MEDICAL HISTORY FORM

Today's Date: _____ / _____ / _____

Patient Name: _____ Date of Birth: _____ / _____ / _____

Address: _____

Cell Phone: _____

Email: _____

Reason for Visit: _____

PAST MEDICAL HISTORY:

Please circle all that apply. You must circle "NONE" if none apply.

Anxiety	Colon Cancer	Hepatitis	Stroke
Arthritis	Coronary Artery Disease	High Blood Pressure	Lung Cancer
Asthma	Depression	HIV/AIDS	Lymphoma
Atrial Fibrillation	Diabetes	High Cholesterol	Prostate Cancer
Bone Marrow Transplantation	End Stage Renal Disease	Thyroid Problems	Radiation Treatment
BPH (Prostate Enlargement)	GERD (reflux)	Hyperthyroidism	Seizures
Breast Cancer	Hearing Loss	Hypothyroidism	
NONE	OTHER:		

PAST SURGERIES:

No prior surgeries

_____

SKIN DISEASE HISTORY:

Please circle all that apply. You must circle "NONE" if none apply.

Acne	Blistering Sunburns	Hay Fever/Allergies	Psoriasis
Actinic Keratosis	Dry Skin	Melanoma	Squamous Cell Carcinoma
Asthma	Eczema	Poison Ivy	NONE
Basal Cell Carcinoma	Flaking or Itchy Scalp	Precancerous Moles	OTHER

- Do you wear sunscreen? Yes No What SPF? _____
- Do you tan in a tanning salon? Yes No
- Do you have a family history of melanoma? Yes No If Yes, who? _____

MEDICATIONS:

No Current Medications

_____

ALLERGIES:

No Allergies

_____

REQUIRED QUESTIONS:

These are required by the Government for all patients.

PREFERRED LANGUAGE: _____ RACE: _____

SMOKING STATUS: (Please circle which applies to you)

- Unknown
- Current someday smoker
- Former Smoker
- Smoker, current status unknown
- Current every day smoker
- Never smoker

ALCOHOL USE: (Please circle which applies to you):

- Less than 1 drink/day
- 1-2 drinks/day
- 3 or more drinks/day
- None

FAMILY HISTORY:

First-degree relatives only

Condition	Yes	No	Relative	Comments
Melanoma				
Non-Melanoma Skin Cancer				
Psoriasis				
Thyroid Disease				
Autoimmune Disease				
Depression				
Diabetes				
Hair Loss (Alopecia)				
Lupus				
Other				

ALERTS:

Please circle all that apply.

Allergy to adhesive
Allergy to anesthetics
Allergy to topical antibiotics
Allergy to latex
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator/Pacemaker
History of MRSA
Require antibiotics prior to surgery
Rapid heart rate with epinephrine

EMERGENCY CONTACTS:

- Name: _____ Phone Number: _____
- Name: _____ Phone Number: _____

REVIEW OF SYMPTOMS:

Are you currently experiencing any of the following? Please circle all that apply.

Fever or chills	Nausea/vomiting	Hay fever	Suicidal thoughts	Neck stiffness
Cough	Dry skin	Chest pain	Photosensitivity	Seizures
Night sweats	Unintentional weight loss	Thyroid problems	Dry eyes	Problems with scarring
Headaches	Abdominal pain	Sore throat	Dry lips	Shortness of breath
Blurry vision	New lumps or bumps	Bloody stool	Anxiety	Immunosuppression
Joint aches	Problems with hearing	Bloody urine	Fatigue	Wheezing
Depression	Rash	Muscle weakness	Bleeding problems	NONE

Patient Financial Policy

Robert Bentley MD / Robert J. Bentley, LLC, believes that part of good health care practice is to establish and communicate a financial policy to our patients. We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policy.

PAYMENT is expected at the time of your visit, at Check In, prior to seeing the Doctor. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing condition clause, payment in full is expected at the time of you visit. A copy of your Insurance Card and a copy of your Driver's License (to prevent possible identity Theft) must be presented at the time of your appointment.

We have a contractual agreement with your Insurance Provider to collect Co-pays at the time of your visit. Your Insurance Provider determines the amount of your Co-Pay.

INSURANCE We are a participating Provider with several insurance plans. We will file all these insurance claims. **Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.** If your insurance company does not pay the practice within a reasonable period of time, you will be billed. If we later receive payment for your insurer, we will promptly refund any overpayment to you.

If our doctors are not listed in your plan's network, you may be responsible for partial or full payment. If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis Be sure to check with

your insurer's member benefits department about services and physicians before your appointment. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. This includes, but is not limited to VA Patients and Medicaid Patients.

We highly recommend you also contact your insurance carrier and check into your coverage for Dermatology. Do not assume that you will not owe anything if you have more than one insurance policy.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge.

RETURNED CHECKS will incur a $30.00 service charge. You will be asked to bring cash, certified funds or a money order to cover the amount of the check plus the $30 service charge to pay the balance prior to receiving services from our staff or the physician. Stop payments constitute a breach of payment and are subject to the $30 service fee and collections action. All bad checks written to this office are subject to collections.

RESPONSIBILITY FOR PAYMENT: I understand that I, personally, am financially responsible to Dermatology Care of Alabama/ Robert J. Bentley LLC, for charges not covered by the assignment of insurance benefits.

SELF PAY PATIENTS / PATIENTS WHO ARE UNINSURED: All Payment is expected at time of service. Effective July 1, 2018 Dermatology Care of Alabama/Robert J. Bentley LLC Self Pay Policy is as follows:

New Patients - $125.00 Co-Pay Due at Check-In– This amount is applied to the cost and coverage of the Office Visit ONLY. This does not include the cost of any procedure the Doctor deems necessary during the course of the clinical exam. The remaining cost of any additional procedure beyond the initial Office visit will be totaled before you leave.

Unless a prior arrangement has been made, you are responsible for the entire cost of any clinical procedure performed by the Doctor at Check Out.

Returning Patients Follow-Up Patients - $75.00 Co-pay Due at Check-In - This amount is applied to the cost and coverage of the Office Visit ONLY. This does not include the cost of any procedure the Doctor deems necessary during the course of the clinical exam. The remaining cost of any additional procedure beyond the initial Office visit will be totaled before you leave.

Unless a prior arrangement has been made, you are responsible for the entire cost of any clinical procedure performed by the Doctor at Check Out.

Dermatology Care of Alabama/ Robert J Bentley LLC does not extend credit. All services are expected to be paid in full at the time of service.

COLLECTION FEES: I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest and fines. I understand that these additional fees will be my personal responsibility to pay in full.

I have read and understand the practice's financial policy and I agree to be bound by its terms.

I also understand and agree that such terms may be amended by the practice from time to time.

(Signature of Patient or Legal Guardian)

(Printed Name of Patient)

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Dermatology Care of Alabama/Robert J Bentley LLC, to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Robert J. Bentley, LLC describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Robert J Bentley, LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Office Manager, 900 Veterans Memorial Parkway, Tuscaloosa, Al 35404. I have the right to request that Robert J. Bentley, LLC restrict how it uses or discloses my PHI to carry out TPO. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. With this consent, Dermatology Care of Alabama/ Robert J Bentley, LLC may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

□ yes □ no

With this consent, Dermatology Care of Alabama/Robert J. Bentley, LLC may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

□ yes □ no

With this consent, Dermatology Care of Alabama/Robert J. Bentley, LLC may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

□ yes □ no

The following person(s) may contact Dermatology Care of Alabama/Robert J. Bentley, LLC inquiring in regards to my health information. You have my permission to release information to them.

Name _____ Relationship _____

Name _____ Relationship _____

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

If I do not sign this consent, or later revoke it, Dermatology Care of Alabama/Robert J. Bentley, LLC may decline to provide treatment to me. _____

Signature of Patient or Legal Guardian _____ _____

Print Patient's Name Date _____

Print Name of Patient or Legal Guardian, if applicable