CLEAR

Dermatology & Aesthetics Center

AUTHORIZATION, ACCEPTANCE OF TERMS AND CONSENTS

I authorize the release of any medical information necessary to process any claim.
I certify that I have read and fully understand the office policies on payment and insurance of Clear Dermatology & Aesthetics Center. I realize that I am responsible for my charges and that any collection of legal fees will be charged to me in the event that my account is not paid in full as described in the terms and conditions above.

I authorize benefits amounts payable by the insurance company to be assigned directly to the provider.

Print Name:_____ Date:_____

Patient Signature (or Guardian): _____

If Guardian representative, describe relationship: _____

RECEIPT/REVIEW OF HIPAA PRIVACY PRACTICE

By signing below, I acknowledge that I have been offered a copy of the Clear Dermatology & Aesthetics Center Notice of Privacy Practices. I have been advised of my rights, and how my health information may be used and disclosed by Clear Dermatology & Aesthetics Center.

Print Name: _____

Patient Signature (or Guardian): _____ Date: _____

If Guardian representative, describe relationship:_____

This acknowledgement will be filed in your records.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

❑ Individual refused to sign

❑ An emergency situation prevented us from obtaining acknowledgement

❑ Communication barrier prohibited obtaining the acknowledgement

❑Other (please specify)_____

*Due to new requirements from the United States Department of Health and Human Resources, we are requesting that all **ALL** patients complete the following questionnaire.*

PATIENT NAME: _____

TODAY'S DATE: _____

SCREENING:

Do you have any of the following conditions?
! Coronary Artery Disease ! Heart Failure ! Diabetes ! Chronic Obstructive Pulmonary Disease (COPD)

TOBACCO USE:

Please choose the option that best describes your tobacco use:
! Never ! Current smoker ! Previous smoker

For current tobacco users, select the option that best describes use:

! 1-3 cigarettes per day ! Up to 1 pack per day ! 1-2 packs per day ! 2 or more packs a day

ALCOHOL USE:

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women?
! Never ! 1-2 times ! 3-5 times ! More than 6 times

IMMUNIZATIONS:

In 2022, did you receive the following vaccinations?
Flu vaccine: ! YES ! NO

(65 YRS OLD AND OVER ONLY) Pneumonia vaccine: ! YES ! NO

BODY MASS INDEX:

Current height: _____ Current weight: _____

PQRS 2022

CLEAR
Dermatology & Aesthetics Center
Brenda LaTowsky, MD

Updated Financial Policy

We require all patients to maintain a valid credit or debit card on file with us. It is the policy of Clear Dermatology to follow all federal and state laws regarding identity theft and financial privacy. Our staff will scan your card with a card reader, which will store your card number in a secure, compliant location in your electronic medical record. For security reasons, only the last four digits will be visible to our staff. Credit and debit cards on file will be used to pay account balances, after your insurance processes your claim.

If we do not receive payment for the amount listed on your statement within 60 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If we are unable to reach you, we will leave you a message, and if our reminder call is not returned within one week, a $50 declined payment fee will be applied and another statement will be mailed.

By signing below, I give Clear Dermatology permission to charge my credit or debit card on file for any patient balance due on my account. If I have insurance coverage, my card will be charged **after** my insurance has paid their portion.

Printed Name: _____

Signature:_____

Date: _____