PATIENT INFORMATION
MCLAUGHLIN DERMATOLOGY
JENNIFER A. MCLAUGHLIN, M.D., CHRISTY HOLMAN, PA-C

Name of Patient _____ **Date** _____

Social Security Number _____

Address_____ **Birth Date**_____

City_____ **State**_____ **Zip**_____

Home Phone _____**Work Phone**_____ **Cell #**_____ **E-mail Address**_____

Preferred method for appointment reminders: □ Text □ Phone (Please Circle) Home Phone or Cell Phone

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Marital Status: □ Married □ Single □ Widowed □ Divorced □ Separated Sex_____ Age_____

Occupation_____ Employer's Name and Address_____

Family Doctor _____ Address _____

Referred by _____ Address _____

Has any correspondence been forwarded to us by your doctor? ___ Have you been seen in this office prior to today? ___

Reason for visit _____

Drug Allergies _____

Person to contact in case of emergency _____ Phone _____

INSURED SUBSCRIBER INFORMATION

Name: _____ SS# _____ DOB: _____

Home Phone: _____ Address: _____

Employer: _____ Relationship to Patient: _____

Complete this section only if Patient is a Minor:

Mother's Name: _____ DOB: _____Father's Name _____ DOB _____

Address: _____ Address: _____

Home Phone: _____ Home Phone: _____

PRIVATE INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS AND INFORMATION RELEASE
I, the undersigned, authorize payment of medial benefits to MCLAUGHLIN DERMATOLOGY, for any services furnished to me by the physicians. I understand that I am financially responsible for any amount not covered by my insurance contracts. I also authorize you to release to my insurance company information concerning health care, advice, treatment or supplies provided to me. This information will be used for the purposes of evaluating and administering claims of benefits.
Date _____ Signature of Patient or Guardian _____ Relationship _____

MEDICARE LIFETIME SIGNATURE ON FILE
I request the payment of authorized Medicare benefits be made either to me or on my behalf to MCLAUGHLIN DERMATOLOGY, for any services furnished to me by physicians. I authorize any holder of medical information about me to release to The Health Care Financing Administration and its agents any information needed to determine these benefits payable to related service.
Date _____ Signature of Patient or Guardian _____ Relationship _____

McLaughlin Dermatology
16 Hospital Circle Suite B
Batesville, AR 72501
(870) 793-7800

PATIENT MEDICAL INFORMATION

Date: _____

Name (Last): _____ (First) _____ (MI) _____

List **Allergies to Medications: _____**

List all current Medications (Prescription & OTC): _____

_____

Do you have any current or past diseases/conditions involving the following:

	Yes	No	Specifics		Yes	No
Lungs	□	□	_____	Anxiety/Depression	□	□
Heart	□	□		High Blood Pressure	□	□
Kidney	□	□		High Cholesterol	□	□
Liver	□	□		Arthritis	□	□
Thyroid	□	□		Pacemaker/Defibrillator	□	□
Seizures	□	□		Bleeding Tendency	□	□
Cancer	□	□		Artificial Joint/Valve	□	□
Diabetes	□	□		Other Mental Illness	□	□
Hepatitis	□	□		HIV	□	□

List Previous Surgeries: _____

Flu Vaccine: Yes or No Pneumonia Vaccine: Yes or No Covid Vaccine: Yes or No

Do you use _____Tobacco Products _____ Alcohol If yes, how much? _____

Do you have a history of substance abuse? _____

(Women) Are you pregnant? _____ Are you breastfeeding? _____

Have you ever had skin cancer? _____ If so, what type & location? _____

Is there a history of melanoma in your family? _____ If yes—parent, sibling, child (please circle)

Reason for today's visit: _____

Previous medication and/or treatment for this condition: _____

History of other skin disorders: _____

Other medical conditions: _____

Patient Signature: _____

Authorization for the Use or Disclosure of Protected Health Information to Family, Friend or Attorney

Compliance/Privacy Officer
JENNIFER A. MCLAUGHLIN, M.D. PLLC
16 Hospital Circle, Suite B, Batesville, AR 72501
870-793-7800

As required by the Health Insurance Portability and Accountability Act of 1996 our office may not use or disclose your health information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of protected health information described herein. You may revoke this authorization at any time by signing and dating the revocation section on your copy of this form and returning it to this office.

AUTHORIZATION SECTION

I, _____ (print patient's name) hereby authorize the use and disclosure of my health information that pertains to me to:

Spouse: _____

Child: _____

Attorney: _____

Other: _____
(Name & Relationship)

I authorize Jennifer A. McLaughlin, MD, PLLC, its physicians, medical and business staff members to make these disclosures of my health information for my personal use and at my request or for my personal use.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and is no longer protected.

I understand that I may revoke this authorization at any time by signing the revocation section of my copy of this form and returning it to the address above. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

I understand that this authorization will automatically expire on _____

I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization or not.

I understand that I have the right to inspect and to obtain a copy of any information disclosed pursuant to this authorization.

I understand that the clinic named above may/will receive compensation for the uses and disclosures that I have authorized. The compensation to be received is $15.00.

_____
Signature Date

REVOCATION SECTION

I hereby revoke this authorization. _____ _____/_____/_____

Revocation received by clinic:

_____
Signature Date

Copy Given to Patient _____ (signature of employee)

Jennifer A. McLaughlin, M.D., PLLC

McLaughlin Dermatology

Policies and Procedures

Thank you for choosing us as your health care provider. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Financial Agreement:
Payment of deductible, co-payments, and any uncovered services are due at time of service. SELF PAY PATIENTS AND COSMETIC SERVICES ARE EXPECTED TO BE PAID IN FULL AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, OR CREDIT CARDS AND CARE CREDIT FINANCIAL SERVICES. It is your responsibility to provide the receptionist with your most current vital information. You will need to provide a copy of your insurance cards upon each visit, and notify us immediately of any changes. If payment cannot be made in full at the time of service a financial agreement can be made between the patient and McLaughlin Dermatology. A credit card on file is required to initiate a financial payment plan. **Interest charge of 10% will be applied to balances after 120 days.** We will send you three statements regarding your balance. The second statement is considered past due. If you should receive a third statement noted "Final" the account balance will be turned over to a collection agency. If your account is turned over to a collection agency, you will be discharged from the practice.

Cancellations/Late Arrivals/No Shows:
Please be at the clinic 15 minutes before your scheduled appointment so we can update your information. **If you cannot make your appointment, kindly notify us 24 hours before your scheduled appointment so that we can contact another patient from our waiting list. If you so not show up for an appointment and fail to cancel, you will not be allowed to reschedule after the 2nd "no show" appointment.** No shows for cosmetic or surgical procedures will result in a fee of $75.00, as longer time slots are allowed for these. If you arrive more than 15 minutes late to your appointment, you may be rescheduled. Please have all paperwork completed before your appointment time so that we can stay on schedule.

Insurance Policy:
Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, we are happy to file your insurance for you. However, you are responsible for paying all co-payments, deductibles, and non-covered services. We are not a party to the contract between the patient and their insurance company and have our own contractual obligations with each of our participating insurance companies. Our facility uses D-Path for histological evaluation of biopsies and excisions. It is the patient's responsibility to determine if his/her insurance is in network with these companies and notify us thereof. The pathological evaluation of these specimens is billed separately by the pathology lab.

Medicare Policy:
We accept Medicare assignment of all Medicare claims. This means that we will reduce our fee to the amount allowed by Medicare. We will file one (1) secondary claim for you. You must provide us with the current and correct information at the time of your visit. If you have more than one (1) secondary insurance, you will have to file it yourself. If you ask us to perform a procedure that we believe Medicare will not approve, you will be required to sign an ABN (Advance Beneficiary Notice). Medicare requires this form be signed prior to you receiving the service. You will be required to pay the cost of the non-covered service at the time of the visit.

Minor Policy:
Patients under eighteen must be accompanied by a parent/legal guardian. If a parent/legal guardian is unable to accompany the minor, the appointment may be rescheduled.

Photography Consent:
I consent to medical photography. I understand that the information may be used in my medical records and for purposes of medical teaching. All photography will be kept private and included in appropriate medical visit record. I understand that I will not receive payment from any party. Refusal to consent to photographs will in no way affect the medical care I will receive. If I have any questions or wish to withdraw my consent in the future, I may do so by contacting the medical practice in writing.

Pharmacy Consent:
I consent for a prescription history request to be performed to allow my provider access to a list of medications that have been prescribed, dispensed, claimed or indicated (OTCs) by a patient. The Medication History may be reconciled with the prescriber's patient record for improved medication management and to assist in clinical decision support.

Skin Cancer Patients:
I understand that if I have a skin cancer that it is my responsibility to seek follow-up care by McLaughlin Dermatology personnel or other dermatology professionals. Failure to seek follow-up care is my responsibility and I do not hold McLaughlin Dermatology personnel professionally or personally responsible for skin cancer follow-up.

Usual and Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Thank you for understanding our Policies and Procedures. Please let us know if you have any questions or concerns. We are committed to making your treatment successful.

I have read, understand, and agree to the Policy and Procedures.

Patient/Guarantor Signature: _____ Date: _____