SANOVA
DERMATOLOGY

PATIENT INFORMATION

First: ______________________ MI: _______ Last: ______________________ DOB: ____________
Address: ______________________________ City: ________________ State: ______ Zip: ___________
Cell #: ____________________ Home / Work #: ____________________ Gender: ❑ Male ❑ Female
Email: ____

Would you like access to your patient portal & newsletter via email? ❑ Yes ❑ No, I decline

It is the policy of Sanova Dermatology to not share your contact and email information with any third parties.

Driver's License #: ____________________ DL State: __________ Social Security #: ____________________
Preferred Language: ❑ English ❑ Spanish ❑ Other (*please specify*): ______________________________
Primary Race: ❑ Black or African American ❑ White ❑ Native Hawaiian/Other Pacific Islander ❑ Asian
❑ American Indian/Alaska Native ❑ Declined to Specify
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Other
Ethnicity: ❑ Not Hispanic or Latino ❑ Hispanic or Latino ❑ Prefer not to answer ❑ Unknown
Employment: ❑ Employed ❑ Disabled ❑ Retired ❑ Part-Time ❑ Not Employed ❑ Student ❑ Unknown
Student Status: ❑ Full Time ❑ Part Time ❑ Not a Student ❑ Unknown

Emergency Contact

Name: ________________________ Relationship: ________________ Phone: ____________________

Primary Care Physician

Physician Name: ______________________________ Did this physician refer you to Sanova? ❑ Yes ❑ No
Office Phone #: ______________________________ Office Fax #: ________________________

Referral Source

❑ Facebook ❑ Twitter ❑ Yelp ❑ Google+ ❑ Insurance List ❑ Friend / Family ❑ Other: ________________

Person Responsible for Bill *(complete only if different from patient)*

Name: ________________________ Relationship: ____________________ DOB: ____________
Address: ______________________________ City: ________________ State: ______ Zip: ___________

Primary Insurance

Primary Insurance: ________________________ Policy #: ________________ Group #: ______________
Policy Holder's Name *(if different from patient)*: ________________________ Policy Holder's DOB *(*req)*: ______________
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________________________

Secondary Insurance

Primary Insurance: ________________________ Policy #: ________________ Group #: ______________
Policy Holder's Name *(if different from patient)*: ________________________ Policy Holder's DOB *(*req)*: ______________
Relationship to Patient: ❑ Self ❑ Spouse ❑ Child ❑ Other: ______________________________

The above information is accurate and complete to the best of my knowledge.

______________________________ ______________________________ ______________

Signature of Patient / Responsible Party Patient / Responsible Party (printed) Date

SANOVA

SANOVA DERMATOLOGY

Patient Medical History

Name____ Date ____________________

Referring Physician____________________ Primary Care Physician____________________ Date of Birth___ / ___/ ______

Reason for visit?____________________ Best phone # to reach you to discuss results?____________________ Okay to leave a message? Y N

Preferred Pharmacy (Include Location)____ Occupation: ____________________

❑Yes ❑No Do you drink alcohol? If yes, how many drinks per day?____________________

❑Yes ❑No Do you smoke? If yes, how many packs per day?____________________

❑Yes ❑No Do you use illegal street drugs? If yes, list ____________________

PAST MEDICAL HISTORY

Have you ever had any of the following?

❑Yes❑ No Anxiety
❑Yes ❑No Artificial Joints
❑Yes ❑No Asthma
❑Yes ❑No Atrial Fibrillation
❑Yes ❑No Cancer (non-skin)
❑Yes ❑No COPD
❑Yes ❑No Coronary Artery Disease
❑Yes ❑No Depression
❑Yes ❑No End Stage Renal Disease
❑Yes ❑No Other: ____________________

❑Yes❑ No Hearing Loss
❑Yes ❑No Hepatitis
❑Yes ❑No High Blood Pressure
❑Yes ❑No HIV/AIDS
❑Yes ❑No High Cholesterol
❑Yes ❑No Seasonal Allergies
❑Yes ❑No Seizures
❑Yes ❑No Thyroid Disease
❑Yes ❑No Valve Replacement

SKIN DISEASE HISTORY

Please check all that apply

❑Yes ❑No Actinic Keratosis
❑Yes ❑No Basal Cell Skin Cancer
❑Yes ❑No Melanoma (malignant)
❑Yes ❑No Squamous Cell Skin Cancer
❑Yes ❑No Precancerous Moles
❑Yes ❑No Atypical/Dysplastic moles/spots
❑Yes ❑No History of bad or blistering sunburns?
❑Yes ❑No Do you use Sunscreen? If yes, what SPF?____________________
❑Yes ❑No Do you have a family history of Melanoma?
If yes, whom?____________________

REVIEW OF SYMPTOMS

Are you currently experiencing and of the following?

❑Yes ❑No Runny Nose/Itchy Eyes
❑Yes ❑No Palpitations/Chest Pain
❑Yes ❑No Leg Swelling
❑Yes ❑No Fever/Chills
❑Yes ❑No Unplanned Weight Loss
❑Yes ❑No Cold/Heat Intolerance
❑Yes ❑No Excessive Thirst/Hunger
❑Yes ❑No Swallowing Problems
❑Yes ❑No Mouth or Cold Sores
❑Yes ❑No Nausea/Vomiting
❑Yes ❑No Diarrhea/ Constipation
❑Yes ❑No Burning with Urination
❑Yes ❑No Blood in Urine

❑Yes ❑No Enlarged Glands/Lymph Nodes
❑Yes ❑No Joint Pains
❑Yes ❑No Muscle Aches
❑Yes ❑No Headaches
❑Yes ❑No Memory Loss
❑Yes ❑No Depression
❑Yes ❑No Anxiety
❑Yes ❑No Wheezing/Asthma
❑Yes ❑No Shortness of Breath
❑Yes ❑No Suppressed Immune System
❑Yes ❑No Rash with Medication or Foods
❑Yes ❑No Problems Healing
❑Yes ❑No Scars/Keloids After Surgery

❑Yes ❑No Do you have immediate family with a history of Skin Disease?
If yes, who/type?____________________

❑Yes ❑No Do you have immediate family with a history of Skin Cancer?
If yes, who/type?____________________

PAST SURGICAL HISTORY

Please list previous surgical procedures.

____
____
____
____
____
____

MEDICATIONS

Please list all current medications (OTC, Herbal, Etc.)

____
____
____
____

ALLERGIES: Please list all allergies and/or adverse reactions

____
____

ALERTS

Are you currently experiencing any of the following?

❑Yes ❑No Allergy to Latex or Tape
❑Yes ❑No Artificial Heart Valve
❑Yes ❑No Blood Thinner Use/Daily Aspirin
❑Yes ❑No Medication Prior to Procedures
❑Yes ❑No MRSA (Resistant Staph)

❑Yes ❑No Allergy to Lidocaine
❑Yes ❑No Artificial Joint in Past 2 Months
❑Yes ❑No Defibrillator
❑Yes ❑No Rapid heart Rate w/ Epinephrine

❑Yes ❑No Allergy to Topical Antibiotic
❑Yes ❑No Accutane Used in Past 6 Months
❑Yes ❑No Pacemaker
❑Yes ❑No Pregnant/Breastfeeding

EDUCATE YOURSELF Our physicians are experts in Cosmetic Dermatology procedures! Please help us maintain the highest level of customer service by checking all areas that interest you:

❑ Botox
❑ Cosmetic Fillers
❑ Non-Surgical Nose Job
❑ Lip Enhancement
❑ Underarm Odor/Sweating

❑ Eyelid Rejuvenation
❑ Eyelash Rejuvenation
❑ Neck Rejuvenation
❑ Neck/Chin Tightening
❑ Sensitivity to Deodorant

❑ Chemical Peels
❑ Acne Scarring
❑ Laser Hair Removal
❑ Spider Vein Treatment
❑ Double Chin Treatment

❑ Facial Redness
❑ Sun Spots
❑ Liposuction/Body Contouring
❑ Skin Care Advice

Patient/Guardian Signature: ____ Date:____________________

Thank you for choosing Sanova Dermatology!

FINANCIAL POLICY

Welcome and thank you for choosing Sanova Dermatology! We are committed to providing you with the best possible medical care. Understanding your financial responsibility is an essential element of your care. Please initial next to each paragraph below signifying that you have read and understand our policy. If you have any questions, contact your Sanova Dermatology office.

Insurance-Claims / Non-Covered Charges. I understand it is my responsibility to know my insurance policy coverage and benefits and that I must notify Sanova Dermatology of any insurance changes in a timely manner. If Sanova Dermatology participates with your managed care or commercial insurance plan under which you are covered, it will bill the carrier for services rendered. Sanova Dermatology tries to verify eligibility and benefits prior to every visit; however, if coverage cannot be verified, I understand that I will be expected to pay any co-payments, deductible amounts, and charges for any non-covered or cosmetic procedures at the time of service. Such procedures include but are not limited to biopsies, injections, wart removal, pre-cancers, or other skin lesions. I understand that the verification of benefits is not a guarantee of payment and that I will be billed a balance if insurance pays less than verified, insurance denies the claim, and/or insurance payment is not received within 60 days from claim filing. If you have specific questions about your insurance coverage, please contact your insurance company.

Authorization / Financial Responsibility. I authorize the release of any medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges, and I agree to this financial policy. I request that my medical insurance carrier make any payment directly to Sanova Dermatology, PLLC for services rendered to me.

Pre-Authorization / Referrals. I understand it is my responsibility to make the appropriate arrangements through my primary care physician to obtain and provide Sanova Dermatology with all necessary referrals, including referrals for follow up visits, if required by my insurance plan. If my insurance requires a referral for appointment and I do not have a current referral on file, I understand that I may be asked to reschedule my appointment.

Medicare. Sanova Dermatology practices are Medicare participating providers; therefore, they will bill Medicare directly. I understand that at the time of service I will be responsible for payment of copayments, annual deductibles, and charges for non-covered or cosmetic services, and that I will be asked to sign an Advance Beneficiary Notice of Non-Coverage in the event a service is provided that is not covered by Medicare.

Patients Without Insurance (Cash Pay) / Out-Of-Network Insurance Plans. I understand that Sanova Dermatology accepts self-pay patients, and if I do not have health insurance or choose to use an out-of-network insurance plan, that full payment is due at the time of service.

Returned Checks. I understand that I will be charged $25.00 for all returned checks and upon notification from a Sanova Dermatology office, payment of the entire balance is due immediately. Sanova Dermatology accepts cash, checks, Mastercard, Visa, Discover, and American Express. Financing may also be available for transactions of $300 or more.

Skin Care Products. If you purchase skin care products from our office, please understand that these items are non-refundable. If the product or supply is defective, Sanova Dermatology will gladly replace the item.

No Show Policy. Sanova Dermatology kindly requests a 24-hour cancelation notice. Failure to call, "no shows," will be charged a $35 missed appointment fee or $100 for missed cosmetic appointments. This fee is not billable to or reimbursable by insurance. These policies include appointments with all providers and aestheticians.

Laboratory Bill. YOU MAY RECEIVE A BILL FROM AN OUTSIDE LABORATORY. If your provider performs a biopsy or lab test during your appointment, it will be sent to an outside laboratory to be examined by a pathologist. The pathologist will communicate your lab results to your provider via a pathology report. Laboratory examinations are performed when more information on your skin condition is needed to ensure your condition is properly treated. The outside laboratory will submit a bill to your insurance company. You may receive a bill from them should you have deductibles, coinsurance, or copayments. If you're a self-pay patient, rates will be discussed with you during your visit. I understand and agree that I may receive a bill from an outside laboratory, in the event that I receive a biopsy or lab test during medical examination.

Your signature below signifies that you have reviewed, understand, and accept all of the above policies. Please sign by typing your name & date of birth.

______________________________ ______________

Signature of Patient / Guardian Date

ACKNOWLEDGEMENT OF RECEIPT OF SUMMARY / NOTICE OF PRIVACY PRACTICES

Please review each paragraph below and initial next to each paragraph signifying that you have read, understand, and agree with our policy. If you have any questions, please contact your Sanova Dermatology office for assistance.

_____ Receipt of Notice of Privacy Practices (HIPPA). I have been given the opportunity to review Sanova Dermatology's Notice of Privacy Practices. I understand that I can request a copy of the Notice of Privacy Practices for my records. This document is available at the front desk or at sanovadermatology.com.

_____ Consent to Telephone / E-mail Communication. I understand that any phone or e-mail communication will be part of my medical record. I also understand that all e-mail communication is not secure and not to be used for any emergent matters, and that response will be given back within three to five business days.

_____ Consent to Treatment. I consent to the performance of examinations, diagnostic procedures, and rendering of treatment by the medical provider and their designated medical office staff as is deemed necessary by the medical provider's judgement. I authorize Sanova Dermatology to take photographs/videos of me for clinical purposes only. I understand that the photograph/video will only be used in my medical record and will not be released without my prior authorization. I am aware that the practice of medicine is not an exact science, and I acknowledge that no guarantee can be made of implied as to the outcome of treatment.

_____ Other Communication. By providing my email or cell phone number to Sanova Dermatology, I authorize Sanova Dermatology to access and receive marketing communication (emails, texts, etc.), including but not limited to newsletters, promotional offers, patient portal, and notifications about events, from Sanova Dermatology. It is the policy of Sanova Dermatology to not share your contact/email info with or use it to communication regarding marketing from third parties. I understand that I can opt out of such emails or texts at any time.

_____ Austin Institute for Clinical Research Contact Consent. AICR is a Sanova Dermatology company specializing in medical and cosmetic clinical trials that focus on the treatment of skin conditions. Get educated about your skin condition by participating in a research study. Be the first to try the latest medical and cosmetic treatments! Participants may receive medication at no cost, plus compensation for time & travel. When you participate in clinical research, it helps finds a solution for you and other suffering with similar skin conditions. I authorize AICR access to contact me by phone, email, or text with upcoming study opportunities.

_____Consent to Telehealth. I have been given the opportunity to review Sanova Dermatology's Consent to Telehealth document, and understand the risks and benefits of the teleconferencing visit. I understand that I can request a copy of the Consent to Telehealth document for my records. This document is available at the front desk or at sanovadermatology.com. I hereby give my consent to participate in a telehealth visit.

_____Consent to Treat a Minor. I hereby grant Sanova Dermatology permission to provide medical treatment to my child when he/she is unaccompanied or accompanied by someone other than a legal guardian to medical visit (grandparent, babysitter, etc.). I understand this excludes the treatment of any new symptoms. I also understand payment of any co-payment or co-insurance is required at the time of service for those dates my child is treated, whether I am present or not.

_____ Contact Permission. Sanova Dermatology needs to contact you regarding an appointment, lab result, medication, or for any other reason, it is permissible to *(please check all that apply):*

- ❑ Leave a message on voicemail / answering machine
- ❑ Text message cell phone number
- ❑ Speak with other Name: ______________________ Phone #: _________________ Relationship: ______________

Your signature below signifies that you have reviewed, understand, and accept all of the above policies and notices.

________________________________	________________________________	________________
Patient/Legal Guardian Signature	Patient/Legal Guardian Name (printed)	Date

*If Legal Guardian, please indicate your relationship to the patient: ❑ Parent ❑ Legal Guardian ❑ Other: _____________

Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained due to: ❑ Individual waived signature ❑ Communication barriers ❑ An emergency situation ❑ Other:

Practice Representative / Date:

MIPS 2024

Patient Name:________________________________Date of Birth: ____________________

In accordance with the Federal Health Policy, please answer the following questions:

1) Tobacco – Asked 1 time per year

- Do you use any tobacco containing products (does not include vaping)?

2) Do you have a surrogate decision maker (for patients 65+)? – Asked 1 time per year

- If yes, enter their information:

  Name: __________________________________

  Phone Number: ___________________________

For patients that will be turning 10 to 13 years old this year:

3) Has the patient had a meningococcal vaccine (serogroups A, C, W, Y), on or between the patient's 11th and 13th birthdays?

4) Has the patient had a tetanus, diphtheria toxoids and acellular pertussis vaccine (Tdap) on or between the patient's 10th and 13th birthdays?

5) Has the patient had at least two HPV vaccines on or between the patient's 9th and 13th birthdays?

6) Did the patient not receive any of the vaccinations above because of a medical reason, including allergic reactions?

Signature:____ Date:______________________________