This form should be filled out completely

Patient Name ______________________ / ______ / ______________________
First Name Middle initial Last Name

(Circle One) Male Female **Date of Birth** ______/______/______

Address ______________________ / ______________________ / ______ / ______
Street Address City State Zip Code

Phone #'s Home ( ) ______________ Work ( ) ______________ Cell ( ) ______________

Email Address ____

Have you been known by another name? ____

Insurance Information: Office Visit Copay ____________________

Primary Ins Carrier Name ____

Please present insurance card(s) with this completed form along with picture ID for scanning and identification purposes

Subscriber Name ______________________ Subscriber Date of Birth ______/______/______

Subscriber's Contract Number ______________________ Group Name or Number ______________________

Subscriber's Employer____

Subscriber Relationship to Patient *(Circle One)* Self Spouse Dependent

Secondary Insurance Carrier *(if applicable)* ____

Subscriber Name ______________________ Subscriber Date of Birth ______/______/______

Please present insurance card

Subscriber's Contract Number ______________________ Group Name or Number ______________________

Subscriber's Employer____

Subscriber Relationship to Patient *(Circle One)* Self Spouse Dependent

Responsible Party Name (if different from patient) ____

Name of person responsible for bill if other than yourself or subscriber, or if address if different

Emergency Contact Name ______________________ Phone ( ) ______________

Referred by ______________________ Phone ( ) ______________

X ____ ______/______/______

Signature of Patient (or patient parent/guardian if the patient is under 18) *Date of signature*

Who is your appointment with today?

Ronald Kerwin, M.D.	Michael Dorman, M.D.	Leonard Cetner, MD	Suzanne Merkle, MD
Stacy Madany, PA-C	Maria Ammori, PA-C	Jessica Tacconelli, PA-C	Jennifer Ward, PA-C
Laser	Mohs Skin Cancer Surgery	Aaron Cetner, M.D.	Leonard Kerwin, MD

ASSOCIATED DERMATOLOGISTS
West Bloomfield | Commerce | Novi

Ronald D. Kerwin, M.D. | Michael A. Dorman, M.D., F.A.A.D. | Leonard M. Cetner, M.D., F.A.A.D.
Suzanne R. Merkle, M.D., F.A.A.D. | Aaron S. Cetner, M.D., F.A.A.D.
Stacy Madany, PA-C | Maria Ammori, PA-C | Jessica Tacconelli, PA-C | Jennifer Ward, PA-C

Dear Patient:

We appreciate your confidence in choosing the Practitioners at Associated Dermatologists of W. Bloomfield, Commerce and Novi. *Please*, take a moment to review our **financial policy** below:

About Co Payments:
If you are an enrollee of a Health plan (HMO, PPO, POS, MC etc), you are required to pay your co-payment: your responsibility for any Office Visit, each time an office visit is billed. This must be paid on the date of service. If you are not prepared to pay on the date of service, you must reschedule.

About Annual Deductibles:
In addition to co-pays for office visits, most health care plans have annual deductibles. If you have not met that deductible, you will be billed for your portion after your insurance company rejects the claim. You should receive an "Explanation of Benefits" that will tell you what your financial responsibility is for any visits or procedures done in this office. If you have Master Medical, you are responsible for payment since you will receive a check from your insurance company, payable to you.

In the event there is a balance due from YOU after your insurance company has paid it's portion, we will bill you. We would appreciate prompt payment of your bill after the first statement. The name of the practice (and the name appearing on the bill is: **RONALD D KERWIN MD, PC***)*

If you are unclear as to the reason (remember to check your Explanation of Benefits, provided by your insurance company) do not hesitate to contact the office and leave a message for our biller. She will investigate your concerns and return your call promptly to answer any questions you might have. If you have questions regarding a laboratory bill, please direct your billing questions to the laboratory, not our office.

About Self-Pay (No insurance or NON-covered services such as cosmetic procedures or products):
If you do not have insurance or you are have non-covered procedures performed or purchasing products from our office, you must pay at the time of service or purchase. We cannot bill you. We accept cash, checks and Visa, Master Card, Discover and American Express.

About Failure to Pay for Medical Care:
If you fail to timely pay your medical bills or amounts owed to us for your medical care and a mutually agreeable suitable resolution cannot be reached (eg. A mutually agreeable payment plan), we reserve the right after giving you 30 days prior written notice to stop providing medical care to you and to end the physician's relationship with you as a patient.

About Referrals:
Many HMO's now allow self-referrals to Specialists (such as Dermatology) and you do not need a written referral to be seen as long as your plan is within the same network. Otherwise, if your insurance plan requires that your Primary Care Physician (Internal Medicine, General Practitioner, Pediatrician, etc) issues a referral to be seen in our office, please check with the office staff to determine which physicians participate with your plan and either bring a referral with you or have your PCP fax over your referral prior to your visit. If you arrive for your office visit without a referral you have two options:

1. *Reschedule*
2. *You may pay for the visit at the end of your visit.*

Treatment will only be provided for the specific procedures requested by your primary physician.

About the Laboratories Used and Your responsibilities:
Your insurance carrier has agreements with laboratories as well as physicians. It is your responsibility to know which laboratory your insurance company requires us to use. Most carriers participate with all of the Labs that we prefer, but if you KNOW that you must have lab work or pathology submitted only to a particular lab without incurring extra costs to you, please advise the Medical Assistant of this information. We submit to many labs for blood, cultures and pathology. Often times your physician chooses a laboratory because of the expertise of a particular pathologist, so if you prefer that we not send your specimens to that lab, please let the doctor know! The following labs are the preferred laboratories of this practice:

PINKUS (Pathology only), BEAUMONT (JVHL LAB), DMC (JVHL LAB), QUEST, LAB CORP, ST. JOSEPH HOSPITAL, ANN ARBOR

Our staff is dedicated to working with you and your insurance carrier to get the best possible reimbursement. Patients also have, however, a certain responsibility to be aware of the scope of their coverage. In addition, to make sure that billing is done appropriately please update the office with ANY changes to your insurance (new card, new numbers, different co-pays), your address and phone information. We will verify this information at each visit by asking to see your insurance card and inquire about any changes in your demographics. We appreciate your patience in working with our staff.

Please sign below and return this prior to your visit.

I have read the above and understand my obligations.

X____ ______/_____/_________
Signature of Patient (or parent/ guardian if the patient is a minor) *Date signed*

I hearby authorize Ronald D Kerwin, M.D, Michael A. Dorman, M.D, Leonard M. Cetner, M.D., Suzanne R. Merkle, M.D., Aaron S. Cetner, M.D. to release to my insurance company/companies or it's representatives any information including my diagnosis and medical records of any treatment or examination rendered.

X____ ______/_____/_________
Signature of Patient (or parent/ guardian if the patient is a minor) *Date signed*

Finally, in the unlikely event that an employee of this practice is stuck by a needle or another sharp instrument during or following a procedure that involves your blood, you will be asked to submit to a blood test for diseases contracted through contact with body fluids (blood). This is MANDATED by OSHA and is meant to protect you and our staff. Any procedure that involves cutting or injecting into the skin requires that you sign this, otherwise, no procedure can be performed.

X____ ______/_____/_________
Signature of Patient (or parent/ guardian if the patient is a minor) *Date signed*

Pertinent Medical History and Intake Form

Past Medical History: *(please circle all that apply)*

Anxiety	Coronary Artery Disease	Hypothyroidism
Arthritis	Depression	Leukemia
Artificial Joints	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Pacemaker
BPH	Hearing Loss	Prostate Cancer
Bone Marrow	Hepatitis	Radiation Treatment
Transplantation	Hypertension	Seizures
Breast Cancer	HIV/AIDS	Stroke
Colon Cancer	Hypercholesterolemia	Valve Replacement
COPD	Hyperthyroidism	None

Other: ____

Past Surgical History: *(please circle all that apply)*

Appendix Removed	Mechanical Valve Replacement	Ovaries Removed: Ovarian Cancer
Bladder Removed	Biological Valve Replacement	Prostate Removed: Prostate Cancer
Mastectomy (Right, Left, Bilateral)	Heart Transplant	Prostate Biopsy
Lumpectomy (Right, Left, Bilateral)	Joint Replacement, Knee (Right, Left, Bilateral)	TURP
Breast Biopsy (Right, Left, Bilateral)	Joint Replacement, Hip (Right, Left, Bilateral)	Skin Biopsy
Breast Reduction	Joint Replacement within last 2 years	Basal Cell Cancer Surgery
Breast Implants	Kidney Biopsy	Squamous Cell Carcinoma Surgery
Colectomy: Colon Cancer Resection	Kidney Removed (Right, Left)	Melanoma Surgery
Colectomy: Diverticulitis Colectomy: IBD	Kidney Stone Removal	Spleen Removed
Gallbladder Removed	Kidney Transplant	Testicles Removed (Right, Left, Bilateral)
Coronary Artery Bypass	Ovaries Removed: Endometriosis	Hysterectomy: Fibroids
PTCA	Ovaries Removed: Cyst	Hysterectomy: Uterine Cancer
None		

Other: ____

Skin Disease History: *(please circle all that apply)*

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin
Asthma	Hay Fever/Allergies	Cancer
Basal Cell Skin Cancer	Melanoma	None
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	

Other: ____

Do you wear Sunscreen? YES NO If yes, what SPF? _______________ Do you tan in a tanning salon? YES NO

Do you have a family history of Melanoma? YES NO

If yes, which relative(s)? ____

Cautions: *(please circle all that apply)*

Have you ever had difficulty stopping bleeding? YES NO Do you have problems with healing or scarring? YES NO

Do you require antibiotics prior to a surgical procedure? YES NO

Have you had an artificial joint replacement? YES NO If yes, when and what body locations? ____________________

Do you have an artificial heart valve? YES NO Do you have a pacemaker? YES NO Do you have a defibrillator? YES NO

Are you pregnant or currently trying to get pregnant? YES NO

Medications: *(enter all medications, oral and topical)* Please list the dose and strength of any prescribed or over-the-counter medications.

____

____

Allergies: *(please enter all allergies to medications and other allergies if known)*

____

____

Social History: *(please circle all that apply)*

Currently Smokes Has Smoked in the Past Drug Use None

Other: ____

Review of Systems: Are you currently experiencing any of the following? *(please circle yes or no for the following)*

Abdominal Pain	YES	NO	Cough	YES	NO	Night Sweats	YES	NO
Anxiety	YES	NO	Depression	YES	NO	Rash	YES	NO
Bleeding Problems	YES	NO	Fever or Chills	YES	NO	Seizures	YES	NO
Bloody Stool	YES	NO	Headaches	YES	NO	Shortness of Breath	YES	NO
Bloody Urine	YES	NO	Hay Fever	YES	NO	Sore Throat	YES	NO
Blurry Vision	YES	NO	Joint Aches	YES	NO	Thyroid Problems	YES	NO
Changing Mole	YES	NO	Muscle Weakness	YES	NO	Unintentional Weight Loss	YES	NO
Chest Pain	YES	NO	Neck Stiffness	YES	NO	Wheezing	YES	NO

Other: ____

Briefly- Main Reason for visit: Rash Acne/Pimples Fungus Psoriasis

Concerns about new or changing Growths/moles Discoloration Cosmetic

History of Skin Cancer- Skin Exam Wart

Other: ____

Your signature is an acknowledgement that you are aware of the posted "Notices of Privacy Practices" of Associated Dermatologists of West Bloomfield, Commerce & Novi and that a copy is available upon request.

X ____ ______/______/______

Signature of Patient (or parent/ guardian if the patient is a minor) ***Date signed***

We are asked to collect certain demographics from all patients. Please answer the following: Again, If you are uncomfortable answering this question, you may choose : "I choose not to answer this question"

How would you describe the race of the patient? (Please mark and "X" in the box adjacent to the answer that best describes this.)

Race:

☐ White ☐ Black or African American ☐ Native American including Alaska Native American ☐ Native Hawaiian or other Pacific Islander

☐ Asian ☐ Two or more races ☐ I choose not to answer this question

Ethnicity:

☐ Hispanic/Latino ☐ Non Hispanic ☐ I choose not to answer this question **Preferred Language : ____________________________**

Primary Care Physician (Family Doctor, Pediatrician, Internal Medicine Doctor)

Name: ____

Phone: ____

City location of Practice: ____

How did you hear about our office (circle one) Dr. Referral Family/Friend Referral Internet Other

Pharmacy (indicate local or mail order)

Pharmacy Name: ____ (local or mail order - circle one)

Pharmacy Phone: ____

Address or Cross Street / City: ____

Other Pharmacy Name (if using both local and mail order) ____

AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and or administrative and clinical staff to disclose the following information to:

☐ Myself only

☐ My spouse or significant other (specify name)____

☐ My parent(s) (specify name)____

☐ Other (specify name & relation)____

Would you like access to your test results on a secure site with a user name and password unique to you? YES NO

If so, please tell receptionist and he/she will set this up for you. It can be done anytime, so if you decide later that you are interested, Please let us know.

Information to be disclosed:

☐ **All information** ☐ Lab results ☐ Diagnosis ☐ Pathology Results ☐ Medications

☐ Dates of service: ___________________________ ☐ Other: ____________________________________

My preferred method of contact is:

☐ Land line (home phone) (____) ___________________________ ☐ Cell phone (____) ___________________________

☐ Work phone (____) ___________________________ ☐ Email ____

Please check the box below regarding the office staff or physician leaving information or confirming appointments on my answering machine, voice mail or with my answering service.

☐ No, I do not want any information left on any message systems

☐ Yes, I give permission for only non-medical messages and appointment reminders to be left on my message system

☐ Yes, I give my permission for medical information, non medical messages and appointment reminders to be left on my message system

This authorization shall be in force and effective until revoked, at which time this authorization expires. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy officer at the address below. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by the federal HIPAA Privacy Rule or state law.

Signature: (parent if minor) ____ Date: _____/_____/______

Patient's Name (please print): ____