David B Pharis MD PC

Dear Patient:

We welcome you as a new patient. Enclosed are the forms to be completed by you and brought to the office at the time of your first visit. Please do not mail them as they may get lost or delayed in the mail. We will need the original forms as well as your insurance cards and a picture ID, such as a driver's license, when you arrive for your visit.

Please be prepared to pay your co-pay at the time of your visit. Surgical patients who are seen in follow up may have an office visit charge depending on the complexity of the surgical procedure and the timing of the follow up visit. A co-pay will be collected at this visit if an office visit is charged. We accept cash, check, Visa, MasterCard, Discover and American Express.

Please make sure you sign all forms and only use black ink.

David B Pharis MD PC

New Patient Information

Patient Name: _____
Last First Middle Initial

Address:_____

City:_____State:_____Zip code:_____

Social Security #:_____-_____-_____Date of Birth:_____Sex: ◯ Male ◯ Female

Marital Status: ◯ Single ◯ Married ◯ Divorced ◯ Widowed ◯ Other

Home Phone: ( )_____Cell Phone: ( )_____

Patient Employer:_____Work Phone: ( )_____

Emergency Contact:_____
Name Relationship

Emergency Contact Phone: ( )_____

Primary Care Physician:_____

Referring Physician:_____

Pharmacy:_____( )_____
Name Address Phone

Prescription History Authorization:

◯ Yes ◯ No I hereby authorize David B. Pharis MD PC to confirm prescription medication history and dosage.

Authorization for Discussion of Care:

◯ Yes ◯ No I authorize David B. Pharis MD PC to discuss my healthcare with the following contact(s):

_____( )_____
Name Relationship Phone

_____( )_____
Name Relationship Phone

_____
Signature Printed Name Date

David B Pharis MD PC

FINANCIAL POLICY AND AUTHORIZATION

Patient Name:_____ Date:_____

Thank you for choosing David B Pharis MD PC as your provider. Dr. Pharis and his staff are committed to providing you with the best possible medical care. Please read this form carefully as it outlines our policy regarding payment and authorization to file your medical insurance claim. A copy will be provided upon request.

All patients should provide accurate and complete personal and insurance information prior to your appointment. It is the patient's responsibility to make sure that we have your most recent information. If we are not provided with accurate information at the time of service, you may be responsible for payment in full for all services rendered. All applicable co-pays and any prior balances are due at the time of service.

David B Pharis MD PC has preferred provider contracts with most insurance companies. Your insurance coverage is a contract between you and your insurance company. David B Pharis MD PC is not responsible for services denied by your insurance company. Please be aware that it is your responsibility to obtain any necessary referrals and authorizations prior to your appointment. It is also your responsibility to know if your insurance company requires a referral prior to your appointment.

Financial Authorization: I hereby authorize my physician to bill my insurance company for services rendered. I also assign to my physician any insurance or other third-party payments for services provided to me. I understand that my physician has the right to refuse or accept assignment of such benefits. If these benefits are not paid to my physician, I agree to forward all health insurance and other third-party payments I receive for services rendered to me immediately upon receipt. I am responsible for the payment of all charges for services rendered to the above patient. Payment will be made promptly, as bills are presented, with the settlement in full or appropriate arrangements for settlement made.

The undersigned certifies that he/she has read this document and that he/she is the patient or is duly authorized by the patient as the patient's general agent to execute these consents and agreements and accept these terms:

Payments: We accept cash, checks, Visa, MasterCard, Discover and American Express. Upon receipt of billing statements, outstanding balances are due within 30 days. Should your account become past due it may be sent to a collection agency for legal action with a 25% fee added.

Returned Checks: Checks returned to our office by the bank will be assessed a $30.00 returned check fee, in addition to the original amount of the check. Upon notice you are immediately responsible to pay the outstanding check and returned check fee. If you do not pay the check plus the returned fee, the account could be sent to a collection agency for legal action. In addition, we may only accept cash or credit cards for all future visits.

Please be aware that there may be an office visit charge and co-pay required for surgical patients seen in follow up depending on the timing of that appointment.

By signing below you acknowledge you have carefully read, understand and agree to the above terms.

Signed:_____ Date:_____

David B Pharis MD PC

Medical History Form

Patient Name: _____
Last First Middle Initial

Reason for today's visit:_____

History of today's problem(s):_____

Skin area involved:_____

How long has the problem been present?_____

Was there any previous treatment? ◯ No ◯ Yes If yes, what was done and when?_____

_____

Previous skin cancer? ◯ No ◯ Yes Previous Mohs surgery? ◯ No ◯ Yes

Check all that apply regarding to today's problem: ◯ None Apply

Change in:	◯ size	◯ color	◯ elevation	◯ hardness
History of:	◯ bleeding	◯ itching	◯ pain	◯ ulceration
	◯ infection	◯ occasional symptoms		◯ constant symptoms
Risk Factors:	◯ X-ray treatments (not routine X-rays)			◯ UV light treatments
	◯ Arsenic exposure		◯ Immunosuppression	

Check ALL that apply regarding your overall health and add any other medical problems:

CARDIOVASCULAR
◯ Normal
◯ Artificial valve
◯ Pacemaker
◯ High blood pressure
◯ Heart attack
◯ High cholesterol
◯ Bypass/other surgery
◯ Mitral valve prolapsed
◯ Other heart problem

GASTROINTESTINAL
◯ Normal
◯ Stomach ulcer
◯ Celiac disease
◯ Inflammatory bowel disease

NEUROLOGICAL
◯ Normal
◯ Stroke
◯ Seizures
◯ Alzheimer's
◯ Dementia

PSYCHIATRIC
◯ Normal
◯ Depression
◯ Anxiety disorder
◯ Other

BLOOD/LYMPH
◯ Normal
◯ Anemia
◯ Enlarged lymph nodes
◯ Bleeding problems

RESPIRATORY
◯ Normal
◯ COPD
◯ Asthma

ENDOCRINE
◯ Normal
◯ Diabetes
◯ Thyroid problem

SKIN
◯ Normal
◯ Poor/slow healing
◯ Keloids

GENERAL
◯ Normal
◯ Fever/weight loss

INFECTIONS
◯ Normal
◯ Hepatitis
◯ HIV/AIDS
◯ Tuberculosis

MUSCULOSKELETAL
◯ Normal
◯ Arthritis
◯ Artificial joint
◯ Fibromyalgia

HEAD/NECK
◯ Normal
◯ Hearing aid
◯ Glaucoma
◯ Plastic surgery

Other medical problems:_____

_____

Major illnesses/hospitalizations: ◯ none ◯ list:_____

_____

Family History: ◯ Melanoma ◯ Other skin cancers ◯ Bleeding problems

Do you wear:	◯ Dentures	◯ Glasses	◯ Contacts
Smoking:	◯ No	◯ Former	◯Yes; packs per day?_____
Alcohol:	◯ No	◯ Social/occasional drinking	

Alcohol or drug problems/addictions: ◯ No ◯ Yes (please describe)_____

Updated_____ Updated_____ Updated_____

Names of Medications
(include aspirin, herbals, and vitamins)

Medications	Dosage

Medication Allergies: ◯ **No** ◯ **Yes (if yes, please list)**

_____

_____

_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by law to provide you with a copy of our Notice of Privacy Practices. These are posted on our website and are available in hardcopy in our office. To ensure that our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

Signature of Patient (of Legal Representative)

Date

Signature of Staff Member Title Date

David B Pharis MD PC

Medical Information Release Form

Patient's Name:_____
First Middle Last

Mailing address:_____

City:_____ State:_____ Zip:_____

Date of Birth:_____/_____/_____ Social Security #_____-_____-_____
Month Day Year

Preferred Phone Number: _____ cell home work (circle one)

The undersigned hereby grants permission to David B. Pharis MD PC to discuss any and all medical bill related information with any medical practitioner, hospital, facility, insurance company or any other agency that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein for the purpose of David B. Pharis MD PC negotiating medical bills on the undersigned's or dependent's behalf.

The undersigned hereby authorizes any medical practitioner, hospital, facility, insurance company or any other person or entity that has medical records or knowledge of the medical records of the undersigned and/or the dependents listed herein, to release such information upon request to David B. Pharis MD PC for the purpose of David B. Pharis MD PC negotiating medical bills on the undersigned's or dependent's behalf.

The undersigned understands that:

- I may revoke this medical information release at any time, in writing, but the release shall remain valid until revoked or upon the expiration of one (1) year after the release is executed, whichever occurs first.
- This release may include medical records of treatment for physical and/or emotional illness, except psychotherapy notes, including treatment of alcohol or drug abuse.
- David B. Pharis MD PC will maintain the privacy of any information obtained and will not disclose such information to any other person or entity except as necessary to effectuate service or by express written permission by me.
- A copy of this form, including a facsimile, may be used in place of the original.

I acknowledge that I have read and understand this Medical Information Release Authorization. Further, I authorize the disclosure of my protected health information in accordance with the terms in this authorization.

_____
Signature Printed Name Date