ASPIRE DERMATOLOGY
Dr. Jason Michaels
MAKE AN APPOINTMENT: 401.239.1800

Please Complete All Sections on All Pages

HOME PHONE # ______________________________ ☐ Preferred ☐ Alternate

CELL PHONE # ______________________________ ☐ Preferred ☐ Alternate

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)

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.

NAME (Last, First, MI) ____ **DATE OF BIRTH** __________________ **SEX:** ________

MAILING ADDRESS (STREET) ____ **Apt#**_______________

CITY ____**STATE**___________________ **ZIP**________________

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 collection's 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 $10 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

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PAST MEDICAL HISTORY

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hyperplasia (BPH)
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ Coronary Arteriosclerosis
- ☐ Depression
- ☐ Diabetes
- ☐ End-Stage Renal Disease
- ☐ Epilepsy
- ☐ GERD
- ☐ High Blood Pressure
- ☐ HIV/AID
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Prostate Cancer
- ☐ Stroke
- ☐ Ulcerative Colitis
- ☐ Other________________________
- ☐ NONE

PAST SURGERIES

- ☐ Appendectomy
- ☐ Coronary Artery Bypass Graft
- ☐ Gallbladder
- ☐ Heart Valve Replacement
- ☐ Hysterectomy
- ☐ Left Knee Replacement
- ☐ Right Knee Replacement
- ☐ Left Hip Replacement
- ☐ Right Hip Replacement
- ☐ Mastectomy (Right, Left, or Both)
- ☐ Pacemaker and/or Defibrillator
- ☐ Prostatectomy
- ☐ Organ Transplant
  Specify:____________________
- ☐ Other______________________
  ____
  ____
  ____
  ____
  ____
- ☐ NONE

SKIN DISEASE HISTORY

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Blistering Sunburns
- ☐ Basal Cell Carcinoma
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking/Itching Scalp
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma
- ☐ Other:______________________
- ☐ NONE

FAMILY HISTORY OF MELANOMA

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Grandmother
- ☐ Grandfather
- ☐ Other: ____________________
- ☐ NONE

MEDICATIONS

_____________________ _____________________ _____________________ _____________________
_____________________ _____________________ _____________________ _____________________

ALLERGIES

_____________________ _____________________ _____________________ _____________________
_____________________ _____________________ _____________________ _____________________

SOCIAL HISTORY

Do you smoke tobacco? ☐ YES, how often? _________
☐ FORMER SMOKER
☐ NO

Do you consume alcohol? ☐ YES, how often? __________
☐ NO

Do you have a Power of Attorney/Healthcare Proxy? Yes, Name: _______________________ ☐ NO

VACCINE HISTORY

☐ Influenza ☐ Pneumonia (65+) ☐ TDAP (under 18) ☐ HPV (under 18) ☐ Meningitis (under 18)

REVIEW OF SYSTEMS (Please check all that apply)

- ☐ Nausea
- ☐ Cough
- ☐ Diarrhea
- ☐ Fever or Chills
- ☐ Headaches
- ☐ Joint Aches
- ☐ Rash
- ☐ Vision Problems
- ☐ Frequent Urination
- ☐ Unusual Fatigue
- ☐ Abdominal Pain
- ☐ Hair Loss
- ☐ Unintentional Weight Changes
- ☐ Depression
- ☐ Dizziness
- ☐ Muscle Weakness
- ☐ Other: ___________________________________

ALERTS

Question	Yes	No
Do you have a Pacemaker or Defibrillator?	☐ YES	☐ NO
Do you have an artificial heart valve?	☐ YES	☐ NO
Do you get faint with procedures?	☐ YES	☐ NO
Do you have an allergy to Latex?	☐ YES	☐ NO
Do you have an allergy to Lidocaine?	☐ YES	☐ NO
Do you have an allergy to adhesive?	☐ YES	☐ NO
Do you have a history of Keloids?	☐ YES	☐ NO
Have you had a joint replacement in the past 2 years?	☐ YES	☐ NO
Do you require antibiotics prior to surgical or dental procedures?	☐ YES	☐ NO
Do you take any blood thinning medications?	☐ YES	☐ NO
Do you take any immunosuppressive medications?	☐ YES	☐ NO
Currently Pregnant or breast feeding?	☐ YES	☐ NO
Rapid heart rate with Epinephrine	☐ YES	☐ NO

Pharmacy Name: ______________________________ Address: ____

Patient Temperature (Taken by staff): ______________

PATIENT SIGNATURE: ____ **DATE:** ______________________

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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: _____________