

Dermatology & Plastic Surgery Associates, S.C.
Rios & Lapinski, Dermatology & Plastic Surgery Institute

Medical Questionnaire

Name _____

Age _____

Questionnaire completed by: SELF PARENT GUARDIAN

Have you ever had skin cancer? YES / NO

If YES: MELANOMA BASAL CELL CARCINOMA SQUAMOUS CELL CARCINOMA UNSURE

What area of the body? _____ How was it treated? _____

Has anyone in your family had skin cancer? YES / NO

If YES: MELANOMA BASAL CELL CARCINOMA SQUAMOUS CELL CARCINOMA UNSURE

Do you have a history of any skin disease or condition? YES / NO

If YES, please describe: _____

Do you have any drug allergies? YES / NO

If YES, please list drug and reaction: _____

Do you drink alcohol? YES / NO

If YES, # of drinks per week: 2 4 6 More than 6

Do you smoke or use tobacco products? YES / NO

If YES: CIGARETTE PIPE CHEW DIP How many packs per day: ½ 1 2 More than 2

Years used: _____ Years since you quit: _____

Do you use illegal drugs? YES /NO

If YES, please describe use: _____

Have you ever been exposed to HIV/AIDS? YES / NO

Do you have any history of : IV drug abuse blood transfusions unprotected intercourse

Do you have artificial joints, stents, valves, or implants of any sort? YES / NO

If YES, what type: _____

Have you ever had a reaction to anesthesia? YES / NO

If YES, explain: _____

Do you bleed easily? YES / NO

If YES, please explain: _____

Are you pregnant? YES / NO **Birth control:** None Oral contraception IUD Tubal ligation Vasectomy Other _____

Please describe your family status: MARRIED DIVORCED SINGLE WIDOW PARTNERED

Number of children: 1 2 3 Other _____ Any pets? Cat Dog Other _____

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What is your occupation? _____

Please describe your race: Caucasian African-American Hispanic Asian Other

Please circle any of the following medical conditions or symptoms you are currently having:

No Medical Problems (check here): _____

AIDS	Bleeding disorder	COPD	Diabetes	Heart murmur
Emphysema	High blood pressure	Weight change	Bronchitis	Hepatitis, type _____
Blood clots (DVT/PE)	Cancer, type _____	Multiple sclerosis	Pacemaker/defibrillator	
Anemia	Arthritis	Chest pain	HIV	Asthma
Heart attack	Kidney disease	Heart disease	Liver disease	Seizures
Depression/suicide	Stroke	Thyroid problems	Ulcers	
History of tuberculosis	Sexually transmitted diseases		History of radiation therapy	

Other: _____

Past surgeries & year:

Appendectomy	C-section	Gallbladder removal	Tonsillectomy
Lumpectomy/mastectomy	Hysterectomy	Hip replacement	Knee replacement
Heart bypass/valve	Breast augmentation	Breast reduction	Liposuction/tummy tuck

Other: _____

Please list all medications you are currently taking (include over the counter/herbs): _____

Skin Review of Systems

Please circle any of the following skin symptoms you are experiencing:

Bruising	Color change	Scar/keloids	Swelling	Itching
Lesions/sores/Growths	Lumps	Rash	Hair problems	Nail problems

Do you use tanning beds? YES/NO Do you tan outside regularly? YES/NO

Please describe the reason(s) for your visit by describing the following:

Location of problem: _____

How long have you had this problem: _____

Symptoms (how does it bother you): _____

Treatments you have tried: _____

Dermatology & Plastic Surgery Associates, S.C.
Paula K. Lapinski, M.D. and Jose L. Rios, M.D.
1124 Essington Road, Joliet, IL 60431

Telephone Information & Communication Release

Call preference:

_____ Home _____ Work _____ Cell

Is there a location we should not call? Please list: _____

I hereby give permission to Dermatology & Plastic Surgery Associates, S.C. to notify me by telephone of the following:

_____ Appointment reminder, either by personal/recorded message

_____ A message to call the office for test results (actual result will not be left)

List any individuals who you authorize to receive the above information on your behalf:

I authorize Dermatology & Plastic Surgery Associates, S.C. to disclose my medical information pertaining to my diagnosis and/or treatment, lab results, medical history, or any other such related information to those listed below:

Name	Telephone #	Relationship
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Name	Telephone #	Relationship
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Name	Telephone #	Relationship
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The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize the release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons not listed above will require specific authorization prior to the disclosure of my medical information.

****Please complete the signature page to acknowledge receipt and understanding of this document.**

Dermatology & Plastic Surgery Associates, S.C.

1124 Essington Road

Joliet, IL 60431

Consent to Treatment

I voluntarily consent to receive medical care services that may include diagnostic procedures, examinations, and treatments.

****Please complete the signature page to acknowledge receipt and understanding of this document.**

Financial Responsibility and Assignment of Benefits

I agree to pay all charges for medical and health care services not covered by my insurance company.

****Please complete the signature page to acknowledge receipt and understanding of this document.**

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GENERAL PATIENT AUTHORIZATION

I hereby authorize physicians of Dermatology & Plastic Surgery Associates, S.C. to render care to me during my office visits and to fulfill the orders of my physicians, including consultants, associates, and assistants of the physicians' choice.

In consideration of services rendered or to be rendered, I assign and transfer to Dermatology & Plastic Surgery Associates, S.C. any benefits payable to me or on my behalf under any insurance coverage. I agree to fulfill all policy provisions which my insurance companies may require for payment. If a Medicare patient, I request that payment of authorized benefits be made on my behalf. I further agree to pay for any items or services not covered by the Medicare Program. I hereby understand that I am financially responsible for services provided which are to be paid on the day services are rendered. This includes co-payments/deductibles with any managed care contract.

I understand that I am responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Dermatology & Plastic Surgery Associates, S.C.. I further understand, should this account become delinquent, I shall pay the reasonable attorney or collections expenses.

I understand that if I do not pay the entire new balance within 25 days of monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in you being unable to provide additional services except for emergencies or where there is prepayment for additional services.

I authorize Dermatology & Plastic Surgery Associates, S.C. to release medical information pertaining to my diagnosis and/or treatment, laboratory test results, medical history, treatment, or any other such related information to:

1. Medicare or Medicaid
2. My insurance company or its designated representatives
3. Any person(s) or entities financially responsible for my care or treatment
4. Representatives of local, state, or federal agencies in accordance with law
5. Employees or representatives of Dermatology & Plastic Surgery Associates, S.C. for investigation and defense of any claim or cause of action, actual or potential, which is or may be asserted against Dermatology & Plastic Surgery Associates, S.C. or the employees of Dermatology & Plastic Surgery Associates, S.C.

****Please complete the signature page to acknowledge receipt and understanding of this document.**

MEDIGAP RELEASE

For Medicare patients with supplemental Medigap insurance, a separate signature is needed. I request Medigap benefits be made on my behalf for services rendered. I authorize to be released to my Medigap carrier any information needed to determine benefits.

****Please complete the signature page to acknowledge receipt and understanding of this document.**

*****Please provide us with your driver's license and insurance cards.**

Dermatology & Plastic Surgery Associates, S.C.

**Paula K. Lapinski, M.D. and Jose L. Rios, M.D.
1124 Essington Road, Joliet, IL 60431**

Patient HIPAA Authorization Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient's Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or dis/closed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this disclosure, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- * Protected health information may be disclosed or used for treatment, payment, or health care operations
- * The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- * The Practice reserves the right to change the Notice of Privacy Practices
- * The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
- * The patient may revoke this Authorization, in writing, at any time and all future disclosures will then cease
- *The Practice may condition receipt of treatment upon the execution of this Authorization

****Please complete the signature page to acknowledge receipt and understanding of this document.**

Practice Policies

In order to serve your needs better, we ask that you read our policies and sign below.

1. We request a 24 hour cancellation notice. Failure to call, no shows, will be charged a \$25 administrative fee that is not billable to insurance. Surgery no shows will be charged \$75.
2. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy for refill requests.
3. If a patient loses their lab requisition form, there is a \$5 administrative fee for a replacement
4. Copays and deductibles are due at the time services are rendered.
5. Patients are responsible for verifying insurance coverage.
6. We attempt to make courtesy phone calls to remind you of an appointment, but are unable to provide this service at all times. Lack of a reminder phone call does not cancel the above no show policy.
7. All returned checks will be charged a \$25 administrative fee

****Please complete the signature page to acknowledge receipt and understanding of this document.**

Dermatology & Plastic Surgery Associates, S.C.

Signature Page

_____ I have read and understand the **“General Patient Authorization”** provided
(initial) to me by Dermatology & Plastic Surgery Associates, S.C.

_____ I have read and understand the **“Medigap Release”** provided to me by
(initial) Dermatology & Plastic Surgery Associates, S.C.

_____ I have completed, and understand the terms of the **Telephone Information
& Communication Release”** provided to me by Dermatology & Plastic
(initial) Surgery Associates, S.C.

_____ I have read and understand the **“Patient HIPAA Authorization Form”**
(initial) provided to me by Dermatology & Plastic Surgery Associates, S.C.

_____ I have read and understand the **“Practice Policies”** provided to me by
(initial) Dermatology & Plastic Surgery Associates, S.C.

_____ I have read and understand the **“Consent to Treatment”** and the
(initial) **“Financial Responsibility and Assignment of Benefits”** policies as
provided to me by Dermatology & Plastic Surgery Associates, S.C.

I, _____, acknowledge that the above initials are my own, and that they represent my understanding of each of the aforementioned documents (**“General Patient Authorization”, “Medigap Release”, “Telephone Information & Communication Release”, “Patient HIPAA Authorization Form”, Practice Policies”, “Consent to Treatment”, “Financial Responsibility and Assignment of Benefits”**).

I understand that a copy of any of the aforementioned documents can be provided to me upon request.

Electronic & scanned signatures shall be accepted by all parties as original signatures.

Patient Signature

Date

Witness Signature

Date