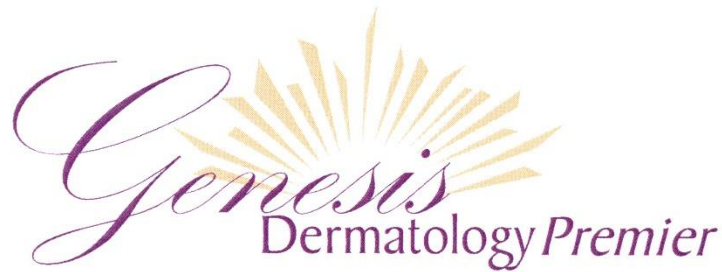


How Did You Hear About Us? ____

Name: ____
(Last) (Middle Initial) (First)

Address: ____

City: ___________________________________ State: ___________ Zip: __________

Cell Phone: ___________ Home Phone: _____________ Date of Birth_____________

E Mail:____

Primary Care Physician: _____________________________ Phone:________________

☐ **Check this box to subscribe to or email discounts, new product updates and promotions**

2nd Address: ____

City: ______________________________ State: ________ Zip: ________

Emergency Contact: ____
(Name) (Phone)

PHARMACY INFORMATION

By supplying the below information, we are striving our best to make your prescription an easy process by having your script available to you as soon as possible. Without complete information below, we may not be able to submit your prescription electronically and may need to give you a hard copy to take manually to the drug store.

PHARMACY NAME:______________________ PHONE # ___________________________

ADDRESS:____

Acknowledgement of Receipt of Notice of Privacy Practices

Genesis Dermatology reserves the right to modify the privacy practices outlined in the notice.

SIGNATURE

I have received a copy of the Notice of Privacy Practices for Genesis Dermatology.

Name of Patient (Print or Type)

Signature of Patient

Date

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form.)

Relationship of Patient Representative to Patient

Receipt of Notice of Privacy Practices

Please list individuals that you give us permission to discuss your medical care with.

Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone
Name	Relationship	Phone

MEDICARE IS WITHIN NETWORK ALL OTHER INSURANCES ARE CONSIDERED OUT OF NETWORK

Patients with insurance plans with which we participate are responsible for appropriate co-pays, co-insurance, and deductibles at the time of service. Not all services are a covered benefit in all contracts. If your insurance company denies any procedure as a “non-covered service”, you will be responsible for these services. If we do not participate with your insurance and you have paid for your visit, as a courtesy, we will submit the claim to your insurance company. Reimbursement is based on each individual’s out of networks benefits. If eligible, your insurance should reimburse you directly. If Genesis happens to receive the reimbursement payment you will be refunded accordingly. We understand temporary financial problems may affect timely payment on your account. We are here to help you and encourage you to contact us promptly for assistance in the management of your account should the need arise. Patient acknowledges that a 29% collection fee and any additional legal fees that accrue from efforts necessary to resolve an unpaid balance will be assessed and are the responsibility of the patient (parent or guardian in the case of minor status at the time of visit). A $25 fee will be incurred for any returned checks.

CANCELLATION/NO SHOW POLICY FOR APPOINTMENTS:

Please help us to serve you better by keeping your scheduled appointments and following our cancellation policy. We require at least 24-hour notice when cancelling or rescheduling your appointment. It will allow us to attend to other patients who may need urgent treatment/care or accommodate patients on the waiting list. Late cancellations and missed appointments may prevent another patient from receiving much-needed care. A fee of $100 will be charged to your account for each missed appointment or any untimely cancellation. It must be paid before any future appointments can be made.

PLEASE PROVIDE YOUR INSURANCE CARDS TO THE FRONT DESK STAFF UPON CHECK-IN.

If you do not wish to give us your insurance information you understand that you are fully responsible for all charges incurred from your visit. Should you receive a bill from the lab due to a biopsy, you will have to address that with the lab directly. Your signature signifies your understanding and agreement with our terms and policies above.

Thank you for your cooperation.

______________________________________ __________________

Signature Date

We are delighted that you have chosen to participate in this program as we continue our commitment to providing the highest level of care to our patients. This 'personal' approach to wellness combines comprehensive and proactive medicine utilizing a concierge platform that is responsive and flexible to meet the changing needs of our patients.

Genesis Premier offers the latest in general and cosmetic dermatology services in a friendly and discreet environment where the doctor-patient relationship takes center stage, and we work together in the best interest of your personal healthcare. Our skilled and compassionate team delivers state of the art care using the most advanced treatments and technologies to address all of your dermatology concerns.

Genesis Premier will enhance our current practice by limiting the number of patients in order to spend more time, devote more energy and be more involved and accessible to our members. Patients will benefit from prompt appointments and extended visits to focus on the individual and dedicate quality time to address all concerns. For insured patients, we will remain under contract with Medicare and services will be billed accordingly. All other insurance companies will be considered out of network and while payment will be required at the time of service, we are happy to submit the claim on your behalf as a courtesy for reimbursement based upon your specific plan coverage.

Please understand that although our practice model has been modified, we remain committed to providing the quality and compassionate care that has made Genesis Dermatology a long-standing leader in the community. With that in mind, we welcome your ideas and suggestions to ensure the success of this new program and encourage you to contact us if there is anything further, we can do to assist you.

Benefits:

- Prompt appointments for emergencies
- Extended office visits with our providers
- Exceptional attention to each patients' individual needs
- All Premier fees can be used towards cosmetic procedures, and/or products

Program:

There are two ways to become a participant

1) Any cosmetic service that totals $1500 or more throughout the year (At checkout you will be charged the amount of your service; this fee will not be charged annually). (Option # 2 below does not apply to you).

OR

2) An annual membership fee of $1500 is required. The entire fee is allocated back to each patient for the use of cosmetic services and product purchases. Unfortunately, this fee cannot be used for medical dermatology visits including co-pays, deductibles, co-insurance, or non-participating insurance charges. All non-participating insurance patients will be required to pay at the time of service. This fee is non-refundable.

I wish to join the Genesis Dermatology Premier Program. I understand the above information and all my questions have been answered. I understand that my credit card information listed below will be charged annually on the month of my renewal and good one year from the date of payment.

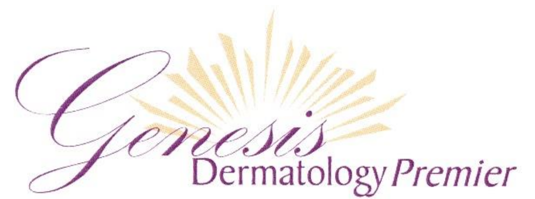
Patient Name: ____

CC Account Number: _____________________________________Exp. Date__________ CVV________

Name on Card (please print): _______________________________ Zip Code associated with card _______

By signing this form I agree to the Terms of Genesis Dermatology's Concierge Program.

Signature: ____ Date: ________________



Due to some recent Affordable Care Act changes, we are now required to ask you additional medical information about your social history. These questions may seem irrelevant to Dermatology but are required of us as a medical practice. Kindly complete the below for your medical record.

Social History

Currently smoke ___________ packs of cigarettes a day.

Previously smoked __________ packs of cigarettes a day and quit __________ years ago.

Medical History

Have you had a current flu vaccine for the current flu season YES **OR** NO (CIRCLE ONE)

Have you had a Tetanus (Dtap) vaccine in the last 10 years YES **OR** NO (CIRCLE ONE)

Have you had a Zoster (Shingles) vaccine if over the age of 50 YES / NO **OR** NOT OVER 50 (CIRCLE ONE)

Have you had a Pneumonia vaccine if over the age of 65 YES / NO **OR** NOT OVER 65 (CIRCLE ONE)

Advance Care Plan - **Advance care planning** is making decisions about the **care** you would want to receive if you become unable to speak for yourself. These are your decisions to make, regardless of what you choose for your **care**, and the decisions are based on your personal values, preferences, and discussions with your loved ones.

Choose ONE

☐ FULL CODE
The patient wishes to have full cardiopulmonary resuscitation efforts to be made.

☐ DO NOT INTUBATE
The patient does NOT wish to have a breathing tube, even if it is required for life savings measures.

☐ DO NOT RESUSCITATE
In the event that the patient's heart stops beating, the patient does NOT wish to have chest compression or an automated external defibrillator to restart the heart, even if it is required for life saving measures.

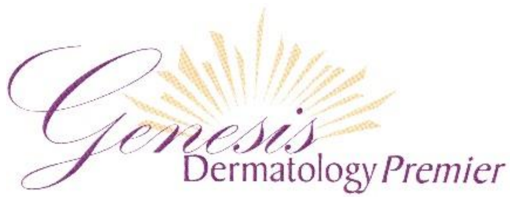
SELECT THE FOLLOWING IF IT APPLYS TO YOU

☐ LIVING WILL
The patient has a living will.

☐ HEALTHCARE PROXY
The patient has a healthcare proxy.

PATIENT SIGNATURE DATE

PLEASE PRINT NAME



Patient Name: ______________________

ALLERGY & MEDICATION LIST

ALLERGIES:

Allergy	Reaction

☐ **No Known Drug Allergies**

Medications: Date:____________ **Reconciled by:**____________

Medication Name	Rx= Prescription OTC= Over the counter, Vitamin/Mineral, Herb Dietary Supplement	Dose	Frequency	Route: Oral, Topical, Injection, Inhalation

Message Consent

It is our policy to verbally notify you, the patient, of all the test results ordered by your care provider and to confirm scheduled appointment. By indicating a response below, you are authorizing our staff to leave a detailed message on your voicemail and/or answering machine.

Please Check Your Response: ☐ **Yes** ☐ **No**