



SWANN DERMATOLOGY PARTNERS

PATIENT HEALTH QUESTIONNAIRE

What is the primary reason for today's visit? (Chief Complaint) _____

Today's Date

Have you ever had a skin cancer? Yes No What type? _____ When? _____

Current medical conditions (check any) _____ Hepatitis _____ Leukemia _____ Cancer _____(type)
_____ Anxiety _____ Diabetes _____ Hypertension _____ Lymphoma _____ Seizures _____ Atrial Fibrillation
_____ Kidney Disease _____ HIV _____ AIDS _____ Radiation _____ Strokes

Past surgeries (check any & write year) _____ Gallbladder _____ Kidney _____ Skin: Basal Cell
_____ Appendix _____ Breast _____ Heart _____ Liver _____ Bladder _____ Skin: Squamous Cell _____ Colon
_____ Joint _____ Prostate _____ Melanoma

ADDITIONAL PAST SURGERY DETAILS

Skin History (check any) _____ Hay Fever/Allergies _____ Poison Ivy _____ Rosacea _____ Acne
_____ Bad Sunburns _____ Flaking Scalp _____ Atypical Moles _____ Wear Sunscreen _____ Dry Skin
_____ Psoriasis _____ Used Tanning Beds _____ Eczema _____ Actinic Keratoses _____ Other

ADDITIONAL SKIN HISTORY DETAILS

Family History of Melanoma? Yes No Which Relative? _____

Are you up to date on Flu vaccine? Yes No Pneumonia Vaccine? Yes No

Skin Medications: _____

ALL Medications: _____

Blood Thinners: Yes No (Circle) Aspirin/ Coumadin/ Plavix/Xarelto/Pradaxa/Eliquis/Vitamin E/Fish Oil/Garlic

Drug Allergies: _____

Smoker: _____ Never smoked _____ Former Smoker _____ Current Smoker _____ Packs per day

Alcohol use: _____ Yes _____ No _____ Amount

Reviews 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 _____ Pregnancy _____ Muscle Weakness _____ Organ Transplant _____ Immunosuppression _____
Pacemaker (year placed: _____) _____ Joint Replacement _____ Artificial heart valve

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



SWANN DERMATOLOGY PARTNERS

FINANCIAL POLICY

At Swann Dermatology we are 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, and credit cards and Care Credit. We do not offer in house payment plans but will refer you to Care Credit. Checks returned from the bank as non-sufficient will incur a \$20 non-sufficient funds fee. 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. Overpayment 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.

No Show Policy

We understand that you may sometimes need to reschedule appointments. We require 24 hours notice to cancel appointments or it will be considered a no-show.

Medicare Payment Policy

We are participating providers of the Medicare program. We will accept assignments on all claims. Patients are responsible 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 Procedures

Payment for any cosmetic procedures 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.

Signature

Date



SWANN DERMATOLOGY PARTNERS

Hulston Cancer Building
Garage Parking Available
3850 S National Ave
Ste 705
Springfield, MO 65807



Hollister Location
590 Birch Rd
Ste 2C
Hollister, MO 65672



SWANN DERMATOLOGY PARTNERS

3850 S. National Ave, # 705 • Springfield, MO 65807 • 417.888.0858 • (fax) 417.889.0476
590 Birch Rd Suite 2-C • Hollister, MO 65672 • 417.690.3858 • (fax) 417.690.3862

_____ **Consent to keep Insurance Authorization on File:**

Initial I authorize any holder of medical or other information about me to release 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 Partners providers.

_____ I authorize any holder of medical or other information about me to release to the

Initial Social Security Administration and Health Care Financing Administration or its intermediaries or carriers 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 apply. 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.

_____ **Payment Policy:**

Initial You are responsible for paying your annual deductible, copayment, and chargers for any non- covered or cosmetic services. We accept checks, credit cards, and CareCredit under these conditions. I have read and understand the office financial policy.



SWANN DERMATOLOGY PARTNERS

3850 S. National Ave, # 705 • Springfield, MO 65807 • 417.888.0858 • (fax) 417.889.0476
590 Birch Rd Suite 2-C • Hollister, MO 65672 • 417.690.3858 • (fax) 417.690.3862

_____ **Photographic Consent (optional):**

Initial I acknowledge that photographs may be taken as a part of documentation in my medical record. By initializing, I agree to the use of my photographs as a part of educational and marketing materials used by Swann Dermatology Partners.

_____ **Consent for Treatment:**

Initial I acknowledge Swann Dermatology Partners 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 healthcare providers. Some tissues and cultures are sent to outside laboratories. If your health 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.

_____ **Consent for Release of Information:**

Initial I authorize Swann Dermatology Partners 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 Partners 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.

Patient Name (please print)

Date

Patient Signature (or parent/guardian signature)

Date

