MEADVILLE DERMATOLOGY &
SKIN SURGERY INSTITUTE

Welcome! We are pleased to have you as a patient. As a means of establishing common ground, we would like to outline some of our office policies.

Appointment Scheduling:

Appointments must be scheduled by the patient, unless patient is a minor or is mentally impaired.

New Patients:

- Your appointment has been scheduled for ________________ @ ________________.
- Please arrive 15 minutes prior to your scheduled appointment times in order to complete necessary paperwork. Our address is 149 N. Main Street, Meadville, PA 16335 & phone is 814-333-3939.
- Please bring **completed** medical history questionnaire, **completed** medication list (name, strength/dose, frequency, route of administration), proof of insurance, photo id, and copayment. (Please do not mail or fax these forms to our office.)

Late/ No Show Policy:

Patients arriving more than 10 minutes after their scheduled appointment time may be asked to reschedule. We make every effort to be on time for all of our appointments, however, due to the nature of our practice, situations do arise which may delay the physician/physician assistant. We apologize for any inconvenience this might cause. We understand your time, as well as ours, is valuable.

We require at least a 24 hour notice for cancelled appointments or a $100 fee for general dermatology/procedure/surgical/cosmetic appointments will be charged. After any missed appointment a new appointment will not be scheduled until the 'no show' payment has been paid. **After 3** 'No Shows' the patient may be discharged from the practice.

Patient Responsibilities:

- Provide Complete and accurate information to the best of his/her ability about his/her health, any medication, including over-the-counter products and dietary supplements and any allergies or sensitivities.
- Follow the treatment plan prescribed by his/her provider.
- Provide a responsible adult to transport him/her home from the facility and remain with him/her for 24 hours, if required by his/her provider for surgical procedures.
- Accept personal financial responsibility for any charges not covered by his/her insurance.
- Be respectful of all the health care providers and staff, as well as other patients.

PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT (DO NOT MAIL BACK)

Patient Name:____

Date of Birth:____________Sex:______Social Security Number: ________________

Street:__________________________City/State/Zip:________________

Home Phone:____________Cell Phone:____________Alt Phone:____________

Email Address:__________________________Marital Status:____________

Ethnicity (please circle): Hispanic or Latino/Not Hispanic or Latino

Religion:____________Race:____________Language:____________

Employer:__________________________Employer Phone:____________

Street:__________________________City/State/Zip:________________

Emergency Contact:__________________________Relationship:____________

Street:__________________________City/State/Zip:________________

Home Phone:____________Cell Phone:____________Alt Phone:____________

Guarantor Name (if patient is under 18):________________Relationship:____________

Date of Birth:____________Social Security Number: ________________________

Street:__________________________City/State/Zip:________________

Home Phone:____________Cell Phone:____________Alt Phone:____________

Insurance:________________Member ID:____________Group:____________

Subscribers Name:__________________________Relationship:____________

Date of Birth:____________Social Security Number: ________________________

Street:__________________________City/State/Zip:________________

Home Phone:____________Cell Phone:____________Alt Phone:____________

Family Doctor:__________________________**Doctor Phone**:________________

PLEASE BRING INSURANCE CARD(S)

MEADVILLE
MEDICAL CENTER
DERMATOLOGY &
SKIN SURGERY INSTITUTE

Dear Patient:

This medical practice provides Hospital-Base Outpatient physician services. Meadville Medical Center offers some of its services in what are known as provider-based or hospital-based outpatient departments. Hospital-based outpatient departments are considered part of the hospital; "private" physicians are not. Centers located miles away from the main hospital campus may still be considered part of the hospital under such an arrangement. When you see a physician or receive services in a hospital-based outpatient department, you are still being treated within the medical center rather than a private physician's office.

How this affects your billing. Because this office is a hospital-based outpatient department, we are required to bill professional services performed by the physician separately from those technical or ancillary (facility) services of the outpatient center and its staff. Therefore, you may receive two (2) types of charges on your combined patient bill for health care delivery at the outpatient center. One charge represents the department or medical center fee. The other charge represents the professional or physician's fee.

It is not unusual for a hospital like MMC to bill this manner for these types of services. It is required under Medicare laws in many integrated healthcare delivery systems across the country.

How this affects co-pays and/or deductibles. Depending on your health care insurance coverage, it is possible you may pay more for certain outpatient services and procedures delivered at the hospital outpatient locations like this one. We recommend you review your insurance benefits or contact your insurance carrier to determine what the insurance policy will pay and what out-of-pocket expenses you may incur.

For further questions. Our charges are available for your review on Meadville Medical Center's website www.mmchs.org and estimates prior to your service can be provided by calling our financial counselors at 814-333-5737.

If you still have questions when you receive your Meadville Medical Center bill, feel free to contact our billing service representatives at 1-888-219-6117.

As always, Meadville Medical Center strives to offer the best, most comprehensive health care services to you. We hope this letter has been helpful to you in explaining how the billing process for this medical practice works.

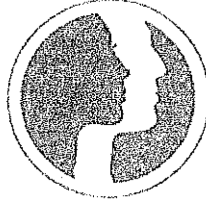
Sincerely,

Your Care Team at Meadville Medical Center

☐ **I have read and understand the above information regarding insurance billing.**

______________________________ ______________

Signature of Patient/Guardian Date



MEADVILLE DERMATOLOGY &
SKIN SURGERY INSTITUTE

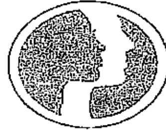
I, ___________________________________, a current patient at Meadville Dermatology & Skin Surgery Institute hereby authorize the attending physician or other designated person(s) to take:

1. Photographs of me for identification purposes ______Yes _______No
2. Photographs of the appropriate parts of my body in order to provide supporting documentation of my medical condition. (I understand that any photographs taken will be placed in and remain part of my medical records). ______Yes ________No
3. I authorize my **non-identifiable** photographs to be used in electronic and printed publications and medical presentations. ______Yes ________No

____

Patient /Responsible Party Signature Date

PLEASE COMPLETE MEDICAL HISTORY AND BRING TO YOUR APPOINTMENT



MEADVILLE DERMATOLOGY &
SKIN SURGERY INSTITUTE

Patient Name: ______________________________ **Date of Birth:** __________________

Past Medical History: (circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
Chronic Obstructive lung disease
Coronary Arteriosclerosis
Depressive Disorder
Diabetes
End Stage Renal Disease
Epilepsy
GERD
H/O Hypertension
Hearing Loss
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Malignant Lymphoma
Malignant tumor of lung
Malignant tumor of breast
Malignant tumor of colon
Malignant tumor of prostate
Radiation Treatment
Transplantation of bone marrow

Other: ____

Past Surgical History: (circle all that apply)

Bilateral replacement of knee joints
Biopsy of breast
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell carcinoma
Excision of melanoma
Excision of squamous cell carcinoma
History of tubal ligation
History of appendectomy
History of bilateral mastectomy
History of cholecystectomy
History of percutaneous transluminal coronary angioplasty
History of tissue graft heart valve replacement
Hysterectomy
Lumpectomy of breast R/L
Mastectomy of breast R/L
Mechanical heart valve replacement
Oophorectomy
Kidney Stone Removal
Prosthetic arthroplasty of bilateral hips
Splenectomy
Prostatectomy
Surgical biopsy of skin
Total nephrectomy
Total orchidectomy
Total replacement of left hip joint
Total replacement of right hip joint
Total replacement of left knee joint
Transplantation of heart
Transplantation of liver

PACEMAKER/DEFIBRILLATOR

Other Surgeries: ____

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratoses
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer

NONE

Other ______________________________

Do you wear sunscreen? Yes No
If yes, what SPF? ________
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? ______________________________

Social History: (Please circle all that apply)

Cigarette Smoking:
Currently smokes
Has smoked in the past
Never smoked
Former smoker

Alcohol Use:
None
Less than 1 drink per day
1-2 drinks per day
3 or more drinks per day

Other______________________________

Family History: (Only first degree relatives)

____
____
____
____
____

Review of Systems: (Please circle all that apply)
Are you currently experiencing any of the following?

Joint Pain Fever Chills Unintentional Weight Loss/Gain Headaches

ALERTS: (Please circle all that apply)

Allergy to adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant? Yes No

MEDICATION LIST

*Due to many insurance plans requiring prior authorizations for prescriptions, it is very important that current and past prescriptions are documented. If you have been treated for the condition which our office is evaluating today, please list below all past treatments and prescriptions.
If you are unsure, you may contact the doctor's office where you were treated or your pharmacy for a list of medications used.

____

____

____

ALLERGIES

Preferred pharmacy name/location: ______________________________
Phone#: ______________________

Verbal Communication Authorization

May we leave messages concerning your appointments/results on your home answering machine?

- ☐ **Yes**
- ☐ **No**

May we leave messages concerning your appointments/results on your cell phone?

- ☐ **Yes**
- ☐ **No**

May we leave messages concerning your appointments/results on work voice mail?

- ☐ **Yes**
- ☐ **No**

I allow employees of MMC and its subsidiaries to discuss my protected health information with the following people:

____

____

____

****

It is the responsibility of the patient or personal representative to contact Meadville Medical Center Health Information Management Department at (814) 333-5535 to revoke a verbal communication authorization.

****

Please print your name and sign below:

Name of patient/personal representative (please print):	**Relationship (please print):**
Signature of patient or personal representative :	**Date/time:**

For office use only:

Date of revocation:____

Comments :____

HIM staff member: ____