Peraza Dermatology Group

Telephone: 603.542.6455|Facsimile: 603.543.0736 www.perazaderm.com

José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.** | **Kira Schachinger P.A.-C** | **Ashwin L. Kumar, P.A.-C**

Name: _____ Email: _____ Date of birth: _____ ☐Male ☐Female

If we need to call you, may we leave detailed personal medical information (such as test results) on your voicemail? ☐Yes ☐No

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Primary Care Physician and Address: _____

Pharmacy Name and Address: _____

How did you hear about us: ☐Online search ☐Facebook ☐Instagram ☐Twitter ☐Newspaper ☐Word-of-mouth ☐Work in this building/complex ☐Insurance website ☐Referred by physician named: _____ ☐Other: _____

What is the reason for your visit? _____

Please circle or list any medical conditions you have been diagnosed with:

Acne	Cold Sores	Heart Murmur	Implanted Metal
Anxiety	Depression	Hepatitis B or C	Pacemaker
Artificial Joints	Diabetes	High Blood Pressure	Seizures
Bleeding Disorders	Eczema	HIV/AIDS	Skin Cancer (List types)

_____

Has anyone in your family had a skin cancer? Who and what type of skin cancer? _____

What prescription medicines, over the counter supplements, and vitamins do you currently take? _____

_____

Medication allergies: _____

Have you ever taken isotretrinoin (aka Accutane)? ☐Yes ☐No When? _____

Do you use Retin-A, Renova, Adapalene, Differin, Tazarotene, Tazorac, Tri Luma, Green Cream or other retinol products ☐Yes ☐No

Do you have a fever today: ☐Yes ☐No
Do you have nausea today? ☐Yes ☐No
Do you have excessive bleeding? ☐Yes ☐No
Are you tan now? ☐Yes ☐No
Do you develop keloid scars? ☐Yes ☐No
Do you use tanning beds? ☐Yes ☐No
Do you get GI upset from antibiotics? ☐Yes ☐No
Do you get yeast infection from antibiotics? ☐Yes ☐No
When were you last in the sun? _____

Smoking status: ☐Current smoker ☐Former smoker ☐Never smoker

For female patients: Are you pregnant or trying to get pregnant? ☐Yes ☐No Breastfeeding? ☐Yes ☐No

I would like to discuss the following (circle all that apply):

Acne scarring	Coolsculpting (fat removal)	Redness on face
Botox	Laser for tattoo removal	Skincare
Brown spots	Laser hair removal	Veins on face
Chemical peels	Laser resurfacing	Emsculpt
Filler injections	Microneedling	Other: _____

Please list all previous cosmetic procedures/surgeries you have had:

_____

Patient signature:_____ Date: _____

Provider signature: _____ Date: _____

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Patient name: _____

Name of primary care/referring provider: _____

Alcohol Use

All adults over 65: How many times in the past year have you had more than 4 drinks in a day? _____
Men 65 or younger: How many times in the past year have you had more than 5 drinks in a day? _____
Women 65 or younger: How many times in the past year have you had more than 4 drinks in a day? _____

Tobacco Use Do you smoke or use tobacco products?

☐ No ☐ Yes ☐ Formerly

Influenza vaccine Check the one that best fits:

- ☐ Received a flu vaccine for the current flu season.
- ☐ Did not receive a flu vaccine this flu season because of medical reasons.
- ☐ Did not receive a flu vaccine this flu season because I do not want one.
- ☐ Did not receive a flu vaccine this flu season.

For Patients 65 and older only:

Have you ever received a pneumococcal vaccine (Pneumovax):

☐ Yes ☐ No

Have you authorized anyone to make health care decisions for you if you cannot?

☐ Yes ☐ No

Do you have a living will?

☐ Yes ☐ No

For women only:

Are you currently pregnant or trying to get pregnant?

☐ Yes ☐ No

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POLICY CONSENT FORM

The following is a summary of our office policies. Some policies may not pertain to your treatment today, but may apply to future visits, treatments or procedures. Please review and sign below.

- **Prescription Refill Policy**: Our physicians normally prescribe sufficient refills to last patients until their next follow-up appointment. If you, the patient, need a refill and do not have a scheduled appointment, please call our prescription line at 603.542.6455. The physician will review the request. If the patient needs to be seen prior to a refill, our staff will call to schedule an appointment. Otherwise, please allow our office 72 hours to process your request.
- **Cancellations and No-Shows**: Our office attempts to contact all patients prior to scheduled appointments. If the patient is unable to keep an appointment, we kindly ask that you provide us with 48 hours' notice. A $50.00 no show/cancellation fee will be applied to all patient accounts when an appointment is not cancelled at least 24 hours prior to the scheduled appointment. This courtesy makes it possible to give appointments to other patients. Patients must cancel all cosmetic appointments 48 hours prior to ones scheduled appointment to receive refund of deposit.
- **Payment Options (*for procedures not covered by insurance*)**: Cash, Check, VISA, MasterCard, Discover, Debit Cards, Money Orders or Cashiers Checks.
- **All cosmetic and private pay fees are due at the time of service. A $100.00, non-refundable deposit is required for all scheduled cosmetic procedures. This deposit will be applied to your service on the day of treatment**.
- Peraza Dermatology Group and the front desk staff will not be able to quote exact prices prior to your appointment.
- **Required Payments at Your Visit**: Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service. It is the patient's responsibility to check these conditions prior to their appointment and bring an approved method of payment, as listed in the payment options section. The appointment will be cancelled and rescheduled if you, the patient, do not bring appropriate means of payment.
- **Regarding Insurance**: Peraza Dermatology will file claims directly with the patient's insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee the patient's insurance will pay for services. It is the patient's responsibility to know if our physicians are considered "in-network" by the patient's insurance. Payment is due within 30 days of receipt of a statement sent from our office.
- **Payment Plans**: In special circumstances, Peraza Dermatology will offer payment plans to those who are unable to pay their balance in one full payment.
- **Authorizations and/or Referrals**: Authorizations/referrals are an arrangement between patients and their insurance carrier. Authorizations/referrals are required prior to treatment. It is the patient's responsibility to bring a copy of their authorization/referral from their primary care doctor to our office. If a patient does not bring their authorization/referral with them, then their appointment will be cancelled and the patient will have to reschedule or be seen as a self-pay patient.
- You authorize Peraza Dermatology Group to pull pharmacy data through SureScripts as to the medications you are currently taking.
- Minors under the age of 18 will receive medical care and/or treatment with a parent, legal guardian or an authorized accompanying adult only. Minors under 18 who are unaccompanied, will not be seen.
- Some surgical pathology and other lab specimens are submitted to outside laboratories for analysis and or slide preparation. These services represent an additional fee charged to you by an outside office. Second opinions are obtained when the physician feels it is necessary to provide optimal care.
- As a patient, you understand that you may receive a separate bill from an outside hospital facility or laboratory such as: Mid Atlantic, DHMC, Borstings Laboratory, Quest, Mass General, etc.

This Consent was signed by: _____

Printed Name – Patient or Representative

_____ ____ /____ /____

Signature Date

Relationship to Patient
(if other than patient): _____

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HIPAA Personal Health Information Permissions

I, _____, consent to the use or disclosure of my "protected health information" as defined in the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)** and this consent by Peraza Dermatology Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Peraza Dermatology Group. I understand that diagnosis or treatment of me by Jose E. Peraza, MD and Daniel M. Peraza, MD and/or their assigns may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have a right to review the Peraza Dermatology Group Notice of Privacy Practices prior to signing this consent. Peraza Dermatology Group's Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills or in the performance of the health care operations of Peraza Dermatology Group duties with respect to my protected health information.

Please also note that as provided in Peraza Dermatology Group's Notice of Privacy Practices, Peraza Dermatology Group reserves the right to change the privacy practices that described in such notice. I may obtain a revised Notice of Privacy Practices by accessing the Peraza Dermatology Group website, by calling the office at 603.542.6455 and requesting a revised copy be sent in the mail or by asking for one at the time of my next appointment.

The following people may have access to my Health Information:

Name	**Relationship**
1.	
2.	

I ☐ DO ☐ DO NOT authorize Peraza Dermatology Group to leave a message either on my answering machine or my voice mail about appointments, billing questions, biopsy/lab reports, prescription information or other information as needed.

By signing this I acknowledge that a copy of Peraza Dermatology Group's Notice of Privacy Policies has been made available to me.

_____
Printed Name – Patient or Personal Representative

_____ _____
Signature of Patient or Personal Representative Date

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The United States Department of Health and Human Services requests additional patient demographic information.

Patient Name: _____

Date of Birth: _____

Preferred Language: _____

Ethnicity (please circle one): Hispanic or Latino Not Hispanic or Latino

Race: _____