SPRINGFIELD
3850 S. National, Suite 705
Springfield, Missouri 65807
ph: 417-888-0858
fx: 417-889-0476

SWANN
DERMATOLOGY & ESTHETICS

HOLLISTER
590 Birch Street, Suite 2-C
Hollister, Missouri 65672
ph: 417-690-3858
fx: 417-690-3862

PATIENT INFORMATION

DEMOGRAPHICS

LAST NAME _____ FIRST _____ M.I. _____ AGE _____ DOB _____ SSN _____

ADDRESS _____ CITY/STATE/ZIP _____

HOME PHONE _____ CELL _____ WORK _____ GENDER (circle one) M F

EMPLOYER _____ OCCUPATION _____ EMAIL _____

PREFERRED PHONE _____ OK TO LEAVE DETAIL MESSAGE? Y N

WHO REFERRED YOU? ☐DERMATOLOGIST _____ ☐PCP/PHYSICIAN _____

☐417 ☐INTERNET ☐FRIEND/FAMILY _____ ☐INSURANCE ☐SPA/BUSINESS _____

PRIMARY CARE PROVIDER (PCP) _____ PCP CITY _____ PCP PHONE NUMBER _____

PHARMACY: NAME & LOCATION _____ EMERGENCY CONTACT: NAME, RELATION & PHONE NUMBER _____

CONSENTS - INITIAL EACH CONSENT INDICATING YOU HAVE READ AND AGREE

_____ initial

Consent for Treatment: I authorize Swann Dermatology and its personnel to provide ongoing medical care, treatment and procedures (skin biopsies, routine surgical procedures etc.) as ordered by the physicians and/or other health care providers. Some tissue and cultures are sent to outside laboratories, if your insurance carrier requires a specific facility, please let our staff know at the time service is rendered. I acknowledge that no guarantee can or will be made as to the results of the care, treatment, and medication prescribed.

_____ initial

Consent for Release of Information: I authorize Swann Dermatology to release to my insurance carrier(s) including Medicare, Medicaid, and any other reimbursing agency information about my identity, treatment, diagnosis, prognosis, and/or services rendered as permitted by state and federal law which may be required or requested, thus releasing Swann Dermatology from any liability for furnishing such information. Information may also be sent to other physicians involved in your care. I understand information may be released through electronic or paper media.

_____ initial

Notice of Health Information Practices: I acknowledge that the Notice of Swann Dermatology Privacy Practices is on file and I may access it at any time.

_____ initial

Photographic Consent (optional): I acknowledge that photographs may be taken as a part of documentation in my medical record. By initialing, I agree to the use of my photographs as a part of educational and marketing materials used by Swann Dermatology.

SIGNATURE OF PATIENT _____ DATE _____

SIGNATURE OF PARENT/GUARDIAN _____ DATE _____

INSURANCE & PAYMENT POLICY

INSURANCE

Please present insurance card(s)and a photo ID to the receptionist to copy. If you are here for a cosmetic procedure only and do not anticipate any services to be covered by your health insurance, you may enter your insurance information which we will keep on file or you may opt to skip this page entirely.

PRIMARY INSURANCE CARRIER	Self Other POLICY HOLDER
SECONDARY INSURANCE CARRIER (IF ANY)	Self Other POLICY HOLDER

If you are not the main policy holder:

NAME OF POLICY HOLDER	DOB	SSN (POLICY HOLDER)
PHONE OF POLICY HOLDER	MAILING ADDRESS OF POLICY HOLDER	

Consent to keep Insurance Authorization on File:

_____ initial
I authorize any holder of medical or other information about me to release to the above insurance company 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 to Swann Dermatology providers.

_____ initial
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 applies. I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services. If you have recently joined (or changed) to a Medicare Advantage plan, please let our staff know so we can update your records and advise you if we are participating providers.

_____ initial
Consent to Share Medical Information with Others: I authorize Swann Dermatology and staff to share my healthcare information with the following people. <u>Please understand that if a person is not listed that we can not discuss any medical information with them</u>, no matter their relationship with you.

NAME	RELATIONSHIP	PHONE	Y N OK TO LEAVE DETAIL MESSAGE?
NAME	RELATIONSHIP	PHONE	Y N OK TO LEAVE DETAIL MESSAGE?
NAME	RELATIONSHIP	PHONE	Y N OK TO LEAVE DETAIL MESSAGE?

_____ initial
Payment Policy:
You are responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic services. We accept checks, credit cards and CareCredit under these conditions. I have read and understand the office financial policy.

SIGNATURE OF PATIENT DATE

HEALTH QUESTIONNAIRE

SWANN DERMATOLOGY & ESTHETICS

LAST NAME _____ FIRST _____ DOB _____

What is the primary reason for today's visit? _____
CHIEF COMPLAINT TODAY'S DATE

_____
ADDITIONAL DETAILS

Have you ever had skin cancer? ☐ YES ☐ NO What type? _____ When? _____

Current medical conditions (check any)

☐ Hepatitis ☐ Leukemia ☐ Cancer _____ TYPE
☐ Anxiety ☐ Diabetes Last Hemogloin A1C:_____ ☐ Lymphoma ☐ Seizures
☐ Atrial Fibrillation ☐ Kidney Disease ☐ HIV/AIDS ☐ Hypertension ☐ Strokes

Past surgeries (check any & write year)

☐ Gallbladder ☐ Kidney ☐ Skin: Basal Cell _____
☐ Appendix ☐ Breast ☐ Heart ☐ Liver ☐ Skin: Squamous Cell
☐ Bladder ☐ Colon ☐ Joint ☐ Prostate ☐ Skin: Melanoma

_____
ADDITIONAL PAST SURGERY DETAILS

Skin History (check any)

☐ Eczema ☐ Poison Ivy ☐ Rosacea
☐ Acne ☐ Bad Sunburns ☐ Flaking Scalp ☐ Atypical Moles ☐ Wear Sunscreen
☐ Actinic Keratosis ☐ Dry Skin ☐ Hay Fever/Allergies ☐ Psoriasis ☐ Used Tanning Beds
☐ Atypical Moles ☐ Other _____ ☐ Other _____

_____
ADDITIONAL SKIN HISTORY DETAILS

Family History of Melanoma? ☐ YES ☐ NO Which relative? _____

All Skin Medications: _____

Last Flu Vaccination: _____ Last Pneumonia Vaccination: _____

Other Medications: _____

_____

Blood Thinners: ☐ YES ☐ NO (CIRCLE) Aspirin Coumadin Plavix Xarelto Pradaxa Vitamin E Fish oil Garlic

Drug Allergies: _____

Smoker: ☐ Never Smoked ☐ Former Smoker ☐ Current Smoker _____ packs per day.

Alcohol use: ☐ Yes ☐ No Amount _____

Review of Systems (check any)

☐ Fever or Chills ☐ Headaches ☐ Problems Hearing ☐ Blurry Vision
☐ Yeast Infections after antibiotics ☐ Abdominal Pain ☐ Joint Aches ☐ Night sweats ☐ Neck Stiffness
☐ GI upset with antibiotics ☐ Problems Healing ☐ Muscle Weakness ☐ Pregnancy ☐ Immunosuppression
☐ Pacemaker (year placed: _____) ☐ Defibrillator ☐ Joint Replacement ☐ Artificial heart valve ☐ Organ Transplant

Any other details you think we should know about your health:

_____

SWANN
DERMATOLOGY & ESTHETICS

LASER & COSMETIC QUESTIONAIRRE

_____ _____
LAST NAME FIRST DOB

If you are interested in a cosmetic service, please help us get to know your skin by answering the following questions:

How would you classify your skin type (check the following boxes):

1. ☐ Oily ☐ vs. Dry
2. ☐ Sensitive vs. ☐ Resistant
3. ☐ Pigmented vs. ☐ Non-pigmented
4. ☐ Wrinkled ☐ vs. Tight

What is your current cosmetic regimen?

Include Cleansers, Toners, Sunscreens, Growth Factors, Retinols, Serums, Moisturizers and Makeup

AM _____ PM _____
AM _____ PM _____
AM _____ PM _____
AM _____ PM _____
AM _____ PM _____
AM _____ PM _____

Cosmetic Procedure History (face/neck lifts, botox, fillers, lasers & any other cosmetic treatments along with the date & treating provider)

_____ _____
_____ _____
_____ _____

Where else do you obtain your cosmetic advice? _____

☐ Dermatologist ☐ Friend/Family ☐ Makeup Counter ☐ Magazines ☐ Internet

Are you interested in meeting with one of our cosmetic staff to create a personalized plan to meet your cosmetic needs? Yes ☐ No, thanks ☐

General appearance or products of interest to you (check any):

☐ Skin Care Advice	☐ Facial Lines / Wrinkles	☐ Brown spots	☐ Dermal Planing
☐ Skin Product Advice	☐ Blotchy Skin	☐ Birthmarks	☐ Acne
☐ Botulinum Toxin (BoTox)	☐ Laser Hair Reduction	☐ Body Shaping / Fat	☐ Cheekbones
☐ Scar Reduction	☐ Thin Lips	☐ Longer Eyelashes	☐ Eyelids
☐ Stretch Marks	☐ Facial veins / redness	☐ Leg Veins	☐ Cellulite
☐ Other _____		☐ Other _____	

_____
PATIENT SIGNATURE DATE

SWANN
DERMATOLOGY & ESTHETICS

FINANCIAL POLICY

Dr. Swann is pleased to participate in a large number of different insurance plans. It is our intent that you know your financial responsibility before your appointment. We will be happy to assist you in any way and answer any questions you may have regarding this policy. Our office accepts various forms of payment including cash, checks, credit cards and Care Credit. We do not offer in house payment plans but will refer you to Care Credit. In the event of non-payment you will be responsible for any collection and legal fees associated with the collection of the balance due. The collection fee is 25% of the total balance and will be added to the account if it is turned over to an outside agency.

Patient with insurance (not including Medicare)

Co-pays and deductible will be collected upon arrival. Your insurance carrier will tell us the amount of your unmet deductible to the best of their ability. Overpayments will be refunded after payment is received from the insurance company. Keep in mind that co-insurance amounts are the patient's responsibility and the patient will be billed after insurance payment is received.

- **HMO**: If your insurance company is an HMO and requires a physician-physician referral, please make sure that information has been obtained prior to your visit so your insurance company will cover the services.
- **Dual Coverage**: If you have dual insurance coverage we will file both insurances and any co-pays or deductibles not covered will be collected at the time of service.
- **In-network/Out-of-network**: It is the patient's responsibility to verify network status with your insurance company prior to your appointment. Any charges applied to your out-of-network benefits will be the patient's responsibility.

Patients without insurance (Self-Pay)

Full payment is due at the time of service. If this cannot be done, arrangement must be made prior to your visit by contacting our office. Please note, if you have a procedure, your specimen may be sent out for tissue processing which could prompt an additional bill from the laboratory/pathologist.

Medicare Payment Policy

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsibile for meeting their annual deductible and paying for the 20% co-insurance. We do file with secondary / supplemental carriers. However, in the event that the secondary does not pay the patient will be responsible for the remaining balance.

Cosmetic Prcedures

Payment for any cosmetic procedure is due, in full, at the time of service. Certain procedures require a prepayment to hold the appointment. Consultation fees and prepayments are kept as a deposit and will be applied to the patient's procedure with the doctor for a period not to exceed one year from the date of consultation.

I have read all of the above terms and hereby assume responsibility for paying any charges according to these terms.

_____ _____

Signature Date