PATIENT HISTORY

Patient's Name ____ Date of Birth ______/______/______

*I prefer to be called ____ Today's Date ______/______/______

Reason/s for Today's Visit	Duration of Condition/s
1. ______________________________	______________________________
2. ______________________________	______________________________
3. ______________________________	______________________________

Past Medication Used for this Condition: ____

Current Medications: ____

Allergies:

[] Adhesive Tape [] Latex [] Lidocaine/Novacaine []Nickel []Perfume [] Poison Ivy [] Sunlight

Please 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 [] Adopted

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? [] Yes [] No Are you breast feeding? [] Yes [] No Have you had a hysterectomy? [] Yes [] No

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(PATIENT HISTORY CONTINUED ON NEXT PAGE)

PATIENT HISTORY (PAGE 2)

Circle all that apply:

- Abdominal Cramps
-
- Breathing Difficulties
- Bruising
-
- Chills
- Cold Intolerance
- Constipation
-
- Depression
- Diarrhea
- Dizziness
- Dry Eyes
- Dry Lips
- Dry Skin
-
- Epigastric pain (stomach pain)
- Extreme Thirst
-
- Fatigue
- Fever
-
- Cold or Flu-like symptoms
-
- Hair loss
- Headaches
- Heat Intolerance
-
- Joint Pain
-
- Muscle Weakness
-
- Nausea
- Night Sweats
- Nail Changes
- Nose Bleeds
-
- Pain
- Pruritus(itchiness)
-
- Shortness of Breath
- Sleep Problems
- Sore Throat
- Swollen Lymph Nodes
- Systematic Malignancy (Cancer)
-
- Weight Change
-
- Yeast Infections

PATIENT INFORMATION ☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS: **Today's Date ______/______/______**

Legal Name: ____ ________________
Last First Middle Initial Prefer to be Called

Date of Birth: ________________ Age: ________ Social Security #: ___________________ Sex: ☐ Male ☐ Female

Mailing Address:

____
Street Address City State Zip

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

As a service to our patients, we provide courtesy appointment reminders and other important communication through a pre-recorded message, text message, or email. By providing the below telephone numbers and email address, you consent to receiving such communication from your healthcare provider. You may opt out of receiving some or all of these communications by notifying the clinic in writing at any time or replying "Stop" to the automated system.

Home Phone: ( )__________________________ ☐ DO NOT leave detailed medical message

Cell Phone: ( )__________________________ ☐ DO NOT send text reminders

Work Phone: ( )__________________________ ☐ DO NOT leave detailed medical message

Primary E-mail Address: ____ ☐ DO NOT send email reminders

Patient's Occupation:____

State and federal law requires we ask the following questions:

Primary Language (circle one):	Race (circle one):	Ethnicity (circle one):
English	Caucasian	Hispanic or Latino
Spanish	Hispanic	Not Hispanic or Latino
Somali	Asian	
Other (please specify) ______________	African American	Other (please specify) __________

RESPONSIBLE PARTY (*if different from patient*)

Name:____
Last First Middle Initial

Address: ____
City State Zip

Home Phone: ( ) _________________________ Work Phone: ( ) __________________________

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

X____ ______/______/______
Patient or Responsible Party Signature **Today's Date**

INSURANCE COVERAGE

INSURANCE COVERAGE – PRIMARY

Insurance Co. Name: ________________________ Phone: (   ) ______________ Ext: ______

Address of Claim Center:____
City State Zip

Name Policy Holder (Insured): ______________________________ Date of Birth: _____/_____/_____

Policy #: ______________________ Group Name or #: ______________________

Policy Type: ☐ HMO ☐ PPO Employer Name: ______________________________

Employer Address: ____

If patient is a child, check relationship: ☐Mother ☐Father ☐ Other ________________________

INSURANCE COVERAGE - SECONDARY

Insurance Co. Name: ________________________ Phone: (   ) ______________ Ext: ______

Address of Claim Center: ____
City State Zip

Name Policy Holder (Insured): ______________________________Date of Birth: _____/_____/_____

Policy #: ______________________ Group Name or #: ______________________

Policy Type: ☐ HMO ☐ PPO Employer Name: ______________________________

Employer Address: ____

If patient is a child, check relationship: ☐Mother ☐Father ☐ Other ________________________

REFERRED BY:____

X______________________________ ______/______/______
Patient or Responsible Party Signature **Today's Date**

REFERRAL INFORMATION, PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: ____ Today's Date: ______/______/______

Other family members that are patient's ____

Primary Care Physician (Dr. Name and Clinic): ____

In case of Emergency, who should be notified? ______________________________ Phone: ( ) _____________

Please be advised: Charles E. Crutchfield III, MD is a Clinical Professor of Dermatology at the University of Minnesota. Often times, he will have a physician or student physician following him.

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature: _____________________________________ Date: ______/______/______

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $100.00 deductible and paying for the 20% co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed the remaining balance.

Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

HMO, PPO or other managed care patients and all other patients: **You will be responsible for paying your annual deductible, co-payment and charges for any non-covered cosmetic/medical services.**

Commercial Patients: **Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay 35 % of the total bill at the time of the service. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.**

Minor Children: **The parent or guardian bringing the child to the office for their visit is responsible for payment independent of what a divorce doctrine may state. Reimbursement must be made between divorced parents. We will not intervene.**

Patient or Responsible Party Signature: ____ Date: ______/______/______

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers of Medicare and Medicaid Services 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.

Signature as it appears on Medicare Card ____ Date ______/______/______

If you have a supplemental policy and it is a **MEDIGAP** policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature 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.

Signature as it appears on MEDIGAP Card ____ Date ______/______/______

AUTHORIZATION 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 all medical and billing information, to the following family members:

Name	Relationship
1. ____	____________________________________
2. ____	____________________________________
3. ____	____________________________________

I understand that this authorization remains valid for one year from today's date. 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.

I understand and agree to the terms of this authorization:

X__________________________________ ______/______/______

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

HIPPA – ACKNOWLEDGEMENT OF RECEIPT – See "Notice of Privacy Practices"

____ ______/______/______

Patient's Name Date of Birth

My signature below indicates that I have been provided with a copy of the Notice of Privacy Practices.

X____ ______/______/______

Patient or Responsible Party Signature Today's Date

PATIENT SATISFACTION AGREEMENT, NO-SHOW POLICY, AND CANCELLATION POLICY

____ ______/______/______

Patient's Name (PLEASE PRINT) 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 take pride in Crutchfield Dermatology's reputation for excellence and standing in the community and are committed to 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 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 and to follow the "Patient Satisfaction Agreement Procedures" outlined below prior to any disclosure of the matter by you to third parties.

First, you agree to provide Crutchfield Dermatology 30 days from communicating your concern to our Satisfaction Director to review and address your matter. Second, Crutchfield Dermatology is a proud member of the Better Business Bureau. If 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 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 authorize the Clinic to verify the source of any communication from you to ensure your authorship and to permit us to address such matters in the future. You further agree that failure to follow this policy entitles Crutchfield Dermatology to equitable relief.

No-Show and Cancellation Policy

Our appointment times are scheduled to address each individual patient's needs. Since appointments with Crutchfield Dermatology are in high demand, we value advance notice from patients unable to keep their scheduled appointments.

To maximize patient access and decrease unnecessary costs, we maintain a No Show/Cancellation Policy for all our patients that requires any appointment that is no longer needed or unable to be kept 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 appointment. Cancellations must be made over the telephone by speaking directly to one of our scheduling professionals. 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 at least 24 business hours before their appointment. If you cancel an appointment with more than a 24 hours' notice on a business day, you will receive a cancellation number which is necessary to verify that you provided proper notification.

In the event an appointment is missed or cancelled with less than 24 hours' notice as described above ("missed appointment"), a $75.00 charge will be billed directly to the patient. In addition to the charge for each missed appointment, Crutchfield Dermatology reserves the right to terminate the patient-doctor relationship if a patient has two or more missed appointments. This policy is in effect for all appointments at our office, including clinical, laboratory, cosmetic, and phototherapy appointments. To secure a future appointment, you must provide a valid credit-card number to be maintained in your file. By signing below, you authorize a $75.00 charge for each missed appointment. This authorization may be withdrawn by you at any time by providing Crutchfield Dermatology notice of the withdrawal in writing. Please note that withdrawal of authorization will result in the cancellation of any future scheduled appointments.

Finally, we advise you to review this agreement with the legal counsel of your choosing. By signing this agreement you acknowledge that you have had an opportunity to review this agreement with the 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**

PERSONAL NOTE FOR YOU FROM CRUTCHFIELD DERMATOLOGY AND WAIT TIMES

Dr. Crutchfield loves to help patients with all their skin care needs. The high demand for dermatology care and Crutchfield Dermatology's commitment to addressing each patient's needs may lead to longer than anticipated wait times. Please note you may experience a delay in being seen by Dr. Crutchfield and should allow ample time when scheduling with us to avoid conflicts if an appointment runs long.

If you believe the best care is worth a little flexibility, we promise to do all we can to get you the best quality care as timely as possible.

We could not be more honored to have you here!

Sincerely,
Charles E. Crutchfield III, M.D.
And the entire staff of Crutchfield Dermatology