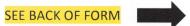
## NEBRASKA DERMATOLOGY LLC

DATE:			
PATIENT FIRST NAME:	LAST: _	MI:	BIRTH DATE:
PREFERRED NAME:	BIRTH SEX: M F GENDER IDENTITY:		
AGE:	MARITAL STATUS	: SINGLE_MARRIED_ WIE	DOWED_ DIVORCED_ SEPARATED_
RACE/ETHNICITY:	PRIMA	RY LANGUAGE:	
EMAIL:			
ADDRESS:			
CITY:	STATE:	ZIP CODE:	
HOME PHONE #:		CELL PHONE #:	
WORK PHONE #:		EMPLOYER:	
IS IT OKAY TO LEAVE A DETAILED ME	SSAGE: YES NO	PREFERRED PHONE #	: HOME CELL WORK
IF PATIENT IS A MINOR, PARENT/LEG	AL GUARDIAN NAME:		BIRTH DATE:
RELATIONSHIP TO PATIENT:	PHONE	#:	
ADDRESS:	APT #:	_ CITY:	_STATE: ZIP CODE:
INSURANCE NAME:		MPLOYER:	
POLICY HOLDER NAME:			
POLICY HOLDER NAME:			
PATIENT'S RELATIONSHIP TO POLICY			
	SECONDARY INSURAN		
INSURANCE NAME:			
POLICY #:			
POLICY HOLDER NAME:			
PATIENT'S RELATIONSHIP TO POLICY	HOLDER:		
	<b>EMERGENCY</b>	CONTACT	
NAME:	RELATIONSHIP: _		PHONE #:
THE FOLLOWING PEOPLE (FAMILY	MEDICAL INFORMA		ES AND/OR MEDICAL DECORDS.
NAME:			
NAME:			
		FFIC	JINLπ.



## **POLICIES**

#### Payment:

Know that your copay and/or patient self-pay balance is due at the time of service. As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefit of your medical insurance coverage. We ask that you read and understand your insurance policy to be aware of coverage benefits and limitations. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. Ultimately, you are responsible for knowing and understanding your coverage. It is your responsibility to provide current or updated insurance information to our office at the time of service. Any balance left after insurance benefits have been paid is the responsibility of the patient, I.E., copay, co-insurance, and/or deductible.

#### **Consent for Medical Treatment and Minor Procedures:**

I understand that:

- During the course of my visit, my provider may recommend that a procedure be performed. Such procedures are not limited to but include: liquid nitrogen destruction (freezing), biopsies, shave removals, excisions, incision and drainage, scissor snip excision, curettage (scraping), electrodessication (use of cautery/heat), and steroid injections.
- The risks, benefits, and alternatives to these procedures will be explained to me at the time of my visit, prior to my provider performing the procedure(s).
- I will be allowed to ask any questions that I have.
- Any and all procedures are optional. I may choose to decline a procedure for any reason.
- There is no guarantee of results; as medicine is not an exact science.
- Some procedures may need to be performed more than once to achieve optimal results.
- Procedures may incur additional charges and I will be responsible for payment.
- If a procedure is deemed cosmetic, and therefore not covered by my insurance, I will be responsible for payment.
- For more invasive procedures and certain cosmetic procedures, a separate consent may be required.
- If I have a biopsy done, the specimen will be sent out of the office for pathologic evaluation and I will be billed for any amount not covered by my insurance.

#### **Assignment and Release**

I authorize payments to be made directly to Nebraska Dermatology LLC by my insurance company. I authorize the release of any demographic and medical information requested by my insurance company in order to pay on the claim. I accept financial responsibility for all services not covered by my insurance. I have read "Consent for Medical Treatment and Minor Procedures" and I consent to routine minor procedures and medical treatment.

#### **Acknowledgment of Receipt of Notice of Privacy Practices**

I acknowledge that I have read the Nebraska Dermatology LLC assignment and Release statement, as well as the Notice of Privacy Practices. These statements describe how my health information may be used or disclosed in order to receive benefits. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the clinic location where I receive health care services as well as on their website.

By signing below, I am (i) providing my express consent to medical treatment and minor procedures, (ii) acknowledging the terms of the Nebraska Dermatology LLC Assignment and Release statement, as well as the Notice of Privacy Practices, and (iii) agreeing to the policies contained in this document.

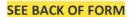
Signature of Patient or Parent/Legal Guardian	Date	
Patient Legal Name (Please Print)	Parent/Legal Guardian Name (Please Print)	Relationship to Patient

# NEBRASKA DERMATOLOGY LLC

## PATIENT DEMOGRAPHICS

Patient Name:		Date of Birth:			
Preferred Pharmacy: Family Physician:		Pharmacy Location:			
		Referring Physician:			
MEDICAL HISTOR  NONE Anxiety Arthritis	Y  □ Cerebrovascular accident (stroke) □ Colon Cancer	□ End-Stage Disease □ Epilepsy	Renal	<ul><li>□ High Cholesterol</li><li>□ Hyperthyroidism</li><li>□ Hypothyroidism</li></ul>	<ul><li>□ Lymphoma</li><li>□ Prostate Cancer</li><li>□ Radiation Treatmen</li></ul>
<ul><li>□ Asthma</li><li>□ Atrial fibrillation</li><li>□ Benign prostatic</li><li>hyperplasia</li><li>□ Breast Cancer</li></ul>	<ul> <li>□ COPD</li> <li>□ Coronary Artery</li> <li>Disease</li> <li>□ Covid-19</li> <li>□ Depression</li> <li>□ Diabetes</li> </ul>	□ GERD (acid reflux) □ Hay Fever □ Hearing Loss □ High Blood Pressure □ HIV/AIDS		□ Inflammatory disease of liver □ Leukemia □ Lung Cancer	☐ Transplantation of bone marrow ☐ Other
PAST SURGICAL F  NONE Adenoids: Adenoidect Appendix (appendecte Bladder (cystectomy - Breast: Biopsy Breast: Lumpectomy (Bereast: Mastectomy (Bereast: Mastectomy (Bereast: Mastectomy) Colon: (colectomy) Colon: Colostomy (sure Gallbladder (cholecyster) Heart: Coronary Arterered Heart: Heart Transplant Heart: Mechanical value Heart: PTCA (angiopla Heart: Tissue graft value Joint Replacement: Kine Kidney: Biopsy Kidney: Stone Removale Kidney: Transplant	omy omy) - surgical removal of bladde both) (left) (right) ooth) (left) (right)  gical removal of colon) rectomy) y Bypass nt ve replacement sty) ve replacement p (both) (left) (right) nee (both) (left) (right)	er)	□ Liver: S □ Ovarie □ Pancre □ Prosta □ Prosta □ Rectun □ Skin: B □ Skin: S □ Skin: S □ Spleen □ Total o □ Tonsils □ Tubal l □ Uterus	Fransplant Shunt Shunt Schunt Schunt Schunt Schunt Schunt Schunt Schunceatectomy Sche: Biopsy Sche: Transurethral Resection (School School Sch	

□ Liver: Hepatectomy





## SKIN CONDITIONS

<ul> <li>NONE</li> <li>Acne</li> <li>Actinic Keratosis (Pre-Skin Cancer)</li> <li>Asteatosis cutis (dry skin)</li> <li>Basal Cell Carcinoma</li> </ul>	<ul> <li>Blistering Sunburns</li> <li>Contact dermatitis due to Poison Ivy</li> <li>Eczema</li> <li>Malignant Melanoma</li> <li>Pre-cancerous Moles</li> </ul>	<ul> <li>Pruritus of Scalp (Itchy scalp)</li> <li>Psoriasis</li> <li>Squamous Cell Carcinoma</li> <li>Other</li> </ul>			
Do you wear sunscreen? ☐ Yes ☐ No	If yes, what SPF?				
Do you tan in a tanning salon?               Yes	□ No				
Family history of melanoma?   Yes   I	No If yes, which relative(s)?	_			
MEDICATIONS					
MEDICATION NAME	DOSAGE	FREQUENCY			
Total Section (Section Section					
	200 A 400 A				
29.00 mg					
		60 12 70 2 19 19 19 19 19 19 19 19 19 19 19 19 19			
		3. 33			
DRUG ALLERGIES:					
HEIGHT:					
WEIGHT:					
VACCINATION STATUS FOR PATIE	NTS AGES 9-13:				
Meningococcal vaccine between the ages of 11-13					
Tdap vaccine between the ages of 10-13 _					
Two-three HPV vaccines between the ages	s of 9-13				
Did the patient not receive any of the vacc	cinations above because of a medical reason o	or allergy?			
SOCIAL HISTORY					
Tobacco product use:  □ Never smoked  □ Occasional smoker (tobacco)	□ Former smoker - Date you quit: □ Occasional smoker (cigarettes/vapor)	□ Cigar smoker			

### **Medicare One Time Authorization**

**Instructions:** This form must be signed and stored in the chart of every patient who has Medicare coverage. Once this form is signed, it does not need to be updated.

I request that payment of authorized Medicare benefits be made either to me or on my behalf to the rendering provider of Nebraska Dermatology, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable for related services.

I request that payment of authorized Medigap benefits be made either to me or on my behalf to the rendering provider of Nebraska Dermatology, LLC for any services furnished to me by that provider. I authorize any holder of medical information about me to release to my insurance company any information needed to determine those benefits or the benefits payable for related services.

This authorization applies to all services until it is revoked by me or my representative.

By signing below, I am (i) authorizing medical information about me to be released to the Center for Medicare & Medicaid Services and its agents and (ii) authorizing medical information about me to be released to my Medigap insurance carrier to determine benefits payable for related services received.

Signature of Patient or Legal Guardian	Date of birth	Date	
Patient Legal Name (Printed)	Legal Guardian Name (Printed)	Relationship to Patient	