ASPIRE DERMATOLOGY
Dr. Jason Michaels
MAKE AN APPOINTMENT: 401.239.1800

Please Complete All Sections on All Pages

PREFERRED PHONE # _____ **ALTERNATE PHONE #**_____

EMAIL ADDRESS_____**BIRTH DATE**_____

PATIENT'S NAME: (Last, First, MI) _____**SEX:**_____

PRIMARY ADDRESS (STREET) _____ **APT#**_____

CITY _____ **STATE** _____ **ZIP**_____ -- _____

ALTERNATE ADDRESS (STREET) _____ **APT#**_____

CITY _____ **STATE** _____ **ZIP**_____ -- _____

Patient Opt-In: By supplying the above phone number(s), email address, and any other personal contact information, I authorize my health care provider to make phone calls for the purpose of notifying me of a pending appointment, a missed appointment, overdue skin checks, balances due, lab results, or any other healthcare related function. I consent to allowing detailed messages being left on my voice mail, if I am unavailable at the number(s) provided by me.

PRIMARY CARE PHYSICIAN / REFERRING PHYSICIAN_____
HOW DID YOU HEAR ABOUT ASPIRE DERMATOLOGY?_____
YOUR EMPLOYER_____

RELEASE OF MEDICAL INFORMATION to other individuals if we are unable to reach you (HIPAA requirements)

I hereby authorize Aspire Dermatology and Jason Michaels, MD to communicate information regarding my procedure/results of my procedure/billing to/with:

Name_____ **Relationship**_____ **Phone:** _____

Name_____ **Relationship**_____ **Phone:** _____

☐ Do not disclose any information regarding appointments, procedures, results or billing to anyone other than myself

FINANCIAL RESPONSIBLE PARTY (FOR MINORS)

NAME (Last, First, MI)_____ **DATE OF BIRTH** _____ **SEX:**_____
MAILING ADDRESS (STREET) _____ **Apt#**_____
CITY _____ **STATE**_____ **ZIP**_____

I CERTIFY THAT I AM AUTHORIZED TO COMPLETE AND SIGN THIS FORM, AND THAT I AM AUTHORIZED TO CONSENT TO TREATMENT FOR THE ABOVE MINOR.

Certification of patient information and phone number consent

I have reviewed the consent to opt-in to receiving phone calls and allowing voicemails from Aspire Dermatology. I have reviewed my patient demographic and insurance information on this date and verify that all information reported to Jason Michaels, MD and Aspire Dermatology is correct. I hereby acknowledge that a copy of the Notice of Privacy Practices for Jason Michaels, MD/Aspire Dermatology has been made available to me. I have the right to obtain a paper copy upon request.

SIGNATURE:_____ **DATE:**_____

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Financial Agreement:

In the event that my insurance will pay all or part of the physician's charges, the physician who renders service to me is authorized to submit a claim for payment to my insurance carrier. The physician's office is not obligated to do so, unless under contract with the insurer or bound by a regulation of a State or Federal agency to process such claim, and if pertinent insurance coverage information is presented at, or prior to the time of the appointment. Aspire Dermatology will expect **payment of co-pays, deductible portions, and co-insurance at the time of service**. A $5.00 administrative fee will be assessed when patients request to delay co-pay, deductibles and co-insurance payment. **Patients with an outstanding balance older than 90 days must make arrangements for payment prior to scheduling appointments. In the absence of a payment plan, collections fees will be applied to the account, and the account will be turned over to a collections agency.** Aspire Dermatology accepts all major credit cards as a form of payment for your convenience. We realize that patients have financial difficulty and our financial counselors will work with you to ensure you receive needed medical care. Please note that Aspire Dermatology and its providers are considered "specialists" and co-pays are generally higher than the co-pays paid to Primary Care Physician.

Non-sufficient Funds Fee: Aspire Dermatology will charge a $30 NSF fee in the event of a returned or bad check for any and all reasons. The patient will have to make arrangements for all future visits to be paid for either by cash or credit card; a check will no longer be accepted. Please note that as the depositor of the check, Aspire Dermatology gets charged a fee by our financial institution.

Missed Visits: Missed appointments represent a cost to us, to you, and to other patients who could have been seen in the time set aside for you.
A **$25.00** missed appointment fee will be added to your account if you do not provide us with the requested 24-hour cancelation or rescheduling notice. A **$75.00** missed appointment fee will be added to your account for missed or rescheduled Mohs surgery appointments under the 24-hour notice.

HMO Insurance Plans: For purposes of claim processing, Aspire Dermatology needs referring information from the patient such as referring physician's name, address and phone number, and the referral form. Without the information, the claim will not process and the bill will be the responsibility of the patient. *If you have an HMO coverage*, you are **required** to get a referral prior to your visit at Aspire Dermatology. If a referral is not obtained prior to the visit, any financial obligations will be billed to the patient.

Insurance Eligibility & Benefits Verification: Aspire Dermatology is dedicated to assisting our patients with precise benefits coverage, by making efforts to verify eligibility and benefits for each patient's insurance policy for any financial obligation, if any, resulting from that date of service; however, we will not be liable for any inaccurate information provided to us wherever the information is available. Policies and coverage determinations may vary from payor to payor, plan to plan, and year to year, even if member ID's and ID cards stay the same. Also, not all services are covered in all insurance plans. Please contact the member services department of your insurance company with additional questions regarding your policy and coverage.

SELF PAY PATIENTS: Please be advised if you have no insurance coverage, you are expected to pay for the "Office Visit" and treatment at the time of your visit. There could be additional fees for treatment performed the day of your visit. Those fees are expected to be paid the same day, or may be invoiced after charges for services rendered are determined.
If there is any lab work or biopsies done during your visit, you will receive a bill from the processing Laboratory. This bill does not come from us. This is an outside bill.

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS: I hereby assign benefits to be paid on my behalf to Jason Michaels, MD, or other physicians who render service to me. The undersigned individual guarantees prompt payment of all charges incurred for services rendered or balance due after insurance payments in accordance with the policy for payment for such bills of Jason Michaels MD for charges not paid for within a reasonable period of time by insurance or third party payer. I certify that the information given with regard to insurance coverage is correct. I authorize Jason Michaels MD to release all or part of my medical records where required by or permitted by law or government regulation, when required for submission of any insurance claim for payment of services or to any physician(s) responsible for continuing care.

The undersigned certifies that he/she has read and understands the foregoing and fully accepts all terms specified above.

_____ **Signature of Patient or Responsible Party**

_____ **Print Name**

_____ Relationship to Patient

_____ Date Signed

PLEASE TURN THE PAGE OVER

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PATIENT NAME:_____ **DATE OF BIRTH:**_____

CLINICAL HISTORY

Please Check All That Apply Under Review of Systems, Patient Alerts, Medical History & Past Surgeries:

REVIEW OF SYSTEMS

- Changing Mole
- Rash
- Problems with Scarring
- Fever or Chills
- Thyroid Problems
- Hay Fever
- Headaches
- Joint Aches
- Sore Throat
- Immunosuppression
- Abdominal Pain
- Bloody Urine
- Muscle Weakness
- Currently Pregnant or Planning a Pregnancy
- Rapid Heartbeat with Epinephrine

PATIENT ALERTS

- Pacemaker
- Artificial Heart Valve
- Premedication Prior to Procedures
- Heart or Organ Transplant
- Joint Replacement: Knee (Right, Left, Both) *within the past 6 months
- Joint Replacement: Hip (Right, Left, Both) *within the past 6 months
- GI Upset with Antibiotics
- Allergy to Topical Antibiotics
- Yeast Infections with Antibiotics
- Allergy to: Adhesive ☐ Latex ☐ Lidocaine ☐
- Blood thinners
- Defibrillator
- Fall Risk
- History of Lymphoma
- HIV/AIDS
- Currently taking Prednisone
- Other_____

PAST MEDICAL HISTORY

- Anxiety
- Arthritis
- Asthma
- Atrial Fibrillation
- BPH (Enlarged Prostate)
- Bone Marrow Transplantation
- Breast Cancer
- Colon Cancer
- COPD
- Coronary Artery Disease
- Depression
- Diabetes
- End Stage Renal Disease
- GERD
- Hearing Loss
- Hepatitis
- Hypertension
- HIV/AIDS
- Hypercholesterolemia
- Hyperthyroidism
- Hypothyroidism
- Leukemia
- Lung Cancer
- Lymphoma
- Prostate Cancer
- Radiation Treatment
- Seizures
- Stroke
- None
- Other_____

PAST SURGERIES

- Appendix Removed
- Bladder Removed
- Mastectomy (Right, Left, Bilateral)
- Lumpectomy (Right, Left, Bilateral)
- Breast Biopsy (Right, Left, Bilateral)
- Colectomy: Colon Cancer Resection
- Colectomy: Diverticulitis
- Colectomy: IBD
- Gallbladder Removed (Cholecystetomy)
- Heart: Biological Valve Replacement
- Heart: Coronary Artery Bypass
- Heart Transplant
- Heart: Mechanical Valve Replacement
- Heart: PTCA (Stent/Angioplasty)
- Kidney Stone Removed
- Kidney Nephrectomy
- Liver Transplant
- Kidney Transplant
- Ovaries Removed: Endometriosis
- Ovaries Removed: Ovarian Cancer
- Ovaries Removed: Ovarian Cyst
- Ovaries: Tubal Ligation
- Prostate Cancer
- Skin : Skin Biopsy
- Skin : Basal Cell Carcinoma
- Skin : Squamous Cell Carcinoma
- Skin : Melanoma
- Spleen Removed
- Testicles Removed
- Uterus (Hysterectomy) : Fibroids
- Uterus (Hysterectomy) : Uterine Cancer or Cervical Cancer
- None
- Other_____

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PATIENT NAME:_____ **DATE OF BIRTH:**_____

SKIN DISEASE HISTORY: Have you had any of the following skin conditions?

- Acne
- Actinic Keratoses
- Asthma
- Basal Cell Skin Cancer
- Blistering Sunburns
- Dry Skin
- Eczema
- Flaking or Itchy Scalp
- Hay Fever/Allergies
- Melanoma
- Poison Ivy
- Precancerous Moles
- Psoriasis
- Squamous Cell Skin Cancer
- None

FAMILY HISTORY OF SKIN CANCER? **Yes** ☐ **No** ☐

If yes, which relative?

- Mother
- Father
- Sister
- Brother
- Daughter
- Other

If yes, what type of skin cancer?

- Basal Cell Carcinoma
- Squamous Cell Carcinoma
- Melanoma
- Other (please specify)_____

PHARMACY INFORMATION - Should Aspire Dermatology need to prescribe medication(s)

Pharmacy Name: _____ Pharmacy Phone Number: _____
Pharmacy Address: _____

MEDICATIONS (Please List)

_____ _____
_____ _____
_____ _____
_____ _____

ALLERGIES (Please list drug allergies, and types of adverse reactions)

_____ _____
_____ _____

SOCIAL HISTORY:

Smoking Status: please check which option applies:

- Current every day smoker;
- Current someday smoker;
- Former smoker;
- Smoker, current status unknown;
- Never smoker;
- Unknown if ever smoked;

Alcohol use

- Alcohol - none
- Alcohol - less than 1 drink per day
- Alcohol - 1-2 drinks per day
- Alcohol - 3 or more drinks per day

If you are 65 or older, 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? _____

Have you received your Flu Vaccination this year? **Yes** ☐ **No** ☐

If you are 65 or older, have you received your Pneumonia Vaccination? **Yes** ☐ **No** ☐

If you are 50 or older, have you received your Shingles vaccination? **Yes** ☐ **No** ☐

SIGNATURE:_____ **DATE:**_____

I certify that all the information provided on this date to Aspire Dermatology is correct. PLEASE NOTE: When it is appropriate and necessary, Aspire Dermatology staff and Providers may take clinical photographs of the following examined areas, but not limited to: biopsies, surgical procedures, sutures, rashes, acne and moles. These photographs are used to aid in tracking outcomes, proper diagnosis, treatment and professional education. Clinical photographs are considered a routine practice of the care and treatment of our patients and are covered within the general admission and consent to treat.

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TISSUE SPECIMENS FINANCIAL DISCLAIMER

I understand that all tissue removed will be sent out to an outside lab for examination and identification. I also understand there could be out of pocket expense associated with this procedure due to my copay/deductible limits.

A bill from the processing laboratory will be sent to me if any lab work or biopsies are performed during my visit, according to my current insurance coverage. This bill does not come from Aspire Dermatology. It is a third party bill. Our preferred tissue specimens processing laboratory is New England Tissue Issue, but we also utilize the services of other laboratories in the Rhode Island area.

Please also note that special stains for biopsies may be needed. The dermatopathologist may need to request that an outside lab perform more intensive studies to ensure a proper diagnosis. These separate additional costs include, but are not limited to, ordering special stains. I may be responsible for additional laboratory processing cost that is determined according to my insurance plan benefits. Please be advised the decision to engage a third party laboratory for special stains is not made by Aspire Dermatology, and any additional monetary responsibility resulting from additional testing is owed to the respective laboratory. Any inquiries regarding additional laboratory co-pay amounts should be directed to the respective third party laboratory.

I certify that I have read and understand all information provided to me, and that all the information provided on this date to Aspire Dermatology is correct.

SIGNATURE:_____**DATE:**_____