

# MARMUR MEDICAL

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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: \_\_\_\_\_

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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 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 24-hours of the scheduled time may result in a \$50 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 or miss an appointment, 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
<input type="checkbox"/> MasterCard <input type="checkbox"/> Visa <input type="checkbox"/> Discover <input type="checkbox"/> 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 \_\_\_\_\_

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## Medical History

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Reason for Today's Visit \_\_\_\_\_

### **Past Medical History:** (please check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety                                   | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Hypertension        |
| <input type="checkbox"/> Arthritis                                 | <input type="checkbox"/> Depression              | <input type="checkbox"/> Hypothyroidism      |
| <input type="checkbox"/> Asthma                                    | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Leukemia            |
| <input type="checkbox"/> Atrial Fibrillation (Irregular Heartbeat) | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Lung Cancer         |
| <input type="checkbox"/> BPH                                       | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Lymphoma            |
| <input type="checkbox"/> Bone Marrow Transplantation               | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Prostate Cancer     |
| <input type="checkbox"/> Breast Cancer                             | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Colon Cancer                              | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> COPD                                      |  | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Other _____                               |  |  |
| <input type="checkbox"/> None                                      |  |  |

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

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Appendix Removed                      | <input type="checkbox"/> Heart: Mechanical Valve Replacement         | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer       |
| <input type="checkbox"/> Bladder Removed                       | <input type="checkbox"/> Heart: Heart Transplant                     | <input type="checkbox"/> Prostate Removed: Prostate Cancer     |
| <input type="checkbox"/> Breast Mastectomy (Right; Left; Both) | <input type="checkbox"/> Joint Replacement: Knee (Right; Left; Both) | <input type="checkbox"/> Prostate Biopsy                       |
| <input type="checkbox"/> Breast Lumpectomy (Right; Left; Both) | <input type="checkbox"/> Joint Replacement: Hip (Right; Left; Both)  | <input type="checkbox"/> TURP                                  |
| <input type="checkbox"/> Breast Biopsy                         | <input type="checkbox"/> Kidney Biopsy                               | <input type="checkbox"/> Skin Biopsy                           |
| <input type="checkbox"/> Breast Reduction                      | <input type="checkbox"/> Kidney Removed (Right; Left)                | <input type="checkbox"/> Basal Cell Cancer Surgery             |
| <input type="checkbox"/> Breast Implants                       | <input type="checkbox"/> Kidney Stone Removal                        | <input type="checkbox"/> Squamous Cell Carcinoma Surgery       |
| <input type="checkbox"/> Colon Cancer Resection                | <input type="checkbox"/> Kidney Transplant                           | <input type="checkbox"/> Melanoma Surgery                      |
| <input type="checkbox"/> Colectomy: Diverticulitis             | <input type="checkbox"/> Ovaries Removed: Endometriosis              | <input type="checkbox"/> Spleen Removed                        |
| <input type="checkbox"/> Colectomy: Inflammatory Bowel Disease | <input type="checkbox"/> Ovaries Removed: Cyst                       | <input type="checkbox"/> Testicles Removed (Right; Left; Both) |
| <input type="checkbox"/> Gallbladder Removed                   |  | <input type="checkbox"/> Hysterectomy: Fibroids                |
| <input type="checkbox"/> Heart: Coronary Artery Bypass Surgery |  | <input type="checkbox"/> Hysterectomy: Uterine Cancer          |
| <input type="checkbox"/> Heart: PTCA                           |  |  |
| <input type="checkbox"/> Other _____                           |  |  |
| <input type="checkbox"/> None                                  |  |  |

### **Skin Disease History:** (please check all that apply)

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Acne                   | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Precancerous Moles        |
| <input type="checkbox"/> Actinic Keratosis      | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis                 |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Hay Fever/Allergies    | <input type="checkbox"/> Squamous Cell Skin Cancer |
| <input type="checkbox"/> Blistering Sunburns    | <input type="checkbox"/> Melanoma               | <input type="checkbox"/> None                      |
| <input type="checkbox"/> Dry Skin               | <input type="checkbox"/> Poison Ivy             |  |
| <input type="checkbox"/> Other _____            |   |  |

Do you wear Sunscreen?     Yes     No    If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?     Yes     No

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**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: \_\_\_\_\_

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## 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

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## 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 home, 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 reviewed 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.

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Signature of Patient or Legal Guardian

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Patient's Name

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Date

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

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Email Address