Walk-in Dermatology™
SEE A BOARD-CERTIFIED DERMATOLOGIST TODAY

Thank you for choosing Walk-in Dermatology as your healthcare provider. We're committed to keeping you healthy and giving you the confidence to look and feel your best.

At Walk-in Dermatology, we believe an exceptional physician-patient relationship is essential for your continuing healthcare needs. You can help develop your relationship with us by making sure all the demographic information and medical history you provide to us is filled out completely and accurately. If you have any questions about the information we're requesting, please ask our staff to assist you.

Reason for visit _____

Today's date _____/_____/_____

Patient's Name _____ **Date of Birth** _____/_____/_____

Address _____
(Street) (Apartment Number)

_____
(City) (State) (Zip Code)

Mobile Tel # _____ **Home Tel #** _____ **Work Tel #** _____

Email Address _____
Providing us with your email address will give you access to a patient portal where you can update your medical records, access test results, and send us private messages.

Preferred Method of Contact ☐ Mobile phone ☐ Home phone ☐ Work phone ☐ Email

Gender ☐ Male ☐ Female

Marital Status ☐ Single ☐ Married ☐ Domestic Partner ☐ Separated ☐ Divorced ☐ Widowed

Race/Ethnicity ☐ White ☐ African American ☐ Hispanic/Latino ☐ Asian ☐ Native American ☐ Other _____

Language ☐ English ☐ Spanish ☐ Farsi ☐ Portuguese ☐ Other _____

Work status ☐ Employed ☐ Unemployed ☐ Disabled ☐ Retired ☐ Student

Occupation _____ **Employer** _____

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Do you have a Primary Care Physician? ☐ Yes ☐ No

Primary Care Physician's Name _____ **Telephone #** _____

Referring Physician Name _____ **Telephone #** _____

Would you like us to send a summary of your visit to your Primary Care Physician? ☐ Yes ☐ No

Would you like us to send a summary of your visit to your Referring Physician? ☐ Yes ☐ No

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How did you hear about Walk-in Dermatology?

- ☐ Friend or family
- ☐ Postcard received in the mail
- ☐ Facebook, Instagram or Twitter
- ☐ Television commercial
- ☐ Saw signage when passing office
- ☐ Insurance company
- ☐ Search engine (Google, Yahoo, Bing, etc.)
- ☐ Physician (name) _____
- ☐ Other _____

Primary Insurance

Insurance Company _____

Policy Holder

Name _____

Policy Holder Date of Birth ___/___/_____

Secondary Insurance

Insurance Company _____

Policy Holder

Name _____

Policy Holder Date of Birth ___/___/_____

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PHARMACY INFORMATION

Preferred Pharmacy Name _____ **Telephone** _____

Street Address _____

City _____ **State** _____ **Zip Code** _____

***New York State mandates that prescriptions are sent electronically**

HEALTH HISTORY

Select any of the following medical conditions that you currently have. If you do not have any of the following medical conditions, select "None."

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Bone marrow transplant
- ☐ Benign prostatic hyperplasia
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage renal disease
- ☐ Heartburn/GERD
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV / AIDS
- ☐ High cholesterol
- ☐ Leukemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Other _____
- ☐ **None (I have none of these medical conditions)**

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SURGICAL HISTORY

Please check the appropriate box if you have had any prior surgeries. If you have not had any prior surgery, select "None."

- ☐ Appendix: Appendectomy
- ☐ Bladder: Cystectomy
- ☐ Breast: Biopsy
- ☐ Breast: Lumpectomy (L / R)
- ☐ Breast: Mastectomy
- ☐ Colon cancer resection
- ☐ Colon: Diverticulitis
- ☐ Colon: Inflammatory bowel disease
- ☐ Colon: Colostomy
- ☐ Gallbladder: Cholecystectomy
- ☐ Heart: Biological valve replacement
- ☐ Heart: Coronary artery bypass
- ☐ Heart: Heart transplant
- ☐ Heart: Mech. valve replacement
- ☐ Heart: PTCA
- ☐ Joint replacement: Hip (L / R)
- ☐ Joint replacement: Knee (L / R)
- ☐ Kidney: Biopsy
- ☐ Kidney: Stone removal
- ☐ Kidney: Transplant
- ☐ Kidney: Nephrectomy
- ☐ Liver: Hepatectomy
- ☐ Liver: Transplant
- ☐ Liver: Shunt
- ☐ Ovaries: Endometriosis
- ☐ Ovarian Cancer
- ☐ Ovaries: Ovarian cyst
- ☐ Ovaries: Tubal ligation
- ☐ Pancreas: Pancreatectomy
- ☐ Prostate biopsy
- ☐ Prostate: Prostatectomy
- ☐ Prostate: TURP
- ☐ Rectum: APR
- ☐ Rectum: Low anterior resection
- ☐ Skin: Biopsy
- ☐ Skin: Basal cell carcinoma
- ☐ Skin: Squamous cell carcinoma
- ☐ Skin: Melanoma
- ☐ Spleen: Splenectomy
- ☐ Testicles: Orchiectomy
- ☐ Uterus: Fibroids
- ☐ Uterus: Uterine cancer
- ☐ Uterus: Cervical cancer
- ☐ Other _____
- ☐ **None (I have had no prior surgery)**

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SKIN HISTORY

Have you ever been seen by a dermatologist? ☐ Yes ☐ No

If yes, have you been treated by a dermatologist in the past year? ☐ Yes ☐ No

What was the purpose of your most recent visit? _____

Have you ever had a full body skin exam? ☐ Yes ☐ No

If yes, when was your last full body exam? _____

Please select any of the following skin conditions you have ever had.

☐ Acne
☐ Actinic keratosis
☐ Blistering sunburns
☐ Dry skin
☐ Eczema
☐ Flaking / itchy scalp
☐ Hay fever / allergies
☐ Melanoma
☐ Poison Ivy
☐ Precancerous / dysplastic moles
☐ Psoriasis
☐ Other_____
☐ **None (I have had none of these skin conditions)**

Have you ever had a Basal Cell Skin Cancer? ☐ Yes ☐ No If yes, indicate location/date _____

Have you ever had a Squamous Cell Skin Cancer? ☐ Yes ☐ No If yes, indicate location/date _____

Have you ever had a Melanoma? ☐ Yes ☐ No If yes, indicate location/date _____

Did you have a sentinel lymph node biopsy? ☐ Yes ☐ No

If yes, do you have routine scans (x-ray, CT scan, PET scan) ☐ Yes ☐ No

Do you have a family history of melanoma? ☐ Yes ☐ No If yes, which relative? _____

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

Have you ever visited a tanning salon? ☐ Yes ☐ No

If yes, how many times: ☐ 1-5 ☐ 6-10 ☐ Over 10

Have you been to a tanning salon in the past year? ☐ Yes ☐ No

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MEDICATIONS

Please list all current medications you are taking (include vitamins and herbal supplements).

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

MEDICATION ALLERGIES & OTHER ALLERGIES

Please select all known allergies and detail your allergic reaction.

☐ Penicillin _____ ☐ Sulfa _____ ☐ Epinephrine _____

☐ Latex _____ ☐ Pet (indicate type) _____ ☐ Food (indicate type) _____

☐ Other _____

☐ **NO KNOWN ALLERGIES**

SOCIAL HISTORY

Cigarette/cigar smoking
- ☐ Never smoked
- ☐ Quit (former smoker)
- ☐ Smoke less than once/day
- ☐ Smoke daily

Alcohol consumption
- ☐ None
- ☐ Less than 1 drink/day
- ☐ 1 to 2 drinks/day
- ☐ More than 3 drinks/day

Recreational drugs
- ☐ Never
- ☐ Quit (former recreational drug user)
- ☐ Consume once/day
- ☐ Consume multiple times/day

Indicate type of recreational drug used:

_____

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FAMILY HISTORY

Do you have a 1st degree relative with any of the following conditions? Please list family member(s) with the condition.

☐ Yes ☐ No Eczema _____

☐ Yes ☐ No Psoriasis _____

REVIEW OF SYSTEMS

Please check any of the following symptoms that apply to your current state of health. If you do not have any of the following symptoms, select "None."

☐ Allergy to adhesive
☐ Allergy to lidocaine
☐ Allergy to topical antibiotics
☐ Blood thinners
☐ Artificial heart valve
☐ Defibrillator
☐ Pacemaker
☐ MRSA
☐ Artificial joints within the past 2 years
☐ Require antibiotics prior to procedures
☐ Rapid heartbeat with epinephrine
☐ Pregnant, planning a pregnancy or breastfeeding
☐ Problems with bleeding
☐ Problems with healing
☐ Problems with scarring
☐ Hay fever
☐ Immunosuppression
☐ Fever or chills
☐ Unintentional weight loss
☐ Thyroid problems
☐ Sore throat
☐ Blurry vision
☐ Abdominal pain
☐ Muscle weakness
☐ Joint aches
☐ Headaches
☐ Anxiety
☐ Depression
☐ Other _____
☐ **None (I have none of these symptoms)**

Have you ever fainted when undergoing a medical procedure? ☐ Yes ☐ No

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Referral Requirement

Due to contractual obligations with insurance companies, it is the policy at Walk-in Dermatology that a valid, non-expired referral must be on file at the time of visit for patients whose insurance requires a referral by their primary care doctor to be seen by a dermatologist. Failure to provide a valid referral can result in denial of the insurance claim and leave the patient responsible for the allowed amount of your visit.

Cancellation Policy

We understand there may be times when you might miss an appointment due to emergencies or obligations to work or family. However, we urge you to contact us 48 hours in advance to avoid being subject to a $25 cancellation fee.

Co-Pay Policy

Some health insurance companies require patients to remit a co-pay for services provided. We require patients to remit this co-pay before each visit.

_____

Signature of Patient Print name Date

_____

Signature of Patient's legal representative (if applicable) Print name Date

Statement of Patient's Financial Responsibility

We appreciate the confidence you have shown in choosing Walk-in Dermatology to provide your healthcare needs. The medical service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. As a courtesy, we will verify and bill your insurance company on your behalf. However, you are ultimately responsible for payment of our fees.

You are responsible for payment of any deductible and copayment/co-insurance as determined by your contract with your insurance company. We expect these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurance company. If your insurance company denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full. In signing below, you hereby give permission to Walk-in Dermatology to release any information concerning your treatment to insurance companies as deemed necessary for the processing of claims.

In signing below, you acknowledge that you have read the above policy regarding your financial responsibility to Walk-in Dermatology for providing services to you. You certify that the information is to the best of your knowledge, true and accurate. You authorize any payment of any insurance benefits to Walk-in Dermatology or the physician indicated on the claim, the full and entire amount of the bill incurred by you or the above named patient; or, if applicable any amount due after payment has been made by your insurance company.

_____

Signature of Patient Print name Date

_____

Signature of Patient's guarantor/legal representative (if applicable) Print name Date

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Consent to Treatment

I, _____, hereby request and consent to diagnostic and medical treatment by Walk-in Dermatology, as deemed necessary in the professional medical judgement of my treating physician. I am aware the practice of medicine and related procedures is not an exact science and I acknowledge that no guarantees as to the outcome of any procedures, treatments or examinations have been made to me during my course of care. Furthermore, I give consent to Walk-in Dermatology to take photographs or other images of me as they relate to my care, which made be used for purposes of documenting my medical status, for my medical benefit and for the purpose of medical education and training.

For female patients: Many oral and topical medications prescribed by dermatologists are unsafe for use during pregnancy. Please inform our office if you are pregnant, breastfeeding, or planning to become pregnant at any time while under the care of Walk-in Dermatology.

_____

Signature of Patient Print name Date

_____

Signature of Patient's legal representative (if applicable) Print name Date

General Release and Acknowledgement of Receipt of Notice of Privacy Practices

I, _____, acknowledge and agree that I have had the right to review a copy of the Walk-in Dermatology Notice of Privacy Practices prior to signing this consent, which provided me a more complete description of potential uses and disclosures of my protected health information (PHI). I hereby consent to Walk-in Dermatology physicians, outside providers who are involved in my care, organized health care arrangements ("OHCA") with which Walk-in Dermatology participates as well as other providers within the OHCA, networks such as IPAs and accountable care organizations that coordinate care for providers who may treat me, and insurers to obtain payment. I am aware that Walk-in Dermatology disclaims any liability or harm resulting from my incorrect or incomplete provision of my primary care physician's contact information, and that Walk-in Dermatology reserves the right to revise its Notice of Privacy Practices at any time. I am also aware that an updated copy of Walk-in Dermatology's Notice of Privacy Practices is available on Walk-in Dermatology's website.

_____

Signature of Patient Print name Date

_____

Signature of Patient's legal representative (if applicable) Print name Date

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Consent to Contact

I hereby consent to Walk-in Dermatology with regard to calling my home, cell phone, business phone or other designated means of communication and leaving a message on my voicemail or in-person in reference to anything that assists in carrying out treatment, payment, and healthcare operations, including but not limited to appointment reminders, insurance items and any call pertaining to clinical care, including laboratory results, medications, and other information relating to treatment.

I hereby consent to Walk-in Dermatology with regard to mailing me materials to my home or other designated address, text messaging or e-mailing me regarding marketing/promotional offers, anything pertaining to my clinical care, including PHI and other matters related to treatment, such as appointment reminders and patient statements, or payment for services. I acknowledge that Walk-in Dermatology cannot and does not guarantee the privacy, security, or confidentiality of an e-mail message or text message sent or received.

I hereby consent to Walk-in Dermatology to have communications with the following people regarding PHI:

1. _____ (relationship) _____

2. _____ (relationship) _____

3. _____ (relationship) _____

Name of emergency contact: _____ (relationship) _____

Telephone of emergency contact: _____

This consent shall specifically include information relating to appointments, after care, and the release of test results.

✎ _____

Signature of Patient Print name Date

✎ _____

Signature of Patient's legal representative (if applicable) Print name Date

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Consent to Telehealth Visit

Patient Name _____ Date of Birth _____

Reason for Visit _____

The purpose of this form is to obtain your consent for a telehealth visit (or "video visit") with a dermatologist at Walk-in Dermatology. The purpose of the visit is to assist in the diagnosis and treatment of your skin condition. In a telehealth visit, you will interact in real-time with your dermatologist via a secure, online videoconferencing technology. Alternatively, the dermatologist may give you the option of submitting a photo and chief complaint via secured electronic messaging. Your dermatologist will look at your skin during the videoconference or review the photos that you submitted. You will then be given advice about your condition and how to treat and take care of your condition.

All federal and state laws covering access to your medical records also apply to telehealth. No one other than your health care provider can view your photos or other information unless you agree to give them access. You may opt out of the telehealth visit at any time. This will not change your right to future care or health benefits.

Telehealth visit charges are billed and collected in the same manner as regular office visits. Your co-payment will be due prior to your telehealth encounter. Final financial responsibility including deductible and co-insurance amounts will be determined after the claim is filed and processed by your insurance carrier(s).

On March 11, 2020, the World Health Organization declared the COVID-19 viral disease to be a pandemic. As a result of this emergency, a rapidly evolving situation, practice patterns for physicians, physician assistants, and nurse practitioners are shifting to accommodate the need to treat in conjunction with unprecedented guidance from federal, state, and local authorities – which include, but are not limited to, self-quarantines and/or limiting physical proximity to others under any number of circumstances. It is within this context (and with the understanding that this method of patient encounter is in the patient's best interest as well as the health and safety of other patients and the public) that telehealth is being provided for this patient encounter rather than a face-to-face visit. This patient encounter is appropriate and reasonable under the circumstances given the patient's particular presentation at this time. The patient has been advised of the potential risks and limitations of this mode of treatment (including, but not limited to, the absence of in-person examination) and has agreed to be treated in a remote fashion in spite of them. Any and all of the patient's/patient's family's questions on this issue have been answered, and Walk-in Dermatology has made no promises or guarantees to the patient. The patient has also been advised to contact our office for worsening conditions or problems and to seek emergency medical treatment and/or call 911 if the patient deems either necessary.

By signing below, you understand and agree that you solely assume the risk of any errors or deficiencies in the electronic transmission of information during your telehealth visit or in the electronic submission of any images to your dermatologist and further understand that no warranty or guarantee has been made to you concerning any particular result related to your condition or diagnosis. To the extent permitted by law, you also agree to waive and release your dermatologist and his/her institution or practice from any claims you may have about this advice or the telehealth visit. The consent provided in this document will expire in one year from the date you sign it, but your waiver and release shall apply indefinitely for any telehealth visits that occur during the one-year period after your signature date.

_____

Signature of Patient or Legal Representative

_____

Date