RUSTAD DERMATOLOGY PC

Patient Information

Today's Date _____/_____/_____ ☐ New Patient Information ☐ Change of Information

Patient Data

Last Name ____ First Name _______________________________ MI ______

Mailing Address ___________________________________ City ______________________ State ______ Zip ________

Date of Birth _____/_____/_____ Social Security Number ________________________ Marital Status __________

Required by Federal Law

Sex: ☐ Male ☐ Female Language: ☐ English ☐ Spanish ☐ Other _____________________ ☐ Decline to Specify

Race: ☐ White ☐ Asian ☐ Black or African American ☐ American Indian ☐ Other _________ ☐ Decline to Specify

Ethnic: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown ☐ Decline to Specify

Contact Information

Emergency Contact: Full Name ____________________________________ Phone (   ) ____________________

Phone Numbers

Home Phone: (   ) ______________ Work Phone: (   ) ______________ Mobile Phone: (   ) _____________

Preferred Phone: ☐ Home ☐ Work ☐ Mobile Is it alright to leave a detailed message? ☐ Yes ☐ No

Email

E-mail Address: ___________________________________ Alternate E-mail: ___________________________________

Employer

Employer Name ______________________ Occupation _____________________ Industry ____________________

Insurance

Please present your PRIMARY AND SECONDARY insurance cards and photo ID. Note that if we do not participate with your insurance, or do not have an insurance card with you, FULL payment is required TODAY.

Pharmacy

Pharmacy Name _____________________ Address ______________________ City ________________ State _____

Primary Care Provider (PCP)

Name _______________________________ Office ______________________ City ________________ State _____

RUSTAD DERMATOLOGY PC

Troy Rustad MD – Elliott Rustad MD

Health and Skin History

Patient Name ___________________________________ Date ____

Past Medical History

Select any medical conditions that you currently have:

- ☐ NONE
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ BPH (Benign Prostatic Hypertrophy)
- ☐ Bone Marrow Transplantation
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD (Emphysema)
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD (Reflux)
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other ________________________________

Past Surgeries

Have you had any surgeries of the following organs?

- ☐ NONE
- ☐ Appendix - Appendectomy
- ☐ Bladder - Cystectomy
- ☐ Breast - Mastectomy, Right Breast
- ☐ Breast - Mastectomy, Left Breast
- ☐ Breast - Mastectomy, Both Breasts
- ☐ Breast - Lumpectomy, Right Breast
- ☐ Breast - Lumpectomy, Left Breast
- ☐ Breast - Lumpectomy, Both Breasts
- ☐ Breast - Breast Biopsy
- ☐ Breast - Breast Reduction
- ☐ Breast - Breast Implants
- ☐ Colon - Colectomy for Colon Cancer
- ☐ Colon - Colectomy for Diverticulitis
- ☐ Colon - Colectomy for Inflammatory Bowel Disease
- ☐ Gallbladder - Cholecystectomy
- ☐ Heart - CABG (Coronary Artery Bypass Surgery)
- ☐ Heart - PTCA
- ☐ Heart - Mechanical Valve Replacement
- ☐ Heart - Biological Valve Replacement
- ☐ Heart - Heart Transplant
- ☐ Joint - Knee Replacement, Right
- ☐ Joint - Knee Replacement, Left
- ☐ Joint - Knee Replacement, Both
- ☐ Joint - Hip Replacement, Right
- ☐ Joint - Hip Replacement, Left
- ☐ Joint - Hip Replacement, Both
- ☐ Kidney – Kidney Biopsy
- ☐ Kidney - Nephrectomy
- ☐ Kidney - Kidney Stone Removal
- ☐ Kidney - Kidney Transplant
- ☐ Ovaries - Oophorectomy for Endometriosis
- ☐ Ovaries - Oophorectomy for Ovarian Cyst
- ☐ Ovaries - Oophorectomy for Ovarian Cancer
- ☐ Prostate - Prostatectomy for Cancer
- ☐ Prostate - Prostate Biopsy
- ☐ Prostate - Prostatectomy (TURP)
- ☐ Skin - Skin Biopsy
- ☐ Skin - Basal Cell Carcinoma
- ☐ Skin - Squamous Cell Carcinoma
- ☐ Skin - Melanoma
- ☐ Spleen - Splenectomy
- ☐ Testicles - Orchidectomy
- ☐ Uterus - Hysterectomy for Fibroids
- ☐ Uterus - Hysterectomy for Uterine Cancer
- ☐ Other ________________________________

Skin Disease History

Have you had any of the following skin conditions?

- ☐ NONE
- ☐ Acne
- ☐ Actinic Keratoses
- ☐ Basal Cell Skin Cancer
- ☐ Blistering Sunburns
- ☐ Dry Skin, Eczema
- ☐ Flaking or Itchy Scalp
- ☐ Hay fever, Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Cancer
- ☐ Other ________________________________

Do you wear Sunscreen? ☐ Yes ☐ No If yes, what SPF? _____
Do you tan in a tanning salon? ☐ Yes ☐ No

Family History

Do you have a family history of any of the following?

Allergy:	☐ NONE	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Diabetes:	☐ NONE	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son
Thyroid Disease:	☐ NONE	☐ Mother	☐ Father	☐ Sister	☐ Brother	☐ Daughter	☐ Son

Medications

Please list all current medications (names only, dose is optional): ☐ NONE

____

____

Allergies

Please list all medication allergies, and the type of reaction you have: ☐ NONE

________________________________ ☐ Anaphylaxis ☐ Angioedema ☐ Diarrhea ☐ Fatigue ☐ GI upset ☐ Hives
☐ Liver toxicity ☐ Nausea ☐ Rash ☐ Shortness of Breath ☐ Swelling ☐ Wheal ☐ Other ____________________

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Social History (Required by Federal Law)

- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown

- ☐ Not sexually active
- ☐ Active one partner
- ☐ Active several partners
- ☐ Same sex partner

- ☐ Drug use
- ☐ IV Drug Use

- ☐ Alcohol: none
- ☐ Alcohol: 0-1 I day
- ☐ Alcohol: 1-2 I day
- ☐ Alcohol: 3+ I day

- ☐ Patient feels safe at home
- ☐ Patient feels unsafe at home

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Assignment Of Benefits

All Insurance Except Medicare

I authorize my insurance company to pay benefits on my behalf directly to Rustad Dermatology PC. I authorize Rustad Dermatology PC to provide to my insurance company, any information necessary to process claims for services rendered to me.

____________________________________ ____________________
Patient or Legal Guardian Signature Date

Medicare

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration 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 to either myself or the party who accepts assignment. Regulations pertaining Medicare assignment of benefits apply.

____________________________________ ____________________
Patient or Legal Guardian Signature Date

Medigap / Medicare Supplement

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 authorize Medigap benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release my Medigap carrier any information needed to determine these benefits of the benefits payable for related services.

____________________________________ ____________________
Patient or Legal Guardian Signature Date

☐ YES ☐ NO Do you or your spouse work in a company which bas more than 20 employees and have insurance coverage through that job?

☐ YES ☐ NO Are you covered by any other insurance that makes Medicare secondary?

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Financial Policy

Effective February 24, 2015

Please read the following policies, initial by each statement, and sign at the bottom. If you have questions, our billing staff will be glad to discuss these policies with you.

_____ I understand that if I do not have my insurance card and co-payment, that my appointment may be **rescheduled** until such time that I am able provide the required documents and payments.

_____ I understand my insurance plan is a contract between my insurance company and me. Rustad Dermatology PC is not a party to my contract. As a courtesy, Rustad Dermatology PC files all primary and secondary insurance claims on behalf of the patient. Rustad Dermatology PC does not verify in advance a patient's insurance coverage. I understand **it is MY responsibility** to know what provisions, restrictions, and requirements are included or excluded in my health insurance policy.

_____ I understand that the majority of procedures done in the office, no matter how minor, are considered “procedures” or “outpatient **surgery”**, and may have a different benefit, such as requiring a **deductible**, than an **office visit**, which requires a **copayment**. In other words, procedures may be “covered” by my insurance, but not “paid for” until I meet my deductible. I understand I am responsible for payment of all fees, including copayments, and amounts applied to my deductible and surgical co-insurance.

_____ I understand **not all insurance plans cover all dermatology services**. Such non-covered services may include but are not limited to treatment of benign skin lesions, fungal nail infections, hair loss, hyperpigmentation or hypopigmentation, and various cosmetic procedures. I understand **payment for all non-covered services is due at the time of service**.

_____ I understand that in separation or divorce cases, the patient or the parent accompanying the minor to the appointment will be held financially responsible. The divorce decree only involves the divorcees and the State, and we reject any further involvement. I agree to provide permission from the insured party to bill their health care policy.

_____ I understand that Rustad Dermatology PC will bill me for any balance that is a patient responsibility, including but not limited to co-insurance, additional co-payments, and deductible amounts. Patient statements are sent each month. I understand I have 30 days after this statement to pay in full the balance indicated on the statement, unless prior financial arrangements have been approved by our billing manager. **If no payment is received after three (3) statements are sent, your account will be forwarded to our collection department** or a third party collection agency for further action.

_____ I understand that if do not have health insurance, I am responsible for all medical services rendered at Rustad Dermatology PC. Payment in full is due at the time of service.

I have read, understand, and agree to abide by its guidelines the payment policy regarding my financial responsibility to Rustad Dermatology PC for providing medical services to me. I certify that the information I provide to Rustad Dermatology PC is, to the best of knowledge, current, true, and accurate.

____________________________________ ____________________

Patient or Legal Guardian Signature Date

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Authorization to Disclose Protected Health Information (PHI)

Please take a moment to read through the PHI information included with your patient paperwork.

___________________________________ ____________________

Patient Name Date of Birth

I request and authorize Rustad Dermatology to disclose the protected health information (PHI) of the above named patient to the following individual(s):

Name ______________________________ Relationship __________ Phone Number ____________________

Name ______________________________ Relationship __________ Phone Number ____________________

Name ______________________________ Relationship __________ Phone Number ____________________

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the Rustad Dermatology PC, Attn: Privacy Officer, 1919 South 40th Street, Suite 330, Lincoln, NE 68506. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire 3 (three) years from the date signed below. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used to disclose as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Privacy Officer at (402) 484-6222.

___________________________________ ____________________

Patient or Legal Guardian Signature Date

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No Show, Cancellation, and Late Policy

Your appointment is important to us - it is a time we have reserved for you, during which multiple members of our practice have made a commitment to provide you with outstanding medical care. We believe in the value of following through on our commitments, and we would like to ask you for the same type of commitment.

We also believe in doing our best to stay on time. If you have a medical condition which requires extra time, be assured that we will take tire time to give you the care you need, and this may cause us to run behind for the patients
after you. This unpredictability is an unavoidable challenge in healthcare. If you are late to your appointment, it also affects every patient after you. We therefore also ask for your help in delivering care in a timely manner.

No Shows And Cancellations

• A patient who does not keep a scheduled appointment, and does not notify us in advance, is considered a **"no show"**.

• A patient who cancels or reschedules an appointment with less than 24 hours prior notice is considered a **"cancellation"**.

• Three (3) or more no shows or cancellations within one (1) year will be considered **"habitual"**.

Late Appointments

• A patient arriving 30 minutes or more after their scheduled appointment is considered **"late"**.

• A patient arriving late will be asked to reschedule.

• Arriving late three (3) or more times within one (1) year will be considered **"habitual"**.

Dismissal

• A patient with habitual no shows, cancellations, or late appointments will be considered for dismissal from the practice.

• A patient who is dismissed from the practice will not be permitted to make future appointments.

We understand that emergencies, illness, weather conditions, and other unforeseeable situations may result in missed or late appointments. In such cases, please telephone our office as far in advance as possible so that your appointment time may be used by another patient.

I have read, understand, and agree to this policy.

____________________________________ ____________________

Patient or Legal Guardian Signature Date