



3025 Governors Place Boulevard
Dayton, Ohio 45409
Phone (937) 293-5567
Fax (937) 293-5568
www.daytonskincare.com

Welcome to our practice!

We hope you will find the following information helpful. We respect your time and would like to make your visit to our office as efficient as possible. Every patient is very important to us.

Medical Information/HIPAA Information: We appreciate your completion of the enclosed forms. **Please complete all pages of this packet and include your name *on every page* as directed, please bring completed forms to your appointment.** Photo identification and all insurance cards will be required at check-in on the day of your appointment.

On Time Arrival: Please arrive 15 minutes before your scheduled appointment time. Late arrival will result in an extended wait time and may require your appointment to be rescheduled.

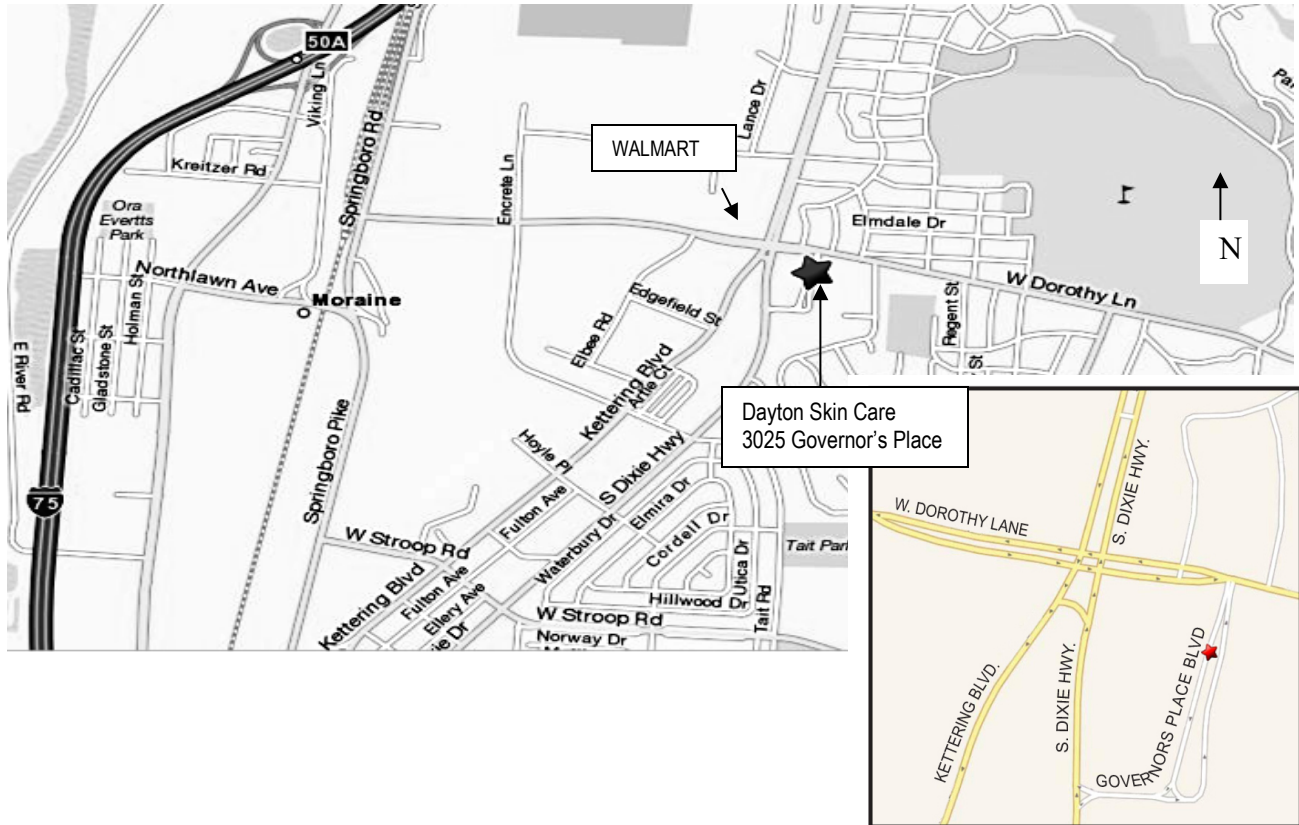
Financial Policy & Medical Insurance: We collect co-pay, deductible and co-insurance at the time services are rendered. Insurance may not cover the full cost of your physician services; final patient responsibility for payment will be based on information received from your insurance company after the claim has been processed. Self-pay patients will be responsible for payment in full on the day of service. If you have any questions or concerns, please contact our Billing Dept. at 937-293-5567, option #4.

Cancellation: We schedule appointments several weeks out and would like the opportunity to accommodate patients on our wait list. Please notify us as early as possible if you are unable to keep this appointment at 937-293-5567, option #2.

If you have any questions regarding the above, or if we can be of further help, please do not hesitate to call our office at 937-293-5567 or visit our website at www.daytonskincare.com. For driving directions, please refer to the enclosed map.

We look forward to meeting you.

Sincerely,
Dayton Skin Care



FROM NORTH DRIVING SOUTH ON I-75S:

Take the OH-741 S/SPRINGBORO RD exit, EXIT 50B. Turn LEFT onto SPRINGBORO RD/OH-741. Turn LEFT onto W DOROTHY LN. Turn RIGHT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

FROM SOUTH DRIVING NORTH ON I- 75N:

Take EXIT 47 toward MORAINE/KETTERING. Turn RIGHT onto S DIXIE HWY. Turn RIGHT onto W DOROTHY LN. Turn RIGHT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

FROM NORTH DRIVING SOUTH ON I-675S:

Take INDIAN RIPPLE/DOROTHY LANE exit, EXIT 10. Turn RIGHT onto E DOROTHY LANE and travel 5.6 miles to GOVERNORS PLACE BLVD. Turn LEFT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

FROM SOUTH DRIVING NORTH I-675N:

Take INDIAN RIPPLE/DOROTHY LANE exit, EXIT 10. Turn LEFT onto E DOROTHY LANE and travel 6.5 miles to GOVERNORS PLACE BLVD. Turn LEFT onto GOVERNORS PLACE BLVD., 3025 GOVERNORS PLACE BLVD is on the RIGHT.

PATIENT INFORMATION

NAME: _____ DATE OF BIRTH: _____
(FIRST) (MIDDLE) (LAST)

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

RACE: _____ PRIMARY LANGUAGE: ENGLISH SPANISH OTHER _____ SEX: MALE or FEMALE

ETHNICITY: HISPANIC OR LATINO NOT HISPANIC OR LATINO EMAIL: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____ CELL PHONE: (____) _____

OCCUPATION: _____ PREFERRED PHARMACY/ADDRESS: _____

REFERRED BY: _____ PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT NAME: _____ PHONE: (____) _____

FINANCIALLY RESPONSIBLE PARTY (If different from the patient)

NAME: _____ DATE OF BIRTH: _____

RELATIONSHIP TO PATIENT: _____ EMAIL: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: (____) _____ WORK PHONE: (____) _____ CELL PHONE: (____) _____

INSURANCE SUBSCRIBER INFORMATION (Please present insurance card at time of check-in)

PRIMARY INS. NAME: _____ SECONDARY INS. NAME: _____

NAME OF SUBSCRIBER: _____ NAME OF SUBSCRIBER: _____

SUBSCRIBER'S DATE OF BIRTH _____ SUBSCRIBER'S DATE OF BIRTH _____

SUBSCRIBER'S ID# _____ SUBSCRIBER'S ID# _____

GROUP # _____ GROUP # _____

RELATIONSHIP TO SUBSCRIBER: _____ RELATIONSHIP TO SUBSCRIBER: _____

ALL PATIENTS: ASSIGNMENT OF INSURANCE BENEFITS. I hereby assign all medical and/or surgical benefits, to include major medical benefits to which I am entitled, private insurance and any other health plans, to Dayton Skin Care Specialists. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not the charges are paid by said insurance. I hereby authorize Dayton Skin Care Specialists to release all information necessary to adjudicate all claims and secure payment for services rendered.

Signature: _____ **Date:** _____

MEDICARE PATIENTS ONLY: I request that payment of authorized Medicare benefits be made on my behalf to Dayton Skin Care Specialists, for services furnished to me by Dayton Skin Care Specialists. I authorize any holder of medical information about me to release to the centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If other health insurance is indicated in Item 9 of the CMS-1500 form or elsewhere on other approved claim forms, my signature authorizes releasing the information to the insurer or agency shown. Dayton Skin Care Specialists accepts the charge determination of Medicare carrier as the full charge, and I am responsible only for the deductible, coinsurance and non-covered services.

Signature: _____ **Date:** _____

DAYTON SKIN CARE POLICIES

Initial	INSURANCE: I understand that my insurance coverage is an agreement between me and my insurance company. I am financial responsible for my co-pay, deductible, coinsurance, and non-covered services. If my insurance plan requires a referral from a primary care physician, I am responsible for obtaining the necessary referral. <u>It is my responsibility to know the requirements of my insurance program.</u> I may be responsible for the total payment of services rendered if a referral is not obtained. Dayton Skin Care strives to assist the patient whenever possible.
Initial	FINANCIAL RESPONSIBILITY: I understand that I am responsible for all co-pay, deductible, coinsurance, and outstanding balances at the time of service. Co-payments and outstanding balances will be collected at check-in. I understand that my appointment may be rescheduled if I cannot meet these obligations. There will be a fee of \$30.00 charged to my account by Dayton Skin Care for each returned check.
Initial	COSMETIC AND AESTHETIC SERVICES: <u>Payment is required in full at the time of your procedure.</u> I understand cancelation of less than 24 hours for cosmetic appointments or less than 5 days for Sculptra appointments will result in forfeit of my deposit. I understand there will be an additional \$100.00 cosmetic consultation fee if I choose to discuss cosmetic services during my routine medical examination.
Initial	LAB FEES: Biopsies may be sent to an outside lab to be analyzed. The fee for this is a separate charge from the office visit and will be billed directly by the processing lab. I understand that it is my responsibility to inform the Dayton Skin Care Specialists staff or providers if my insurance policy requires use of a contracted lab or facility.
Initial	COLLECTION AGENCY COSTS: In the event my account is referred to a collection agency or attorney for collection, I agree to pay all collection fees, attorney fees, court costs, and expenses.
Initial	MISSED APPOINTMENTS: In fairness to other patients and our physicians we require a minimum of 24 hour notice to cancel an appointment. I acknowledge I may be charged a \$35 fee for missed or cancelled appointments. Missing more than three appointments without providing at least 24-hour notice is grounds for discharge from the practice.

My signature below indicates that I have read and agree to the above policies of Dayton Skin Care.

Signature: _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTICES

A copy of the Dayton Skin Care Notice of Privacy Practices and Notice of Nondiscrimination Practices can be found on our web site, www.daytonskincare.com under Patient Information / Forms and Policies. A written copy is also available by request at the reception desk.

PRIVACY PRACTICES:

I acknowledge that I have received or been offered a copy of Dayton Skin Care. Notice of Privacy Practices.
_____ (Initial)

I acknowledge my right and have been offered the option to request to receive communications of my personal health information by alternative means or at alternative locations. I understand that Dayton Skin Care may refuse to accommodate my request if it is not reasonable. _____ (Initial)

I authorize my healthcare provider and/or any entity authorized by my healthcare provider, including those using automated dialing systems, automated messages, email, text messaging and/or other electronic communication to contact me for any reason by using any telephone number, email address and/or mailing address associated with my account. _____ (Initial)

I authorize my healthcare provider to access my pharmacy data electronically to determine pharmacy benefits, including plan formulary coverage for prescription medications and to download a historic list of all medications prescribed by any provider. _____ (Initial)

PRIVACY INSTRUCTIONS:

Yes No May we leave detailed messages on your answering machine or voice mail (e.g. test results, billing information, etc.)? If yes, **please provide your preferred phone number:** _____

Yes No May we discuss details regarding your care, your test results, billing information, or appointment information with someone else, other than you? If yes, please list the name and relationship of each individual below

	Name	Relationship	Phone
1.			
2.			
3.			

You may revoke or update this information at any time, in writing.

You may refuse to sign this acknowledgement and authorization. In refusing we may not be allowed to process your insurance claims. Reason for refusal (may be completed by patient or staff): _____

NONDISCRIMINATION PRACTICES:

Dayton Skin Care complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex.

I acknowledge that I have received or been offered a copy of Dayton Skin Care. Notice of Nondiscrimination Practices.
_____ (Initial)

Signature of Patient or Representative: _____ **Date:** _____

Print Name: _____

Relationship of Representative/Authority to act on behalf of the Patient: _____

Medical History

Name: _____ Date of Birth: _____ Today's Date: _____

Appointment/Surgery Date: _____ Reason for today's visit: _____

Referred by: _____ Primary Care Physician: _____

Past Medical History

Please indicate if you have ever experienced any of the following conditions. Please include the date of experience. **Please also indicate that you have not experienced any of the following conditions by checking the No box.**

	Yes	No		Yes	No		Yes	No				
Anxiety			Year _____			Crohn's disease			Year _____			Year _____
Arthritis			Year _____			Deep Vein Thrombosis			Year _____			Year _____
Asthma			Year _____			Dementia			Year _____			Year _____
Atrial fibrillation			Year _____			Depression			Year _____			Year _____
Bladder			Year _____			Diabetes Type I			Year _____			Year _____
Blood clots			Year _____			Diabetes Type II			Year _____			Year _____
Bowel/Stomach			Year _____			Fainting			Year _____			Year _____
Bypass surgery (heart)			Year _____			Glaucoma			Year _____			Year _____
Cancer (other than skin)			Year _____			Heart attack			Year _____			Year _____
Chest pain			Year _____			Heart murmur			Year _____			Year _____
Chronic cough			Year _____			Hepatitis type ____			Year _____			Year _____
Chronic morning cough			Year _____			High blood pressure			Year _____			Year _____
Congestive heart failure			Year _____			Hyperlipidemia			Year _____			Year _____
COPD			Year _____			Irregular heart rhythm			Year _____			Year _____
Coronary artery disease			Year _____			Irritable bowel syndrome			Year _____			Year _____
									Year _____			Year _____
									Year _____			Year _____
									Year _____			Year _____
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									Year _____			Year _____
									Year _____			Year _____
									Year _____			Year _____

Are you immunosuppressed? Yes No

Have you had or have you been exposed to HIV (AIDS)? Yes No

Have you ever been diagnosed with Chronic Lymphocytic Leukemia? Yes No When _____

Have you ever had skin or any other type of cancer? Yes No If Yes, what type? _____

Have you ever been treated with chemotherapy? Yes No

Have you ever been diagnosed with DPD (Dihydropyrimidine Dehydrogenase) deficiency? Yes No

Cardiologist Name & Phone # _____ Current Weight _____ Current Height _____

Do you drink alcohol? Yes No If Yes, _____ drinks per day and what type _____

Do you use IV drugs? Yes No If Yes, what? _____ How much? _____

Have you ever had dental anesthesia (Novocain)? Yes No Any bad reaction? Yes No

Skin:

When you are exposed to sun do you: Tan only _____ Tan and burn _____ Burn _____

Do you have a history of skin infection? Yes No

Has anyone in your family had skin cancer? Yes No If Yes, relationship? _____

Do you have a family history of other cancer? Yes No If Yes relationship? _____ Type? _____

Do you have a family history of diabetes? Yes No If Yes, relationship? _____

Do any of your first-degree relatives have a drug reaction to medication? Yes No If Yes, what type? _____

Do you have a history of any specific skin diseases? Yes No

If Yes, please list _____

List any other disease or condition we should know about: _____

List surgical procedures you have had in the last 6 months: _____

Please answer the following questions:

A. Do you currently smoke OR vape? Yes No If Yes, what type and how much? _____ Have you tried to quit? Yes No
If No, did you ever smoke? Yes No What type and how much? _____

B. Do you bleed easily? Yes No

C. (Women) Are you pregnant or nursing? Yes No Due Date: _____

D. Do you have artificial joints, valves? Yes No

E. Are you claustrophobic? Yes No

F. When was your last Influenza Immunization Month/Year ___/___ or N/A

G. When was your last Pneumonia Immunization Month/Year ___/___ or N/A

H. When was your last Colonoscopy Month/Year ___/___ or N/A

I. Female Patients: When was your last Mammogram Month/Year ___/___ or N/A

J. What is your occupation? _____ What are your hobbies? _____

Patient Signature

Date

MEDICATIONS/ALLERGIES

NAME: _____ DATE OF BIRTH: _____
(FIRST) (MIDDLE) (LAST)

Are you allergic to any medications: Yes No If yes, please list below.

1. _____ What type of reaction do you experience?
2. _____ What type of reaction do you experience?
3. _____ What type of reaction do you experience?

CURRENT MEDICATIONS **INCLUDING PRESCRIPTION DRUGS, VITAMINS, HORMONES, ASPIRIN, TYLENOL, ETC.**

IF YOU ARE NOT ON ANY MEDICATIONS PLEASE CHECK HERE

Patient Signature

Date

