account will be deemed your responsibility including balances of insurance responsibilities not paid within 60 days from the date of service.
- You will be notified on your first statement from our billing office of the balance which is due and payable upon receipt of the statement.

2. Options for Paying Account Balances (please select one)

☐ OPTION 1 - MANUAL PAYMENT: Payment will be made within 30 days of the first statement issued. Payment can be made in the office, over the phone or online at www.thedermclinic.net.

☐ OPTION 2 – CREDIT CARD AUTHORIZATION: Provide credit card information and sign credit card authorization in the office to ensure that the balance will be paid in a timely fashion. Your card will be charged for any remaining balance 30 days after your statement is mailed. Please note:

- We will NOT call prior to charging your card. If you are using a debit card, it is possible you may incur overdraft charges at your bank.
- You have the right to dispute any charges which you feel may be incorrect. You still have the right to question your insurance company's determination of payment.
- We will mail you a paper statement prior to charging your credit card.

3. Chargeback & Non-Sufficient Funds (NSF) Fee Policy

- A $35 fee will be assessed for any returned checks, non-sufficient funds (NSF) payments, or credit card chargebacks where the original charge is found to be valid. Unpaid fees may result in a hold on future appointments and services until the account is settled.

4. Additional Lab Fees

- Procedures like biopsies, wound cultures, or lab tests may result in separate charges from outside lab facilities.
- These are billed directly to you and/or your insurance by the lab performing the test.

5. No-Show & Late Cancellation Policy

Definitions:

- No-Show: Failure to attend a scheduled appointment without prior notice.
- Late Cancellation: Cancellation or rescheduling less than 24 business hours before the scheduled time.

In the event you no-show your scheduled appointment or cancel with less than 24 business hours' notice, the following fees will be incurred:

Service Type	Fee
Medical Services	$50
Cosmetic Services	$50
Laser Services	$50
Aesthetic (Spa) Services	$50
Surgical Procedure Services	$100

***These fees are not covered by insurance and must be paid before future appointments can be scheduled.**

6. Booking Fees

- A $50 booking fee is required for all scheduled laser, aesthetic (spa) and cosmetic injectable appointments or consultations.
- You may prepay the $50 booking fee or place a credit card on file. If you place a card on file, your card will only be charged:
  - In the event of a no-show or late cancellation or if you are notified in advance of a charge

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Policies:

- The fee is applied toward the service cost if the appointment is kept and attended.
- If you no-show or late cancel, the fee is non-refundable and applied toward the corresponding fee.
- If no service is rendered at the time of the appointment, the $50 booking fee can be used toward a product or service within 3 months, provided no additional no-shows or cancellations occur.
- After 3 months, if the fee is not applied to a service or product, the booking fee becomes non-refundable.

7. Prepayments for Packages

- If you prepay for a series of treatment, you must redeem all services within one year of purchase at the office in which you purchased the service initially.
- Any unused treatment after one year will be forfeited, and no refunds will be issued.
- Booking fees still apply and will be refunded if no-show/late cancellation policies are followed.

8. Return & Exchange Policy for Retail Products

- **Return Period:** Products may be returned or exchanged within 14 days of purchase.
- **Eligibility:** Both opened and unopened products are eligible for return or exchange. Products should be in their original packaging and lightly used. Heavily used or altered items may be eligible for exchange or store credit at our discretion.
- **Processing:** Approved refunds will be applied to the original payment method. Please allow 5-7 business days for payment to process.
- **Exchanges:** When exchanging a product, any cost differences will be handled at the time of exchange.

9. Authorization & Release

By signing below, you agree to the following:

- I authorize the release of any information, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care, to third party payers and / or other health practitioners.
- I authorize my insurance company to pay benefits directly to The Dermatology Clinic, PLLC.
- I understand that I am responsible for any charges not covered by my insurance.

For Medicare patients:

- I request that authorized benefits be paid to The Dermatology Clinic, PLLC for any services provided.
- I authorize the release of medical information to Medicare or its agents as needed to determine these benefits.

I have read and acknowledge the Financial Policy of The Dermatology Clinic, PLLC.

X _____ _____ / _____ / _____
Signature of Patient (or Parent if Minor) Date

Credit Card Authorization (optional)

☐ I authorize The Dermatology Clinic, PLLC to keep my credit card on file and to charge it in the following instances:

- A **no-show** or **late cancellation** (less than 24 hours' notice) in accordance with the clinic's cancellation policy.
- Any **remaining balances** on my account that are unpaid **30 days after a statement is issued**.

I understand that this authorization will remain in effect until I provide written notice of cancellation.

☐ Visa ☐ MasterCard ☐ American Express ☐ Care Credit ☐ Discover

Account Number _____ Expiration Date _____ CVV _____

Name as it appears on the card (please print) _____

Signature _____ Date _____ / _____ / _____

Email to send credit card receipt _____
(Please print clearly)

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Patient Notice of Privacy Policy Acknowledgement

Patient Name _____ DOB _____ / _____ /_____

I acknowledge that I have been given an opportunity to review The Dermatology Clinic, PLLC's Notice of Privacy Practices, which is displayed in the lobby and will be provided a copy if I desire one. In order to assist The Dermatology Clinic, PLLC in protecting my privacy, I have answered the following questions on how the clinic may disclose my medical information.

- You may call me on these numbers:

  Home _____ Cell _____ Work _____

- Leave messages on my answering machine / voicemail: ☐ Home ☐ Cell ☐ Work

- Send appointment reminders to: ☐ Home ☐ Cell

- Text Message Reminders (if reminders are sent to a cell phone) Cell _____

- You may leave messages regarding my care with the following persons:

  Name _____ Relationship _____

  Phone # _____

  Name _____ Relationship _____

  Phone # _____

- ☐ Yes ☐ No You may photograph my skin for documentation purposes.

X _____ _____ / _____ / _____
Signature of Patient (or Legal Guardian) Date

_____
Legal Guardian's Name (Please Print)