Peraza Dermatology Group

Telephone: 603.542.6455|Facsimile: 603.543.0736 www.perazaderm.com
José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.**

Name: _____ Email: _____ Date of birth: _____ ☐Male ☐Female

If we need to call you, may we leave detailed personal medical information (such as test results) on your voicemail? ☐Yes ☐No

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Primary Care Physician and Address: _____

Pharmacy Name and Address: _____

How did you hear about us: ☐Online search ☐Facebook ☐Instagram ☐Twitter ☐Newspaper ☐Word-of-mouth ☐Work in this building/complex
☐Insurance website ☐Referred by physician named: _____ ☐Other: _____

What is the reason for your visit? _____

Please circle or list any medical conditions you have been diagnosed with:

Acne	Cold Sores	Heart Murmur	Implanted Metal
Anxiety	Depression	Hepatitis B or C	Pacemaker
Artificial Joints	Diabetes	High Blood Pressure	Seizures
Bleeding Disorders	Eczema	HIV/AIDS	Skin Cancer (List types)

_____

Has anyone in your family had a skin cancer? Who and what type of skin cancer? _____

What prescription medicines, over the counter supplements, and vitamins do you currently take? _____

_____

Medication allergies: _____

Have you ever taken isotretrinoin (aka Accutane)? ☐Yes ☐No When? _____

Do you use Retin-A, Renova, Adapalene, Differin, Tazarotene, Tazorac, Tri Luma, Green Cream or other retinol products ☐Yes ☐No

Do you have a fever today: ☐Yes ☐No
Do you have excessive bleeding? ☐Yes ☐No
Do you develop keloid scars? ☐Yes ☐No
Do you get GI upset from antibiotics? ☐Yes ☐No
Do you have nausea today? ☐Yes ☐No
Are you tan now? ☐Yes ☐No
Do you use tanning beds? ☐Yes ☐No
Do you get yeast infection from antibiotics? ☐Yes ☐No
When were you last in the sun? _____

Smoking status: ☐Current smoker ☐Former smoker ☐Never smoker

For female patients: Are you pregnant or trying to get pregnant? ☐Yes ☐No Breastfeeding? ☐Yes ☐No

I would like to discuss the following (circle all that apply):

Acne scarring	Coolsculpting (fat removal)	Redness on face
Botox	Laser for tattoo removal	Skincare
Brown spots	Laser hair removal	Veins on face
Chemical peels	Laser resurfacing	Emsculpt
Filler injections	Microneedling	Other: _____

Please list all previous cosmetic procedures/surgeries you have had:

_____

Patient signature: _____ Date: _____

Provider signature: _____ Date: _____

Peraza Dermatology Group

252 Broad Street
Claremont, New Hampshire 03743
Telephone: 603.542.6455|Facsimile: 603.543.0736
www.perazaderm.com
José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.**

Patient name: _____ DOB: _____

Name of primary care/referring provider: _____

Signature: _____ Date: _____

Tobacco Use: Do you smoke or use tobacco products?

☐ No ☐ Yes ☐ Formerly

List any new medications/supplements you have started taking since your last visit:

List any medications/supplements you have stopped taking since your last visit:

For Patients 65 and older only:

Have you authorized anyone to make health care decisions for you if you cannot?

☐ Yes ☐ No Name of authorized person: _____

Authorized person's phone: _____

Do you have a living will/advance directive?

☐ Yes
- ☐ Full cardiopulmonary resuscitation
- ☐ Do not intubate
- ☐ Do not resuscitate

☐ No

Peraza Dermatology Group

Telephone: 603.542.6455|Facsimile: 603.543.0736 www.perazaderm.com

José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.**

HIPAA Personal Health Information Permissions

I, _____, consent to the use or disclosure of my "protected health information" as defined in the Health Insurance Portability and Accountability Act of 1996 **(HIPAA)** and this consent by Peraza Dermatology Group for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Peraza Dermatology Group. I understand that diagnosis or treatment of me by Jose Peraza, MD and Dan Peraza, MD and/or their assigns may be conditioned upon my consent as evidenced by my signature on this document.

My "protected health information" means health information, including but not limited to my demographic information, collected from me and created or received by my Physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me.

I understand I have a right to review the Peraza Dermatology Group Notice of Privacy Practices prior to signing this consent. Peraza Dermatology Group's Notice of Privacy Practices has been provided to me and describes the types of uses and disclosures of my protected health information that may occur in my treatment, payment of my bills, or in the performance of the health care operations of Peraza Dermatology Group duties with respect to my protected health information.

Please also note that as provided in Peraza's Dermatology Group's Notice of Privacy Practices, Peraza Dermatology Group reserves the right to change the privacy practices that are described in such notice. I may obtain a revised Notice of Privacy Practices by accessing the Peraza Dermatology Group's website, calling the office (603) 542-6455 and requesting a revised copy be sent in the mail, or asking for one at the time of the next appointment.

The following people may have access to my Health Information:

Name	Relationship
1.	
2.	

I ☐ DO ☐ DO NOT authorize Peraza Dermatology Group to leave a message either on my answering machine or my voice mail about appointments, billing questions, biopsy/lab reports, prescription information or other information as needed.

By signing this I acknowledge that a copy of Peraza Dermatology Group's Notice of Privacy Policies has been made available to me.

_____

Printed Name – Patient or Representative

_____ _____

Signature Date

_____

Relationship to Patient (if other than patient):

Peraza Dermatology Group

Telephone: 603.542.6455|Facsimile: 603.543.0736 www.perazaderm.com

José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.**

You are contracted with your Insurance Company to pay a Copayment, Co-Insurance and/or Deductible. These charges are reduced from the payment our providers receive from your insurance company. Co-payments listed on your insurance card are due at the time of your visit. Copayments may be charged, even for Annual Exams; if your plan does not require a copayment for a specific visit, a credit will be placed on your account for a future visit.

Peraza Dermatology Group now offers patients the opportunity to leave a credit card on file to pay for Deductibles and Co-Insurances as soon as claims are adjudicated. Peraza Dermatology Group will maintain your credit card information in a secure non-electronic manner until your insurance company provides your explanation of benefits to us; at that time your card will be charged ONLY the amount your insurance company states you owe.

Should any insurance claims be processed incorrectly and the insurance changes the patient responsibility, your card will be credited or debited the amount necessary to resolve your claim balance.

Accepting your insurance does not place all financial responsibilities onto this practice and you will be held accountable for any unpaid balances by your plan or declined charges on your credit card. (If/when the credit card on file expires a statement will be mailed to you. The credit card information on file with be destroyed.)

Although we are contracted with most insurance carriers, our services may not be covered by your insurance plan, we highly recommend you also contact your insurance carrier and check into your coverage(s). Our office does not verify coverages only active status; it is the patient's responsibility to know their insurance plan(s).

Please remember that you are 100 percent responsible for all charges incurred: our verification of your insurance benefits is not a guarantee of payment by your insurance company. Do not assume that you will not owe anything if you have more than one insurance policy.

By signing below you acknowledge that you have read and understand the Peraza Dermatology Group Payment Policy. You also understand that you may be charged upfront for your Copayment and charged upon Explanation of benefits receipt for your Deductible and/or coinsurance.

Options to keep Credit Card information on file:

☐ I do <u>not</u> wish to keep a Credit Card on file. I understand I am responsible for paying Peraza Dermatology Group my Deductible/Co-Insurance billing statement (Must be paid within 30 days.) I will pay my Copayment on the date I am seen.

☐ Please keep my Credit Card on file and charge patient liabilities such as deductibles and/or coinsurances to my card once my claim is adjudicated. My card may be charged for my Copayment on the date I am seen. I understand that I will receive an Explanation of Benefits from my insurance showing what I owe/what was charged.

Please present the CC you wish to keep on file to the Front Office Staff at today's visit.

_____ _____

Signature that I have read and understand the policy Date

_____ _____

Printed Name Date of birth

Peraza Dermatology Group

Telephone: 603.542.6455|Facsimile: 603.543.0736 www.perazaderm.com
José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.**

POLICY CONSENT FORM

The following is a summary of our office policies. Some policies may not pertain to your treatment today, but may apply to future visits, treatments or procedures. Please review and sign below.

- **Prescription Refill Policy**: Our physicians normally prescribe sufficient refills to last patients until their next follow-up appointment. If you, the patient, need a refill and do not have a scheduled appointment, please call our prescription line at 603.542.6455. The physician will review the request. If the patient needs to be seen prior to a refill, our staff will call to schedule an appointment. Otherwise, please allow our office 72 hours to process your request.
- **Cancellations and No-Shows**: Our office attempts to contact all patients prior to scheduled appointments. If the patient is unable to keep an appointment, we kindly ask that you provide us with 48 hours' notice. A $50.00 no show/cancellation fee will be applied to all patient accounts when an appointment is not cancelled at least 24 hours prior to the scheduled appointment. This courtesy makes it possible to give appointments to other patients. Patients must cancel all cosmetic appointments 48 hours prior to ones scheduled appointment to receive refund of deposit.
- **Payment Options (*for procedures not covered by insurance*)**: Cash, Check, VISA, MasterCard, Discover, Debit Cards, Money Orders or Cashier's Checks.
- **All cosmetic and private pay fees are due at the time of service. A $100.00, non-refundable deposit is required for all scheduled cosmetic procedures. This deposit will be applied to your service on the day of treatment**.
- Peraza Dermatology Group and the front desk staff will not be able to quote exact prices prior to your appointment.
- **Required Payments at Your Visit**: Payment of co-insurance, co-pays, deductibles or fees for non-covered services, when applicable, is required at the time of service. It is the patient's responsibility to check these conditions prior to their appointment and bring an approved method of payment, as listed in the payment options section. The appointment will be cancelled and rescheduled if you, the patient, do not bring appropriate means of payment.
- **Regarding Insurance**: Peraza Dermatology will file claims directly with the patient's insurance carrier for services where covered benefits have been verified. Insurance verification does not guarantee the patient's insurance will pay for services. It is the patient's responsibility to know if our physicians are considered "in-network" by the patient's insurance. Payment is due within 30 days of receipt of a statement sent from our office.
- **Payment Plans**: In special circumstances, Peraza Dermatology will offer payment plans to those who are unable to pay their balance in one full payment.
- **Authorizations and/or Referrals**: Authorizations/referrals are an arrangement between patients and their insurance carrier. Authorizations/referrals are required prior to treatment. It is the patient's responsibility to bring a copy of their authorization/referral from their primary care doctor to our office. If a patient does not bring their authorization/referral with them, then their appointment will be cancelled and the patient will have to reschedule or be seen as a self-pay patient.
- You authorize Peraza Dermatology Group to pull pharmacy data through SureScripts as to the medications you are currently taking.
- Minors under the age of 18 will receive medical care and/or treatment with a parent, legal guardian or an authorized accompanying adult only. Minors under 18 who are unaccompanied, will not be seen.
- Some surgical pathology and other lab specimens are submitted to outside laboratories for analysis and or slide preparation. These services represent an additional fee charged to you by an outside office. Second opinions are obtained when the physician feels it is necessary to provide optimal care.
- As a patient, you understand that you may receive a separate bill from an outside hospital facility or laboratory such as: Mid Atlantic, DHMC, Borstings Laboratory, Quest, Mass General, etc.

This Consent was signed by: _____
Printed Name – Patient or Representative

_____ _____
Signature Date

Relationship to Patient
(if other than patient): _____

Peraza Dermatology Group

Telephone: 603.542.6455|Facsimile: 603.543.0736 www.perazaderm.com

José E. Peraza, M.D., F.A.A.D. | **Daniel M. Peraza, M.D., F.A.A.D.**

The United States Department of Health and Human Services requests additional patient demographic information.

Patient Name: _____

Date of Birth: _____

Preferred Language: _____

Ethnicity (please circle one): Hispanic/ Latino Not Hispanic/ Latino

Race: _____