PATIENT DEMOGRAPHICS

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
Board-Certified Dermatologist

PATIENT

Full Name ______________________ Marital Status ______________________

Social Security Number ______________________ Employment Status ______________________

Date of Birth __________ Gender __________ Referral Source ______________________

CONTACT

Address ______________________ Home Phone ______________________

City __________ State __________ ZIP __________ Work Phone ______________________

E-Mail ______________________ Mobile Phone ______________________

Primary Care Physician ______________________ Emergency Contact ______________________

Referring Physician ______________________ Emergency Phone ______________________

GUARANTOR / FINANCIAL RESPONSIBILITY (ONLY FOR MINORS, LEGAL GUARDIANS, OR POWER OF ATTORNEY)

Guarantor Name ______________________ Address ______________________

Relationship ______________________ City __________ State __________ ZIP __________

Phone __________ E-Mail __________ DOB __________

E-MAIL LIST SIGN-UP:

☐ Cosmetic Specials ☐ Flash Sales ☐ Compensated Clinical Trials ☐ Newsletter

FINANCIALS

Self-Pay: ☐ Yes ☐ No

Primary Insurance Company ______________________ Relationship to Policy Holder ______________________

Primary Policy Number ______________________ Policy Holder Name ______________________

Primary Policy Group ______________________ Address ______________________

Policy Holder DOB __________ Gender__________ City __________ State __________ ZIP __________

Secondary Insurance Company ______________________ Relationship to Policy Holder ______________________

Secondary Policy Number ______________________ Policy Holder Name ______________________

Secondary Policy Group ______________________ Address ______________________

Policy Holder DOB __________ Gender__________ City __________ State __________ ZIP __________

RELEASE OF MEDICAL RECORDS

I authorize Westgate Skin & Cancer to release my medical records to: ☐ Emergency Contact ☐ Guarantor ☐ Other

Other Contact Name ______________________ Relationship __________ Phone __________

SIGNATURE

I understand that my signature below confirms that the information on this form is accurate and complete to the best of knowledge.

______________________ ______________________

Patient, Guardian, or Responsible Individual Signature Date Signed

FEBRUARY 2022
PATIENT FINANCIAL POLICY AGREEMENT

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
Board-Certified Dermatologists

Thank you for choosing Westgate Skin & Cancer for your Dermatology needs. We aim to deliver outstanding and transparent service. It is important that patients understand their rights and responsibilities. Herein, "Westgate Skin & Cancer, PLLC" will be known as "the Practice."

PLEASE REVIEW AND INITIAL EACH POLICY

______ **Scheduling Policy:** The Practice requires a Credit Card on File (CCOF) or an on-account deposit to hold appointments. The Practice securely stores and encrypts card information, and once stored, card information cannot be retrieved.

Select One (Required)

☐ **CCOF**: I understand, consent, and authorize Westgate Skin & Cancer to securely store my card on file and charge my card for any cancellation or rescheduling fees, telemed visits, or release of record requests.

☐ **Deposit**: I understand, consent, and authorize Westgate Skin & Cancer to keep a $50 deposit for consults or a $200 deposit for advanced procedures.

Select One (Optional)

Auto Bill: I do not want to receive a paper statement. You may automatically charge the card on file for any balance under:

☐ **$100** ☐ **$300** ☐ **$1,000** ☐ **All**

______ **Statement of Financial Responsibility and Authorization to Treat:** I understand and consent that, except as defined by my health insurance, I am financially responsible for any and all charges for services rendered by the Practice. I understand that I have the right to call my insurance before care is received if I have questions. I understand that I have the right to refuse treatment for any reason including the inability to fulfill financial obligations. I authorize medical treatment and procedures to be performed on myself, or the patient listed below, at the discretion of the Practice's providers and staff.

______ **In-Network Insurance Claims, Assignment, and Estimates:** I understand that the Practice will bill all provided in-network insurance policies for medically necessary services rendered. I understand and consent to the release of information to my insurance company regarding my treatment at the Practice. I authorize assignment of insurance payments to be made directly to the Practice for all insurance benefits. I understand that the Practice will verify my eligibility and benefits with my insurance company, but verification of benefits is not a guarantee of payment or coverage.

I consent to pay at the time of service for:
- Co-Pay estimates
- Deductible estimates
- Co-Insurance estimates
- Any other estimated out-of-pocket costs

I understand that I will be billed if:
- My insurance company pays less than what is estimated
- My insurance company denies my claim
- My insurance company does not pay within 90 days
- My insurance company recoups payment or benefits at a later date

______ **Self-Pay Patients and or Out-of-Network Insurance Claims:** I understand that payment is due in full at the time of service. If I pay by cash, it is my responsibility to ensure that I receive a receipt for payment. I understand that elective services or packages must be purchased in full at the time of my visit and past services or procedures will not apply to the package. Packages expire 1 year from the date of purchase. I understand that I am responsible for filing out-of-network insurance claims and any insurance benefits are between myself (the patient) and my insurance company.

______ **Practice Fees:** I understand and consent to pay the following fees that are not covered by my insurance. All appointments must be cancelled or rescheduled 24 business hours in advance.
- **No-Show Fee** – $50 for all medical consults, cosmetic consults, basic medical procedures, and basic cosmetic procedures
- **No-Show Procedure Fee** – $200 for all advanced procedures including fillers, surgeries, area laser treatments, and sclerotherapy
- **Returned Check Fee** – $50 in addition to any outstanding balance if my check is returned for any reason
- **Delinquent Account Fee** – I will pay my past due balance and an additional 34% service fee if my account is sent to collections
- **Re-Instatement Fee** – $200 if I am dismissed from the practice, and upon approval from the medical director, reinstate my care
- **Release-of-Records Service Fee** – $25 for the first 500 pages, $50 for over 500 pages for any request received with my signature

______ **Pathology and Lab Fees:** I understand and consent to be billed by an outside lab for services rendered. I understand that certain procedures, such as biopsies or cultures, require pathology and or lab services. I will make financial arrangements directly with these organizations. Fees may range between $100 to $400 per sample/specimen and determination of fees may not be possible until after orders are processed.

______ **Product Purchases:** I understand that the Practice has partnered with Dermly for all product purchases and product fulfillment. All product purchases are final, and should an issue arise with the product itself, the item can exchanged for similar/like products. Additional terms and conditions are available at dermly.com/terms

SIGNATURE

I understand that my signature below confirms that I have read, understand, and consent to Westgate Skin & Cancer's Financial Policies.

______________________________	______________________________	______________
Patient, Guardian, or Responsible Individual Signature	Patient Name	Date Signed

WESTGATE SKIN & CANCER

PATIENT MEDICAL HISTORY

Blakely Richardson, DO, FAAD
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Board-Certified Dermatologist

PAST MEDICAL HISTORY

Check any medical conditions that you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Irregular Heartbeat
- ☐ Bone Marrow Transplant
- ☐ BPH
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV / AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke

If other, what conditions? ☐ **None**

☐ **By Checking, I confirm this section is accurate**

____

____

List any surgeries that you have ever had:

- ☐ Appendix (Appendectomy)
- ☐ Bladder (Cystectomy)
- ☐ Breast: Biopsy
- ☐ Breast: Lumpectomy (Both)
- ☐ Breast: Lumpectomy (Left)
- ☐ Breast: Lumpectomy (Right)
- ☐ Breast: Mastectomy (Both)
- ☐ Breast: Mastectomy (Left)
- ☐ Breast: Mastectomy (Right)
- ☐ Colon: Colon Cancer Resection
- ☐ Colon: Diverticulitis
- ☐ Colon: Inflammatory Bowel Dis
- ☐ Colon: Colostomy
- ☐ Gallbladder (Cholecystectomy)
- ☐ Heart: Biological Valve Replac
- ☐ Heart: Coronary Bypass
- ☐ Heart: Transplant
- ☐ Heart: Mechanical Valve Repl.
- ☐ Heart: PTCA
- ☐ Joint Replacement: Hip (Both)
- ☐ Joint Replacement: Hip (Left)
- ☐ Joint Replacement: Hip (Right)
- ☐ Joint Replacement: Knee (Both)
- ☐ Joint Replacement: Knee (Left)
- ☐ Joint Replacement: Knee (Left)
- ☐ Kidney: Biopsy
- ☐ Kidney: Stone Removal
- ☐ Kidney: Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: Endometriosis
- ☐ Ovaries: Cancer
- ☐ Ovaries: Cyst
- ☐ Ovaries: Tubal Ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate: Biopsy
- ☐ Prostate: Prostatectomy
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Rectum: Anterior Resection
- ☐ Skin: Basal Cell Carcinoma
- ☐ Skin: Melanoma
- ☐ Skin: Biopsy
- ☐ Skin: Squamous Cell Carcin.
- ☐ Spleen (Splenectomy)
- ☐ Testicles (Orchiectomy)
- ☐ Hysterectomy: Fibroids
- ☐ Hysterectomy: Uterine Cancer
- ☐ Hysterectomy: Cervical Cancer
- ☐ **None**

If other, what surgeries?

____

SKIN DISEASE HISTORY

Check any skin conditions that you have ever had:

- ☐ Acne
- ☐ Actinic keratoses
- ☐ Asthma
- ☐ Basal cell skin cancer
- ☐ Blistering sunburns
- ☐ Dry skin
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Hay fever / allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Squamous cell skin cancer

If other, what skin diseases? ☐ **None**

____

____

Do you wear sunscreen? ☐ Yes ☐ No
If yes, what SFP? __________
Do you tan in a tanning salon? ☐ Yes ☐ No
Do you have a family history of Melanoma? ☐ Yes ☐ No

If yes, who? ______________________________

MEDICATIONS

Are you taking any medications? ☐ Yes ☐ No
If yes, what medications? If you have a list, please provide it.

____

____

____

DRUG ALLERGIES

Do you have drug allergies or reactions? ☐ Yes ☐ No
If yes, what medications? If you have a list, please provide it.

____

____

SOCIAL HISTORY

Check your Smoking Status:

☐ Everyday ☐ Some days ☐ Former Smoker ☐ Never

Check all Social History Details that Currently Apply:

- ☐ Not sexually active
- ☐ 1 Sexual Partner
- ☐ Multiple Sexual Partners
- ☐ Same Sex Partner
- ☐ Drug Use
- ☐ No Alcohol Consumption
- ☐ Less than 1 drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day
- ☐ IV Drug use

FAMILY HISTORY

Check any conditions that run in your family.
First degree relatives only (mother, brother, sister etc.)

- ☐ Arthritis Who? __________
- ☐ Asthma Who? __________
- ☐ Psoriasis Who? __________
- ☐ Cancer Who? __________
- ☐ Skin Cancer Who? __________

If yes, what type of skin cancer? __________
If there is additional family history, what conditions and family which family members?

____

CONTACT INFORMATION

OK to leave a Detailed Voicemail? ☐ Yes ☐ No

PHARMACY

Provide the name and intersection or address:
If you don't have a pharmacy or want to support local businesses, we suggest Victory Medical across from Target.

____

PRACTICE INFORMATION

Do you have a primary care physician? ☐ Yes ☐ No
If yes, who is the physician?

____

Were you referred by a Physician? ☐ Yes ☐ No
If yes, who was the physician, PA, or nurse?

____

EDUCATE YOURSELF

Check any areas of interest:
Our practice offers expert cosmetic advice and outstanding aesthetic services by utilizing the latest procedures. Please take a moment to check anything that interests you:

- ☐ Botox Cosmetic
- ☐ Lip Enhancements
- ☐ Neck Rejuvenation
- ☐ Scar Reduction
- ☐ Red/Brown Spots
- ☐ Anti-Aging
- ☐ Chemical Peels
- ☐ Fat Reduction
- ☐ Fillers
- ☐ Facial Redness
- ☐ Neck/Chin Tightening
- ☐ Acne Scarring
- ☐ Sun Damage
- ☐ Spider Vein Treatments
- ☐ Laser Services
- ☐ Skin Elasticity

If other, what cosmetic or aesthetic services interest you?

____

REVIEW OF SYSTEMS

Check any situations that apply:

- ☐ Changing Moles/Lesions
- ☐ Itchiness
- ☐ Rash
- ☐ Extreme Fatigue
- ☐ Unintentional Weight Loss
- ☐ Problems with Bleeding
- ☐ Swollen Glands/Lymph Nodes
- ☐ Numbness/Tingling
- ☐ Cough
- ☐ Abdominal Pain
- ☐ Diarrhea
- ☐ Frequent Urination
- ☐ Muscle Weakness
- ☐ Allergy to Adhesive
- ☐ Allergy to Topical Antibiotic
- ☐ Pacemaker/Defibrillator
- ☐ Bone Marrow Transplant
- ☐ Blood Thinner /Daily Aspirin
- ☐ Immunosuppression
- ☐ MRSA (Resistant Staph)
- ☐ Accutane in the 6 months
- ☐ Hair Loss
- ☐ Problems with Scarring
- ☐ Blood Clots
- ☐ Fever/Chills
- ☐ Night Sweats
- ☐ Headaches
- ☐ Insomnia
- ☐ Excessive Thirst
- ☐ Shortness of Breath
- ☐ Bloody Stool
- ☐ Difficulty Swallowing
- ☐ Joint Aches
- ☐ Chest Pain
- ☐ Allergy to Lidocaine
- ☐ Artificial Heart Valve
- ☐ Pregnant or Planning
- ☐ Stomach Ulcers
- ☐ Organ Transplant
- ☐ Hepatitis B or C
- ☐ HIV/AIDS

SIGNATURE

I understand that my signature below confirms that the information on this form is accurate and complete to the best of knowledge.

Patient, Guardian, or Responsible Individual Signature	Patient Name	Patient DOB	Date Signed

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES AND OFFICE POLICIES

Blakely Richardson, DO, FAAD
Sital Patel, DO, FAAD
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PLEASE REVIEW AND INITIAL EACH SECTION

_______ **Receipt of Practice's Policies Acknowledgement:** I understand and acknowledge that I have been given the opportunity to read the Practice's policies. This includes the Notice of Privacy Practices, Financial Policies, and Office Policies. I have the right to request a copy of these documents in office or I can acquire them by visiting www.westgateskin.com.

- **Notice of Privacy Practices** – Your rights under HIPAA and how the Practice follows HIPAA law.
- **Financial Policies** – Your Financial Responsibilities and how the Practice addresses financial matters.
- **Office Policies** – General office policies and how the Practice handles care

_______ **Contact and Communications Consent:** I understand and acknowledge that I have been given the opportunity to confirm my communication rights under HIPAA. In the event the practice needs to communicate my information that is protected under HIPAA, I confirm that it is permissible to:

☐ Speak to a spouse or trusted person about my information. **Name**: ______________________________

☐ Speak to an additional trusted person about my information. **Name**: ______________________________

☐ Leave a message on a voicemail system that includes my information. **Number**: ______________________

☐ **Dr. Epstein Patients:** Gather, digitize, and organize my medical records that you may already have.

_______ **Insecure, Timely, and Limited Communication Acknowledgement:** I understand and acknowledge that e-mail, text, and some phone conversations are considered insecure under HIPAA privacy laws. The Practice cannot secure in-bound communications that I initiate. I understand and acknowledge that priority or emergency communications must be made via voice phone call and that any other form of communication may take several business days before being received. Additionally, I understand that if I release my information or make public commentary, in most cases, no response will be provided since HIPAA law prohibits the Practice from acknowledging patients in a public forum.

_______ **Contact Method and Entity Acknowledgment:** I understand and acknowledge that my address, phone number, and or e-mail may be used as contact methods for the purposes of clinical care and or informative information. I understand that I may be contacted based on my selected contact interests at any point in the future by our Providers, the Practice, and or associated clinical parties (labs, referrals, etc.) as per HIPAA guidelines and HIPAA privacy protections.

_______ **Photography, Videography, and Recording Devices Privacy Acknowledgement:** I understand and acknowledge that any photos or videos taken by the Practice are protected under HIPAA law. Some procedures, such as cosmetic and or elective procedures, require photos per office policy in order to provide care. The release of videos or photos by the Practice requires my written consent. The use of personal photography, videography, and or recording devices by patients is forbidden. I understand and acknowledge that the use of these devices and or in conjunction with social media puts other patients' privacy at risk and may lead to a breach of privacy under HIPAA law. The Practice, its facilities, and its staff do not consent to being captured or recorded by any photography, videography, and or recording devices under any circumstances unless written approval by the practice manager is obtained in advance.

_______ **Telemedicine Acknowledgement:** I understand and acknowledge that the Practice provides telemedicine in accordance with HIPAA guidelines should I choose to schedule a telemedicine appointment. Telemedicine has been found to be effective in treating many disorders and conditions, however; there is no guarantee that treatments will be effective due to inherit limitations in video technology and the inability to perform physical procedures such as, but not limited to, injections, destructions, and biopsies etc.

_______ **Patient Dismissal Acknowledgement:** I understand and acknowledge that the Practice is committed to service and reserves the right to dismiss patients for breaking office policies. Examples include, but are not limited to, financial negligence, abuse of staff, falsification of information, non-compliance with a care plan, unauthorized use of personal recording devices, and or derogatory or defaming commentary. In extreme cases, the Practice reserves the right to seek damages.

SIGNATURE

I understand that my signature below confirms that I have reviewed and agree to the privacy, financial, and office polices of the Practice.

______________________________	______________________________	______________
Patient, Guardian, or Responsible Individual Signature	Patient Name	Date Signed