

Dermatology Medical History

Patient: _____

Date: ____/____/____

Reason for today's visit: _____

Are you allergic to any medications? YES NO If yes, please list: _____

Have you ever had dental anesthesia (Novocain) or local anesthesia (Lidocaine)? YES NO
Any bad reaction? YES NO Explain, if yes: _____

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins, and herbals ex: cannabis):

Primary Physician: _____ Referring Physician: _____

General Health: Poor Fair Good Excellent Height: _____ Weight: _____

Do you currently have, or have you ever had any of the following diseases or conditions: (Please check YES or NO)

Lungs:	YES	NO	Other Systemic:	YES	NO	Infectious Diseases:	YES	NO
Bronchitis			Diabetes			HIV/AIDS		
Emphysema			Lupus			Hepatitis A, B, or C		
Asthma			Thyroid Disease			Syphilis/other sexually		
Chronic Cough			Kidney Disease			transmitted diseases		
Tuberculosis			Bladder Infections					
Shortness of Breath			Connective Tissue					

Cardiovascular:	YES	NO	Gastrointestinal			Females:	YES	NO
High Blood Pressure			Stomach Disorder			Are you pregnant?		
Heart Attack			Stomach Ulcers			Could you be pregnant?		
Heart Murmur			Nausea, vomiting, diarrhea			Date of last menstrual cycle: ____/____/____		
Irregular Heartbeat			when taking antibiotics			Type of Birth Control: _____		
Pacemaker			Yeast infection when			Previous Pregnancies: _____		
Varicose Veins			taking antibiotics			_____		
Blood Clots			Arthritis/Joint Deformity			_____		
Bleeding Disorders			Convulsions					
Prolonged Bleeding			Epilepsy					

Skin:	YES	NO	Anxiety/Depression			Past Medical History: _____
History of skin cancer			Mental Disorder			_____
If yes, type: _____			Glasses or Contacts			_____
Family history skin cancer			Anemia			
If yes, type: _____			Stroke			
History of specific			Liver Disease			
skin diseases			Cancer			
Problems with healing			Type: _____			

Excessive scarring/Keloids			Social History:	YES	NO	Past Surgical History: _____
Easy bleeding			Do you smoke/vape?			_____
Skin rashes			Do you drink alcohol?			_____
Reaction to Medications			If yes, _____ per day			_____
Reaction to Food			Do you use			_____
Reaction to Environment			recreational drugs?			_____
Sensitivity to Sunlight			If yes, what? _____			

I hereby declare that I have honestly and completely answered the above questions to the best of my knowledge. I understand that it is my obligation and responsibility to notify Dr. Hopkins of any changes in my medical condition or medications during my medical treatment or at follow up visits.

Reviewed By _____ Date _____ Patient Signature _____ Date Signed _____

AUTHORIZED CONSENT

I accept full responsibility for services rendered and understand that payment in full is due at the time of service.

Please present insurance cards and photo ID to the receptionist so copies may be made.

I authorize and request that all insurance payments be made direction to Dr. Hopkins and Dr. Farris, should she/he elect to bill my insurance company and accept such payments.

I hereby authorize and consent Dr. Hopkins, Dr. Farris, and Staff to:

1. Evaluate and treat my medical conditions.
2. Call me at home or my place of employment regarding appointment reminders, lab results, or any other information pertaining to my care.
3. Leave a message on my answering machine with appointment reminders, or regarding lab results. (Results will not be left in the form of a message).
4. Send information to me in the mail, via text or email regarding appointments or patient education/information.
5. Release medical records to my referring or primary physician, and to my insurance company, if applicable.
6. If you have questions concerning the cost of a planned procedure, it is your responsibility to discuss this with the office manager or a staff member **BEFORE** the procedure is done. Payment of charges is required at the time of the office visit. **WE ARE ONLY CONTRACTED WITH BLUE CROSS BLUE SHIELD, HUMANA, MEDICARE AND UNITED HEALTHCARE.** We will give you the proper forms to be submitted to your insurance company for reimbursement. Cosmetic procedures are not likely to be reimbursed by insurance and other fees may be reimbursed at reduced insurance fees; and therefore, all your expense may not be covered.

*******WE DO NOT ACCEPT MEDICAID INSURANCE*******

At my request, discuss my medical condition or appointment with another member of my household/family?

Yes

No

If yes, whom: _____ Relationship: _____

Telephone #: _____

Patient Signature

It is my responsibility to notify this office of any change in the above information. I understand that by signing this form I have read and understand my responsibility.

Signature

Date

M. JANINE OSWALT HOPKINS, M.D. and DOUGLAS FARRIS, M.D.

Acknowledgement of Receipt of Notice of Health Information Privacy Practices

I, (Printed Patient Name) _____,
acknowledge receipt of the Notice of Health Information Privacy Practices.

By: (Patient Signature) _____

This _____ day of _____ 20____.

Patient & Visitor Photography and Recording Acknowledgment

Photos and videos taken by patients and visitors are not subject to the HIPAA photography rules because the images are not being created, received, transmitted, or stored by a covered entity, and HIPAA does not apply. However, potential privacy issues exist when visitors take photos and videos that include other patients and/or visible patient information, because, if the photos and videos are publicly shared, the unauthorized disclosure of individually identifiable health information could violate state privacy laws, other federal privacy laws (for example, [42 CFR Part 2](#) relating to the confidentiality of substance use disorder patients), or international privacy laws such as the EU's General Data Protection Regulation ([GDPR](#)).

The practice is not responsible for images or recordings captured by patients or visitors. Any unauthorized photography, recording, or distribution that results in the disclosure of identifiable information may violate applicable state, federal, or international privacy laws and may result in corrective action, including being asked to stop recording or leave the premises.

By signing below, you acknowledge and agree that you will not photograph or record other patients, staff members, or any visible patient information without explicit consent. You further agree not to share, post, or distribute any images or recordings that include other patients or identifiable health information.

I, _____ acknowledge and accept the terms of this agreement.

Patient Signature

Date

HOPKINS DERMATOLOGY OFFICE FINANCIAL AGREEMENT

Welcome and thank you for choosing Hopkins Dermatology as your healthcare provider. Your clear understanding of our practice financial and office policies is important to our professional relationship. The following information outlines your responsibility related to payment and appointment reservations for professional services.

Insurance: We work to have your insurance verified at the time of your appointment. However, if we are unable to verify insurance coverage, it is the patient's responsibility to contact the insurance company directly with any questions regarding benefits and coverage.

Referrals and Preauthorization: It is your responsibility to understand your insurance benefits and obtain a referral from your Primary Care Physician if it is required. If the referral is not sent to us prior to your scheduled appointment, you will be asked to reschedule the visit until it is received. It is also your responsibility to obtain a preauthorization for services if required by your insurance company prior to your appointment.

Co-Payment: A co-payment is a dollar amount set by your insurance company which you are responsible for at each visit. Some insurance plans may also have co-insurance, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. All co-payments must be paid at the time of service.

Deductible: An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay. Deductibles are due at the time of service.

Self-Pay: Patients who do not have insurance or, insurance that we are contracted with, are considered self-pay. Payment in full is due at the time of service. Superficial Radiation Therapy patients are required to pay their patient responsibility at the start of their simulation appointment.

Small Credit Balances: Patient accounts with credit balances of \$10 or less remaining after six months will be adjusted off. This adjustment is final and cannot be reversed.

Missed Appointments: If you are unable to keep your appointment, please notify our office at least 48 hours in advance. Failure to provide this notice will result in a \$75 no-show fee.

Dismissal from Practice: Please note that compliance with treatment plans (including medications and/or lab work), keeping recommended follow-up appointments is your responsibility. A patient that fails to follow recommended treatment plans, return phone calls or emails from the practice informing of pathology results, will relinquish Hopkins Dermatology of any adverse responsibility and will be released from care. Patients who repeatedly cancel or fail to show for appointments, exhibit inappropriate/abusive behavior towards staff may also result in dismissal from our practice.

Cosmetic Services: Cosmetic or elective procedures such as removal of benign lesions or any service not covered or billed to insurance are considered self-pay. We require a one-time cosmetic consultation with Dr. Hopkins or Dr. Farris. The fee for this consultation is priced at \$200 and is not applied towards any treatment. A \$200 deposit is required when scheduling an elective appointment. If you are unable to keep this appointment, please notify our office at least 48 hours in advance to cancel or reschedule. Failure to provide this notice will result in a \$200 non-refundable fee.

Laboratory and Pathology Fees: It may be necessary to obtain a tissue sample or perform lab tests to confirm a diagnosis or determine a course of treatment. Specimens sampled are sent to outside laboratories to process, and fees associated with this service are separate from the procedure performed by your treatment provider. You may receive an additional bill for services by that lab that are not covered by your insurance. If you have identified as "self-pay" you shall be responsible for all fees incurred from the lab.

I, _____ acknowledge and accept the terms of this agreement.

Patient Signature

Date

Are there any other services that you are interested in?
Dr. Hopkins specializes in the following:

- Dermal Fillers & Injectables
 - Trinity of Anti-Aging Injections
 - Lip Injections
 - Jawline Enhancement
 - Tear Trough Injections
 - Non-Surgical Liquid Facelift
 - Liquid Necklift
 - Anti-Aging Hand Injections
 - Neurotoxins
 - Botox
 - Daxxify®
 - Jeuveau
 - Dysport®
 - Xeomin
 - Microneedling
 - PRP Facials
 - Geneo Facials
 - Laser Hair Removal
 - Skin Tightening
 - TIGHTLASE
 - Cellulite Treatment with AVELI®
 - TIGHTSCULPTING
 - Hormone Replacement Therapy
 - PRP Injections for Laser Hair Restoration
 - Acne
 - Acne Scars
 - Discoloration/Uneven Skin Tone
 - Hyperpigmentation/Sun Damage
 - Fine lines/Wrinkles
 - Rosacea
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****If you would like to further discuss these services, a cosmetic consultation is required which is priced at \$200.***