MARMUR MEDICAL

Today's Date_____

Last Name _____ **First Name** _____ **Middle initial**_____
Name of parent or guardian (if applicable) _____

Date of Birth _____ **Gender** □ Male □ Female □ Transgender
Cell Phone _____ **Home Phone** _____ **Work Phone**_____
Email Address_____
Address _____ **Apt #**_____
City _____ **State** _____ **Zip** _____

Preferred Method for Appointment Confirmation: □ Email □ Cell Phone □ Home Phone □ Work Phone

Preferred Method for RESULTS: □ Email □ Cell Phone □ Home Phone □ Work Phone

If phone, is it ok to leave a message with RESULTS? □ Yes □ No

Ethnicity □Hispanic or Latino □Not Hispanic or Latino **Race:** _____
Marital Status □Single □Married □Legally Separated □Divorced □Widowed □Domestic Partner

Emergency Contact _____
Name Relationship Tel. No.

Primary Care Physician _____ **Tel. No.** _____

Referring Physician _____ **Tel. No.**_____

Employer _____ **Tel. No.**_____
Occupation_____

Pharmacy Name _____ **Tel. No.**_____
Address _____

PRIMARY INSURANCE
Insurance Company _____
ID No. _____**Group Number**_____
Name of Insured _____**Relationship to Patient**_____
Insured's Birth Date _____**Insured's Employer**_____
Address _____**Tel No.**_____

SECONDARY INSURANCE
Insurance Company_____
ID No. _____**Group Number**_____
Name of Insured _____**Relationship to patient**_____
Insured's Birth Date _____**Insured's Employer**_____
Address _____**Tel No**_____

MARMUR MEDICAL

As a courtesy service to our patients, the Practice participates with several insurance carriers and employs a billing service to manage claims to those companies. Please familiarize yourself with your insurance's practices, policies and our policy below.

1. If your insurance carrier requires you to pay a portion of your healthcare visit by way of co-pays, co-insurances, etc., we are legally required to collect them, no exceptions will be made. Co-pays are collected at the time of your visit.
2. If your carrier requires you to have a referral to be seen in our office, you must provide a referral before your appointment or you cannot be seen. Attaining referrals is the responsibility of the patient. If a claim is denied due to a missing referral, you are responsible for the cost of the visit.
3. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered, if you have not met your deductible.
4. You have been informed that we do not accept any health plans obtained through the Health Exchange or as a result of the Affordable Care Act, otherwise known as "Obamacare." If a claim is denied for non-coverage, you are responsible for the cost of the visit.
5. Only medical office visits will be billed to your insurance. Consultations and/or questions regarding cosmetic procedures to improve or enhance your appearance are NOT covered by insurance and are considered to be cosmetic.

Assignment and Release

I, the undersigned, have insurance coverage and assign all medical benefits to Marmur Medical. I understand that I am financially responsible for all charges, in full or in part, not paid by my insurance. This includes copays, deductibles, co-insurance, claims unpaid due to the lack of a valid referral, and missed appointment/cancellation fees. If uninsured at time of visit, I understand that I am financially responsible for all charges. I hereby authorize the Practice to release all information necessary to secure the payment of benefits and to use this signature on all my insurance submissions.

Signature _____ **Date** _____

6. **Cancellation Policy:** We require a 48-hour notice prior to cancelling or rescheduling an appointment. Monday appointments should be notified by noon on the previous Friday. Cancelling or rescheduling your appointment within 2 business days of the scheduled time may result in a $75 cancellation fee for non-cosmetic appointments or 50% of the fee for the scheduled cosmetic procedure(s). If you are unable to give sufficient notice, miss an appointment, or more than 15 minutes late; a cancellation fee may automatically be billed to your account. The cancellation fee is non-refundable. By making an appointment with us, you are agreeing to this policy.
7. **Your credit card information is required**. This information is held securely online. Any remaining balance owed by you will be charged to your card. A copy of the charge will be sent to you. Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment.

I authorize Marmur Medical to charge outstanding balances/fees to the following credit card:

	Account Number	Exp. Date	CVV Code	Billing Zip Code
☐ Mastercard ☐ Visa ☐ Discover ☐ American Express				

Signature _____**Name on Card** _____ **Date** _____

We will contact you via email regarding your balance. Check here ____if you prefer this correspondence via phone.

HIPAA Privacy Practices Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that the Practice is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and conducting health care operations.

Signature_____ **Date**_____

MARMUR MEDICAL

Medical History

Name: _____ DOB: _____

Reason for Today's Visit _____

Past Medical History: (please check all that apply)

☐Anxiety
☐Arthritis
☐Asthma
☐Atrial Fibrillation (Irregular Heartbeat)
☐BPH
☐Bone Marrow Transplantation
☐Breast Cancer
☐Colon Cancer
☐COPD
☐ Other _____
☐ None

☐Coronary Artery Disease
☐Depression
☐Diabetes
☐End Stage Renal Disease
☐GERD
☐Hearing Loss
☐Hepatitis
☐HIV/AIDS

☐Hypertension
☐Hypothyroidism
☐Leukemia
☐Lung Cancer
☐Lymphoma
☐Prostate Cancer
☐Radiation Treatment
☐Seizures
☐Stroke

Past Surgical History: (please check all that apply and circle side when applicable)

☐Appendix Removed
☐Bladder Removed
☐Breast Mastectomy (Right; Left; Both)
☐Breast Lumpectomy (Right; Left; Both)
☐Breast Biopsy
☐Breast Reduction
☐Breast Implants
☐Colon Cancer Resection
☐Colectomy: Diverticulitis
☐Colectomy: Inflammatory Bowel Disease
☐Gallblader Removed
☐Heart: Coronary Artery Bypass Surgery
☐Heart: PTCA
☐ Other _____
☐ None

☐Heart: Mechanical Valve Replacement
☐Heart: Heart Transplant
☐Joint Replacement: Knee (Right;Left; Both)
☐Joint Replacement: Hip (Right;Left; Both)
☐Kidney Biopsy
☐ Kidney Removed (Right; Left)
☐ Kidney Stone Removal
☐ Kidney Transplant
☐Ovaries Removed: Endometriosis
☐Ovaries Removed: Cyst

☐Ovaries Removed: Ovarian Cancer
☐Prostate Removed: Prostate Cancer
☐Prostate Biopsy
☐TURP
☐ Skin Biopsy
☐ Basal Cell Cancer Surgery
☐Squamous Cell Carcinoma Surgery
☐Melanoma Surgery
☐Spleen Removed
☐Testicles Removed (Right; Left; Both)
☐Hysterectomy: Fibroids
☐Hysterectomy: Uterine Cancer

Skin Disease History: (please check all that apply)

☐Acne
☐Actinic Keratosis
☐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

☐ Other _____

Do you wear Sunscreen? ☐Yes ☐No If yes, what SPF? _____

Do you tan in a tanning salon? ☐Yes ☐No

MARMUR MEDICAL

Family History:
Do you have a family history of melanoma? ☐Yes ☐No If yes, which relative(s)?_____

Medications: (Please list all current medications):

Name_____Strength_____ Route_____ Dose____ Dose Form_____ Frequency _____ Date Started ____
Name_____Strength_____ Route_____ Dose____ Dose Form_____ Frequency _____ Date Started_____
Name_____Strength_____ Route_____ Dose____ Dose Form_____ Frequency _____ Date Started_____

Allergies: (Please list all allergies and associated reactions):

_____

Vaccines: last influenza _____ Are you over the age of 65 and received pneumonia? If yes, when _ _____

Social History:

☐Alcohol- <1 drink daily
☐Alcohol- 1-2 drinks daily
☐Alcohol- ≥3 drinks daily
☐Alcohol - None
☐Drug Use

☐Currently Smokes - daily
☐Currently smokes- not daily
☐Has smoked in the past
☐Has never smoked

☐ Other
_____

Are you currently experiencing any of the following? (Please check yes or no for the following)

Symptom	Yes	No
Personal History of Melanoma		
Pacemaker		
Defibrillator		
Artificial Joints within past two years		
Artificial heart valve		
Premedication prior to procedures		
Allergy to adhesive		
Allergy to topical antibiotic ointments		
Blood thinners		
Pregnancy or planning a pregnancy		
Breastfeeding or lactation		
Allergy to lidocaine		
Rapid heartbeat with epinephrine		
Problems with bleeding		
Problems with healing		
Problems with scarring (hypertrophic or keloid)		
Yeast infections with antibiotics		
GI upset with antibiotics		
Fainting		
Immunosuppression		
Changing mole		
Rash		
Hay fever		
Wheezing		

Other: _____

MARMUR MEDICAL

Cosmetic Treatment History

Have you had Botox, Dysport, Fillers or Laser Treatments? ☐Yes ☐No

Would you like us to talk to you about your skin care regimen? ☐Yes ☐No

Are you concerned about?

- ☐Forehead Wrinkles
- ☐Wrinkles around the eyes or mouth
- ☐Maintaining a more youthful appearance
- ☐Skin Discolorations
- ☐ Other _____
- ☐Improving skin tone and texture
- ☐Unwanted Hair
- ☐Red or Blue Leg Veins
- ☐Fat Reduction

How did you hear about Marmur Medical?

☐ Word of mouth/ Who shall we thank? _____

☐TV, Media, Magazine _____

☐ Internet Search _____

☐ Referring MD _____

☐Advertisement _____

☐ Other _____

Would you like to receive our Marmur Medical newsletter by email?

☐ Yes

☐ No

MARMUR MEDICAL

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby consent to Marmur Dermatology And Cardiology, PLLC D/B/A Marmur Medical (the "Practice") using and disclosing my protected health information (PHI) to carry out treatment, payment and healthcare operations (TPO). I hereby acknowledge that I have had the right to review the Practice's Privacy Policy prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my PHI. I am aware that the Practice reserves the right to revise its Privacy Policy at anytime. I am also aware that a revised Privacy Policy may be obtained by my forwarding a written request for same to the Practice.

Consent to Calls/Mail/Email

I hereby consent to the Practice calling my hone, cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment.

I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

I hereby consent to the Practice emailing me any items or communications that assist the Practice in carrying out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I understand that by signing this form, I have reviews the Practice's non-disparagement policy and that I agree that I will not, directly or indirectly, in public or private, whether in oral, written, electronic or other format, disparage, deprecate, impugn or otherwise make any statements or remarks that would tend to or be construed to defame or slander the personal or professional reputations, professional qualifications, services and/or the Practice and/or its owner(s), independent contractors, employees and/or agents and/or successors, nor shall I in any manner assist or encourage any third party in doing so.

By signing this form, I am consenting to the Practice's use and disclosure of any PHI as specified in the Privacy Policy and this Patient Consent for Use and Disclosure of Protected Health Information.

I understand that I may revoke my consent in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, I understand that the Practice may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian

_____ _____

Patient's Name Date

_____ _____

Phone Number(s) (Cell/Home/Work) Email Address