Macaione and Papa and all its affiliates, PA

AUTHORIZATIONS AND CONSENTS FOR PRECERTIFICATION, FINANCIAL RESPONSIBILITY, ASSIGNMENT OF BENEFITS AND RELEASE OF CLAIMS INFORMATION

Precertification & Financial Responsibility: I understand that it is the insurer's responsibility to review anticipated courses of treatment. I understand that if the insurer determines that the treatment plan is necessary and appropriate and issues certification, the benefits of my health plan will be available to me according to my policy terms. However, if certification is denied, benefits may be withheld. I understand that precertification may be the responsibility of the patient or financially responsible party and his or her physician. I also understand that I may be financially responsible for any and all related charges incurred as a result of this treatment plan should the insurer either refuse to pre-certify the treatment or retrospectively determine that a specific service was inappropriate, or should the certification occur too late to be valid. I understand that to protect myself from unnecessary personal financial obligations, I must review my obligations with my insurance company and personal physician in advance of my appointment.

Assignment of Benefits: In consideration of the services provided to me, I hereby assign and transfer to Macaione and Papa and all its affiliates, all medical provider benefits payable and any related rights existing under the insurance policies described (but not to exceed the amount of charges for this period of service). I authorize and direct the insurance company to pay all such benefits to Macaione and Papa. I understand that this assignment does not relieve me of any responsibility I may have for payment of charges not paid by the insurance company, unless otherwise provided by the terms of an agreement between the insurer and Macaione and Papa.

Authorization to Release Claims Information: I hereby authorize Macaione and Papa and all its affiliates, their employees and agents to release and disclose all information that has been and that will be received, recorded or compiled by any or all of them concerning my (or the patient's) medical care and treatment to all appropriate persons. This is for the purpose of evaluating claims for payment or reimbursement for charges and expenses under any public Title XVIII of the Social Security Act (Medicare), or any private reimbursement which may have a bearing on benefits by or on behalf of any such person. I hereby authorize Macaione and Papa, its employees and agents to act on my behalf in completing claims.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. If we file a claim with your insurance you are still responsible for any unmet deductible, non-covered services and co-payments.

I HAVE READ AND FULLY UNDERSTAND THE PRECERTIFICATION & FINANCIAL RESPONSIBILITY AUTHORIZATIONS, ASSIGNMENT OF BENEFITS CONSENTS AND AUTHORIZATION TO RELEASE CLAIM INFORMATION PRINTED ON THIS FORM AND FULLY ACCEPT AND CONSENT TO EACH OF THEM. THIS INFORMATION IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Patient's Signature: _____ Date: _____/_____/_____

Patient's Printed Name: _____

I am legally authorized to provide consent on behalf of the patient listed above. My relationship to the patient is as follows:

Signature of Authorized Representative: _____

Relationship to Patient: _____ Date: _____/_____/_____

Witness: _____ Date: _____/_____/_____

Height: _____ Weight: _____

PAST MEDICAL HISTORY

Do you have a history of, or currently have, any of these conditions? **Please answer yes or no to all questions.**

Skin:

PreCancer/Actinic Keratosis	Y	N
Melanoma	Y	N
Basal cell carcinoma	Y	N
Squamous cell carcinoma	Y	N
Abnormal moles	Y	N
Other skin condition	Y	N

Cardiovascular:

High blood pressure	Y	N
Artificial heart valve	Y	N
Pacemaker/defibrillator	Y	N
High cholesterol	Y	N
Irregular heart rhythm	Y	N
Heart murmur	Y	N

Endocrine:

Diabetes	Y	N
Thyroid disease	Y	N

Hematologic:

Bleeding disorder	Y	N
Blood clotting disorder	Y	N
Lymphoma or leukemia	Y	N

Immunologic / Infections:

AIDS / HIV disease	Y	N
Hepatitis B	Y	N
Hepatitis C	Y	N
Autoimmune disease	Y	N
History of MRSA / Staph	Y	N
Tuberculosis/positive PPD	Y	N
Immunosuppression	Y	N

Neurologic:

Multiple sclerosis	Y	N
Guillain-Barre syndrome	Y	N
Migraines	Y	N
Parkinson's disease	Y	N
Seizures	Y	N
Stroke	Y	N

Psychiatric:

Anxiety disorder	Y	N
Bipolar disease	Y	N
Depression	Y	N

Respiratory:

Asthma	Y	N
Other lung disease	Y	N

Surgical:

Organ transplant	Y	N
Heart surgery	Y	N
Spinal or brain surgery	Y	N
Artificial joint	Y	N

OTHER:

Any kidney problem	Y	N
Arthritis	Y	N
Glaucoma	Y	N
Inflammatory bowel disease	Y	N
Liver disease	Y	N
Reflux (GERD)	Y	N
Stomach ulcers	Y	N
Internal cancer (non-skin)	Y	N
History of radiation	Y	N
Currently attempting to conceive children	Y	N

Females only:

Hysterectomy	Y	N
Tubal ligation	Y	N
Currently pregnant	Y	N
Currently breastfeeding	Y	N

Current Smoker? Y N

Former Smoker? Y N

If yes to smoking, how much and starting /end dates: _____

Alcohol use? Y N

If yes, # times in past year you drank more than 5 (men) or more than 4 (women)? _____

Date of last flu shot: _____

Date of last pneumonia shot: _____

Tanning bed use? Y N

Sunscreen usage? Y N

Prior blistering sunburns? Y N

Pharmacy: _____

Allergies: _____

_____

_____

Medications (continue on back of this page if needed):

_____

_____

_____

Occupation? _____

Primary Care Provider: _____

If yes, sunscreen used: _____

If yes, # of times and dates: _____

Additional Details / Other: _____

FAMILY HISTORY (please circle):

Melanoma Basal cell cancer Squamous cell cancer Psoriasis Eczema Acne

MACAIONE AND PAPA AND ALL ITS AFFILIATES
CONSENT FOR USE OR DISCLOSURE OF INFORMATION
FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS (HIPAA)

I hereby consent to the use or disclosure of my identifiable health information ("protected health information") by Macaione and Papa and all its affiliates in order to carry out treatment, payment, or health care operations. I have been given the opportunity to review Macaione and Papa and all its affiliates' Notice of Privacy Practices for Protected Health Information for a more complete description of the potential uses and disclosures of such information. I have the right to review such notice prior to signing this consent form.

Macaione and Papa and all its affiliates reserves for itself the right to change the terms of its Notice of Privacy Practices for Protected Health Information at any time. If Macaione and Papa and all its affiliates does change the terms of its Notice of Privacy Practices, you may obtain a copy of the revised Notice by requisitioning the Notice from the Front Office Staff of Macaione and Papa and all its affiliates.

I retain the right to request that Macaione and Papa and all its affiliates further restrict how my protected health information is used or disclosed to carry out treatment, payment, or health care operations. Macaione and Papa and all its affiliates is not required to agree to such requested restrictions; however, if Macaione and Papa and all its affiliates does agree to my requested restriction(s), such restrictions are then binding on Macaione and Papa and all its affiliates.

At all times, I retain the right to revoke this consent. Such revocation must be submitted to Macaione and Papa and all its affiliates in writing. The revocation shall be effective *except* to the extent that Macaione and Papa and all its affiliates has already taken action in reliance on the consent. *Macaione and Papa and all its affiliates may refuse to treat you, if you do not sign this Consent Form* (except to the extent that Macaione and Papa and all its affiliates has the right to refuse to provide further treatment to you as of the time of revocation (except to the extent that the Facility is required by law to treat individuals)).

PHONE CONSENT: I AUTHORIZE THE PHYSICIANS AND STAFF OF MACAIONE AND PAPA AND ALL ITS AFFILIATES TO:

Leave a message on my answering machine or voice mail at home? ___ Yes ___ No Tele# _____

Leave a message on my cell phone? ___ Yes ___ No Tele# _____

Text message my cell phone? ___ Yes ___ No Tele# _____

Email me a message ___ Yes ___ No email address:_____

Leave a message at my place of employment? ___ Yes ___ No Tele# _____

Discuss my medical condition with a member of my family or a friend? ___ Yes ___ No

If yes, please print names: _____ Relationship _____ Tele# _____
_____ Relationship _____ Tele# _____
_____ Relationship _____ Tele# _____

I HAVE READ AND UNDERSTAND THIS INFORMATION. I AM THE PATIENT OR AM AUTHORIZED TO ACT ON BEHALF OF THE PATIENT TO SIGN THIS DOCUMENT VERIFYING CONSENT TO THE ABOVE STATED TERMS.

_____ ____/_____/_____ Date_____/_____/_____
Signature of Patient Date of Birth

_____
Please Print Name

_____ _____ _____
Signing on behalf of Patient Please Print Name Relationship to Patient

CONSENT FOR MINOR TO PRESENT FOR TREATMENT
(If a patient is under 18, a parent or guardian must sign)

I,_____, give my consent for _____ to bring _____ to the office for routine health care, which may include diagnosing and the treatment of presenting problems. This consent shall be effective from the date of my signature until the date I terminate it in writing or at the time a minor consent for treatment is no longer needed.

Parent's signature_____ Date_____

Witness_____ Date_____