Patient Service Agreement

IMPORTANT: PLEASE INFORM US IN THE FUTURE IF YOUR INFORMATION CHANGES

**Patient Name**

BILLING INFORMATION:

In order to control our costs of billing, we request that charges be paid at the time services are rendered unless we will be billing your insurance. To encourage this, a discount of 10% will be given for cash or check and 5% for credit card payment at the time of service. Charges for cosmetic procedures do not receive a discount and must be paid at the time of the visit.

Insurance Information: If you desire that we bill your insurance, please present your insurance card(s} at the front desk. In addition, please provide the following information to expedite processing your claim:

**Insured (the person listed on the policy):**

**Patient’s Relationship to the Insured:**

Insured’s Date of Birth: / /

M D Y



Please read and sign below:

I authorize the release of the information in my medical record as necessary for my treatment, payment, and healthcare options. I authorize payment of medical insurance benefits to POWAY DERMATOLOGY, a division of Compass Dermatopathology, Inc. and understand that regardless of my insurance coverage, I am financially responsible for all medical services received. I have received a copy of POWAY DERMATOLOGY'S Notice of Privacy Policy Practices.

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**Signature of Patient or Guardian Date**

Date: / /

M D Y

Name: Age: DOB: / / \_

Last First Middle M D Y

Address: \_

Number/Street City State Zip

Phone: Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message on your phone regarding lab and biopsy results? Yes I No

Soc. Sec.#:\_\_\_ \_\_ -\_\_\_\_­\_ -\_\_\_\_\_ Sex: M I F Ethnicity (please circle): Non-Hispanic I Hispanic

Race: Caucasian African or African American Asian or Asian American Middle Eastern

Native American Native Hawaiian Pacific Islander Other Race

Marital Status: S I M I W Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Preferred Pharmacy/Pharmacy Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact: Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_

Address (if different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (if different):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the reason for your visit today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are you currently using on your skin (liquids, creams, oils, sunscreens)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications and dosages (Prescriptions, Over the Counter Medications, Herbs, Vitamins, Supplements):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please list all known allergies (please include type of reaction): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have a personal (P) or family (F) history of: (circle all that apply)

P I F - Asthma P I F - Diabetes P I F - High Blood Pressure P I F - Psoriasis

P I F - Basal Cell Cancer P I F - Eczema P I F - Melanoma P I F - Squamous

P I F - Bleeding Disorder P I F - Heart Disease P I F - Multiple Sclerosis Cell Cancer

P I F - Other: \_

Are there any other medical or surgical conditions that affect your day to day health?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? Yes I No Quantity: \_\_\_\_\_\_\_\_\_\_ Have you previously smoked? Yes I No

Referring Doctor’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) How did you hear about us?

Family Member / Friend: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient Fusion

Doctor Referral: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Special Event

Facebook Yelp

Google Insurance Carrier Website (Provider Directory):

News Station \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Powaydermatology.com Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Optional) Do you have any cosmetic concerns such as?

Acne scars Skin resurfacing / scar treatment

Brown spots Skin tags

Crow’s feet Smile / laugh lines

Eyelash thinning Smoker’s / lip lines

Eyebrow drooping Sunken eyes

Forehead lines Sunspots

Frown lines Under eye circles

Jawline changes Uneven skin color texture

Jowls / marionette lines Varicose veins

Lip appearance Wrinkles

Other concern(s) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_