Medicare Patient Information

Legal Name: _____ _____

Last First Middle Initial Prefer to be called

Date of Birth: _____/_____/_____ Age: _____ Social Security #: _____ Sex: ☐ Male ☐ Female

Mailing Address:

_____

City State Zip

Home Phone: ( ) _____ ☐OK to leave detailed message

Work Phone: ( ) _____Ext: _____ ☐OK to leave detailed message

Other: ( ) _____ ☐OK to leave detailed message

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO.

YES NO

☐ ☐ Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?

☐ ☐ Are you covered by a HMO/PPO which makes Medicare secondary?

☐ ☐ Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)?

☐ ☐ Do you or your spouse work and have coverage through the insurance at your job?

☐ ☐ Are you eligible for any benefits under the Federal Black Lung Program?

☐ ☐ Are you coming to this office due to Medicare disability coverage?

☐ ☐ Are you covered by the Federal End Stage Renal Disease Program?

☐ ☐ Are you presently receiving Workers' Compensation?

☐ ☐ Is the illness or injury you are coming to this office for the result of work-related causes?

☐ ☐ Do you have medical assistance through Welfare or State-Aid?

If you answered YES to ANY of the above questions: _____

(Name of Company)

Policy Number: _____ Group Number: _____

Referring Physician: _____

Name of Spouse or Close Relative or Friend _____

(In Case of Emergency)

Phone #: ( ) _____

Name As It Appears On Your Medicare Card

_____

(Please Print)

Medicare Health Insurance Claim Number as it appears on your card

_____

(This is usually your social security number. Be sure to include the letter after the nine digit number. It is important that we have both number and letter.)

Please Sign So We May Have Your Medicare Authorization On File:

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 apply.

Date _____ Signature _____

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare. (MEDIGAP Coverage)

Name of Insurance Company _____

Policy Number _____ Group Number _____

Please Sign So We May Have Your Supplemental Authorization On File:

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.

Date _____ Signature _____

Crutchfield Dermatology

Patient Satisfaction Agreement and No-Show and Cancellation Policy

PLEASE PRINT PATIENT'S NAME **Date of Birth**

Patient Satisfaction Agreement

Dr. Charles Crutchfield III, MD and Crutchfield Dermatology, PA (collectively called "Crutchfield Dermatology") hold your satisfaction as our top priority. If at any time during your communication with our staff, your treatment by our medical professionals, or any service follow up you have a question, issue, or concern, we want to do everything possible to answer your questions or address your issues and concerns.

We also take pride in Crutchfield Dermatology's reputation for excellence and our great standing in the community, and we are committed to earning the positive reputation and maintaining that standing every day. As we agree to work as hard as we can to meet your satisfaction, you agree to report any question, issue, or concern you have related in any way to the care we have provided to our Satisfaction Director at (651) 209-3600 or at satisfactiondirector@crutchfielddermatology.com. You further agree to follow the following process ("Patient Satisfaction Agreement Procedures") prior to any disclosure of the matter by you to third parties.

First, you agree to provide Crutchfield Dermatology 30 days from the time you provide notice of your concern to our Satisfaction Director as described above for review and to address your matter. Second, Crutchfield Dermatology is a proud member of the Better Business Bureau. In the event we are unable to resolve a matter to your satisfaction within 30 days as described above, you agree to submit your concern to the Better Business Bureau for a determination regarding your concern. Finally, if you believe your concern remains inadequately addressed after these time periods and processes, you agree to provide Crutchfield Dermatology with a written copy of any communication you plan to disseminate regarding an unresolved issue prior to doing so. You also authorize the Clinic to verify the source of any such communication from you to ensure concerns and issues are properly reported to permit us to address such matters in the future. You further agree that a failure to follow the above policy entitles Crutchfield Dermatology to equitable relief.

No-Show and Cancellation Policy

Please understand that our appointment times are scheduled to allow us to take care of each individual patient's needs during the patient's visit. Since appointments with Crutchfield Dermatology are in high demand, we value advance notice from our patients who are unable to keep their scheduled appointments.

In an effort to decrease unnecessary costs and to contain our fees, we maintain a No Show/Cancellation Policy for all our patients. To promote efficient access to our clinic, we require that any appointment that is no longer needed or unable to be kept must be cancelled more than 24 hours in advance. Cancellations must be made between 8 a.m. and 5 p.m. on workdays at least one full business day before the scheduled appointment. Cancellations must be done over the telephone by speaking directly to one of our scheduling professionals, who will provide a cancellation number. Cancellations done by selecting a cancellation response on our automated appointment reminder system are also acceptable. Patients will not be charged for an office visit if cancellation is made 24 business hours before their appointment and a cancellation number is received.

In the event an appointment is missed or cancelled with less than 24 hours notice or no notice, a $75 charge will be billed. If a second no-show or same day cancellation occurs, we reserve the right to terminate the patient-doctor relationship. This policy is in effect for all appointments at our office, including clinical, laboratory, cosmetic, and phototherapy appointments. Again, all no-shows or same-day cancellations will be invoiced $75 if not cancelled with a 24 business hour notification with a received cancellation code.

Finally, we advise you to review this agreement with the counsel of your choosing and by signing this agreement you acknowledge that you have had an opportunity to review this agreement with counsel of your choice if you desire to do so. This agreement shall be valid and enforceable for five years from Crutchfield Dermatology's last date of service to you. Crutchfield Dermatology reserves the right to modify any policies without notice.

My signature below indicates that I have read and understand these policies.

X

Patient or Responsible Party Signature **Today's Date**

Crutchfield Dermatology

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Patient or Responsible Party Signature **Today's Date**

Patient History

Patient's Name_____ Date of Birth _____
* I prefer to be called_____ Today's Date_____

Reason/s for Today's Visit
1._____
2._____
3._____

Duration of Condition/s
_____
_____
_____

Past Medications Used For This Condition:
_____
_____
_____

Current Medications:
_____
_____
_____

Allergies:
- ☐ Adhesive Tape
- ☐ Latex
- ☐ Lidocaine/Novacaine
- ☐ Nickel
- ☐ Perfume
- ☐ Poison Ivy
- ☐ Sunlight

List Allergies to Medications:
_____
_____
_____

Past Medical History:
- ☐ Any Dermatologic Problems
- ☐ Arthritis Conditions
- ☐ Asthma
- ☐ Cardiac Diseases
- ☐ Diabetes
- ☐ Eczema
- ☐ Hypertension
- ☐ Lipid Disorders
- ☐ Musculoskeletal Problems
- ☐ Skin Cancer
- ☐ Thyroid Disorder
- ☐ Cancer
  Type_____
- ☐ Pacemaker/Implanted Device
  Other_____

Family History:
- ☐ Any Dermatologic
- ☐ Problems
- ☐ Skin Cancer

Social History:
Do you drink alcohol?
☐ Yes ☐ No
If yes, how often?
_____
Do you smoke?
☐ Yes ☐ No
If yes, how much per day?
_____

Female Patients Only:

Are you pregnant?	Are you breast feeding?	Have you had a hysterectomy?
☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

Medical History Review of Systems

Please check all that *currently* apply to you:

- ☐ Abdominal cramps
- ☐ Bruising
- ☐ Cold intolerance
- ☐ Depression
- ☐ Dizziness
- ☐ Dry lips
- ☐ Epigastric pain (stomach pain)
- ☐ Fatigue
- ☐ Cold or Flu-like symptoms
- ☐ Headaches
- ☐ Joint pain
- ☐ Nail changes
- ☐ Night sweats
- ☐ Pain
- ☐ Shortness of breath
- ☐ Sore throat
- ☐ Systemic Malignancy (Cancer)
- ☐ Yeast infections
- ☐ Breathing difficulties
- ☐ Chills
- ☐ Constipation
- ☐ Diarrhea
- ☐ Dry eyes
- ☐ Dry skin
- ☐ Extreme thirst
- ☐ Fever
- ☐ Hair loss
- ☐ Heat intolerance
- ☐ Muscle weakness
- ☐ Nausea
- ☐ Nose bleeds
- ☐ Pruritus (itchiness)
- ☐ Sleep problems
- ☐ Swollen lymph nodes
- ☐ Weight change

Cosmetic Interest Questionnaire

_____ _____

Patient's Name **Date of Birth**

Our practice is constantly striving to offer you the safest, most advanced procedures for facial rejuvenation and overall physical improvement. Please check any of the following health issues that you would like to receive more information on, or to schedule a consultation with Dr. Crutchfield:

- ☐ Forehead
- ☐ Lip Enhancement
- ☐ Frown Lines
- ☐ Crow's Feet
- ☐ Marionette Lines
- ☐ Sun spot/freckles
- ☐ Overall Skin Rejuvenation
- ☐ Medical skin care products/make up
- ☐ Treatment for unwanted facial lines
- ☐ Unwanted fat/cellulite
- ☐ Treatment for spider veins/facial veins
- ☐ Laser hair removal
- ☐ Excessive sweating: ☐ under arms ☐ hands ☐ feet
- ☐ Other/Specific treatments: _____

I would like to schedule a consultation with Dr. Crutchfield about:

_____

Would you like to receive information via email or USPS mail?

☐ Yes ☐ No

If **YES**, please list **email address:** _____

If **YES**, what **address** can we send it to? _____

_____

Request for Family Member to have Access to Protected Health Information

_____ _____
Patient's Name **Date of Birth**

I, _____
authorize Crutchfield Dermatology to disclose my Protected Health Information (PHI) including billing information, to the following family members:

	Name	Relationship
1.	_____	_____
2.	_____	_____
3.	_____	_____

I understand I may revoke this authorization by sending a written request for revocation to Crutchfield Dermatology. I understand that when Crutchfield Dermatology discloses this information pursuant to this authorization; the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

I understand and agree to the terms of this authorization:

X_____ _____
Patient or Responsible Party Signature **Today's Date**