LOWE DERMATOLOGY

JULIE LOWE, MD
LAUREN BOYDSTUN, PA-C

Dear New Patient:

We would like to take this opportunity to welcome you to Lowe Dermatology. Please review the paperwork included with this mailing and bring the enclosed forms with you to your upcoming appointment. In order to ensure that we stay on schedule, **we ask that you complete the paperwork before you arrive to your appointment**. If your paperwork is not complete at the time of your appointment, we will reschedule your visit.

Please make sure that you have your insurance information and a photo ID with you at your appointment(s). If your insurance plan requires a referral, it is your responsibility to ensure that your referral is complete before your visit. If your plan requires a referral and we have not received it prior to your arrival, we will reschedule your appointment to a later date.

Your appointment was scheduled based on your specific complaint. Often one appointment does not provide enough time to address every problem. If more time is needed, or if other problems develop, we will schedule future appointments for you to make sure that your questions are all answered. Please focus on your greatest concerns at your first visit. Many problems require follow up visits to ensure that our treatment efforts are successful.

Please note that in some cases a procedure cannot be performed at the time of your consultation. Many procedures require extra time for preparation with our staff and from the provider. We often have to obtain approval from your insurance plan before a procedure can be performed. We will plan accordingly once we have the opportunity to meet you and evaluate your condition. For these reasons, we often perform procedures at separate appointments.

We are honored that you have chosen to trust us with your care. If you have any questions about your upcoming visit, please call us at 405-608-6877 or visit our website at www.lowedermatology.com.

Sincerely,
Julie Lowe, MD
Lauren Boydstun, PA-C

Reminders:

- Bring Your Completed New Patient Paperwork to Your Appointment
- Bring Your Insurance Card & Driver's License to Your Appointment
- Ensure that Your Primary Care Provider Has Sent Your Referral (if Necessary)
- Bring a Copy of your Current Medication List to your Appointment
- All Services must be Paid as Care is Rendered, Including Co-Payments & Deductibles
- Failure to Provide 48 Hours' Notice when Cancelling an Appointment Will Result in a Cancellation Fee

LOWE DERMATOLOGY HEALTH HISTORY FORM

Name:_____ Home Phone: _____

Date of Birth: _____ Age: _____ Height / Weight: _____ Cell Phone: _____

Occupation: _____ Email Address: _____

Primary or Referring M.D.: _____ Preferred Pharmacy & Phone #_____

Please state the MAIN reason you are here to see us: _____

Are you allergic to any medication: (Yes) (No) If yes, which medication(s): _____

Please list all medications that you are currently taking. Include prescription & non-prescription medications.

_____

_____

Please list all surgeries that you have had, including the year:

_____

_____

How much alcohol do you drink / week? _____ Tobacco / week? _____How often do you use tanning beds? _____

Have you had Skin Cancer? ( ) Yes ( ) No
Type, location, and year treated: _____

Family History (hypertension, diabetes, cancer, etc.) _____

_____

Have you been previously diagnosed with, treated for, or received any of the following: Please circle Yes or No

AIDS/HIV Infection	Y	N	Artificial Hip(s) and / or Knee(s)	Y	N
Daily Aspirin or Blood Thinner	Y	N	Rheumatoid Arthritis	Y	N
Bleeding Excessively or Blood Clots	Y	N	Crohns Disease or Ulcerative Colitis	Y	N
Cancer (other than skin) _____	Y	N	Organ Transplant	Y	N
Psychiatric Illness, Inc. Depression / Anxiety	Y	N	Immunosuppression	Y	N
Cold Sores / Fever Blisters	Y	N	Enlarged Lymph Nodes	Y	N
Seasonal Allergies or Asthma	Y	N	Liver disease / Hepatitis	Y	N
Eczema or Psoriasis	Y	N	Scarring / Keloids	Y	N
Bandaid or Adhesive Allergies	Y	N	Non-healing Wounds	Y	N
Allergy to Topical Antibiotics	Y	N	Stomach Ulcers	Y	N
Heart Pacemaker or Debrillator	Y	N	Frequent Yeast Infections with Antibiotics	Y	N
Heart Rhythm Disturbance	Y	N	Nausea or Vomiting from Antibiotics	Y	N
Heart Murmur	Y	N	Past Ultraviolet light treatments	Y	N

Do you need to take antibiotics before undergoing dental procedures? _____

Patient Signature & Date: _____ _____/_____/_____

Provider Signature & Date: _____ _____/_____/_____

Lowe Dermatology

Name: _____
(Last) (First) (Middle) (Mother's Maiden Name)
Address: _____ **Email:** _____
City, State, Zip: _____
Home Phone: (_____) _____ **Cell/Primary Phone:** _____
Sex: _____ Age: _____ Race: _____ **Date of Birth:** _____
Marital Status: _____ **Social Security Number:** _____

Employer Name & Address: _____
Employer Phone: (_____) _____ Occupation: _____
Employment Status (Full/Part Time/Retired): _____

Spouse Name: _____
Spouse Employer & Address: _____
Employer Phone: (_____) _____ Spouse Occupation: _____
Employment Status (Full/Part Time/Retired): _____
In Case of Emergency Contact: _____ Phone: (_____) _____
Address: _____ Relationship: _____

Person Responsible for Payment if Other than Above
Name: _____ Home Phone: (_____) _____
(Last) (First) (Middle)
Address: _____ City, State, Zip: _____
Relationship to Patient: _____ Social Security No: _____
Employer Name & Address: _____
Employer Phone: (_____) _____ Occupation: _____

Primary Insurance
Insurance Carrier _____ **Employer:** _____
Address: _____ ID #: _____
City, State Zip: _____ Group # / Name: _____
Is a Referral Required for Specialist Visits? _____

Name of Policyholder: _____ **DOB:** _____
Relationship to Patient: _____ **Social Security #:** _____
Medicaid / Medicare # _____ State: _____

Secondary Insurance
Insurance Carrier _____
Address: _____ ID #: _____
City, State Zip: _____ Group # / Name: _____
Name of Policyholder: _____ DOB: _____
Relationship to Patient: _____ Social Security #: _____

Primary Care Physician: _____
Phone: (_____) _____ Address: _____ City, State: _____

Referring Physician (If different than Primary): _____ Self or Not Referred (Circle)
Phone: (_____) _____ Address: _____ City, State: _____

HOW DID YOU HEAR ABOUT US (Circle)?
Friend • Insurance • Internet • Magazine • Newspaper • Patient • Physician • TV-Radio • Unknown • YellowPages
Other_____ **Today's Date**___/___/____

Lowe Dermatology

AUTHORIZATION FOR MEDICAL TREATMENT & FINANCIAL RESPONSIBILITY

1. CONSENT

I authorize the providers who may attend to my care, their assistants, and those employed by Lowe Dermatology, to provide the medical care, tests, procedures and supplies considered necessary for my care. In consenting to treatment, I have not relied on any statements as to results. I further authorize my provider, or her associated staff, to examine, use, store, and/or dispose of in any manner any tissue, fluids or parts removed from my body.

I authorize Dr Lowe and her designated representatives to obtain a clinical photograph, if necessary, of my skin condition or lesion. I consent to this with the understanding that such photographs are for clinical record purposes only and will not be used for distribution. Photographs are only shared in the instance that another physician becomes involved in the care of a skin lesion, and in that case a photograph may be necessary to confirm the appropriate location for further treatment.

In the event that any personnel assisting in the provision of care and treatment suffer inadvertent exposure to any of my blood and/or other bodily substance capable of transmitting disease, I will consent to testing to determine the presence, if any, of antibodies to hepatitis B & C, and HIV. I also agree to update this office of any related information and health history that may change over the course of my care.

2. STORAGE AND RELEASE OF INFORMATION

I consent to the electronic storage and transmission of my patient health information. I hereby authorize Lowe Dermatology to release by electronic means, or otherwise, any medical and/or billing information that concerns my care, including copies of my medical records, to the following:

- Another medical provider who may become necessary to assist in my care.
- Any governmental (or other) entity, as required by law, for purposes of reporting, or for purposes of determining eligibility in government sponsored benefit programs.
- The supplier of any blood or blood products which may be administered to me for the purposes of quality control and recipient monitoring.
- Any continuing care, residential or long-term care facility, or home health agency for the purposes of providing services for my care.

3. MEDICARE / OTHER INSURANCE BENEFITS

I certify that the information given by me in applying for payment under the Title XVIII of the Social Security Act is correct. I authorize the release of medical or other information to the Medicare Program or its Intermediaries or carriers concerning this or a related claim filed by Lowe Dermatology. I request payment of authorized benefits be made on my behalf. I understand that I am responsible for the Part B deductible for each year and/or visit, the remaining co-insurance and any other non-covered personal charges.

4. ASSIGNMENT OF INSURANCE BENEFITS

In consideration of any and all medical services, care, drugs, supplies, equipment and facilities furnished by Lowe Dermatology, I authorize direct payment to Lowe Dermatology of all insurance benefits applicable to these medical services, which are now, or which shall become, due and payable. In addition, I hereby authorize payment to Lowe Dermatology of applicable insurance benefits for medical and/or surgical services rendered by physicians or representatives for whom the entity is authorized to bill and collect.

I understand that Lowe Dermatology may utilize facilities or other services in or out of my insurance network. Fees or other concerns associated with such interactions should be addressed with that entity directly. Certain ancillary services (i.e. lab work or pathology) or facilities that are routinely out-sourced by the practice may not be partially or fully covered by my insurance. Lowe Dermatology has no way to guarantee that other consultants or services will be covered by my insurance plan. I understand that I should contact my insurance for further information. I also understand that if my insurance plan has specific restrictions on such services, I need to make a formal request in advance of care for special accommodations. In some cases, based on the restrictions of the insurance plan, accommodations cannot be made and an out of pocket cost may be incurred if care is to be provided.

Patients who receive treatment for a medical condition and provide payment via insurance will be billed based on a standard fee schedule. Those conditions deemed medically indicated, which are generally covered by insurance, will be billed based on a pre-determined fee schedule. The actual fee paid is often reduced due to contractual agreements between the provider and insurance network. Lowe Dermatology reserves the right at any time to cancel, not renew, or re-negotiate any health plan based on contract terms.

5. GUARANTEE FOR PAYMENT

In accordance with the above terms and in consideration of the services provided, I agree whether as the patient or the guarantor, to pay Lowe Dermatology and any related facilities for services rendered. If the requirements for referral, second opinion, pre-certification, or predetermination for a procedure, or any other requirement otherwise outlined by the insurer, benefit plan or other payer, have not been fully followed, I understand that I am still responsible for the charges incurred. If I fail to pay within a timely manner or my payment is invalid or insufficient, extra charges will be incurred. Payment plans may also be arranged in some circumstances with our billing agency, Heartland Billing. A collection agency will be utilized if necessary.

I am responsible for my deductibles, copayments, and non-covered services (i.e. extra medical supplies, extra clerical work, etc). I agree to pay these fees, regardless of my interpretation of any information provided from the staff or physicians. I agree to be responsible for understanding the complexities of my own insurance plan.

9. RELEASE OF INFORMATION TO FAMILY AND FRIENDS

I authorize the following person(s) (or class of persons) to receive my protected health information:

_____

HIPAA-Notice of Privacy Practices Acknowledgement

I acknowledge I have been given the opportunity to receive a copy for review only of the "Notice of Privacy Practice" that explains when, where, and why my confidential health information may be used or shared, I acknowledge Lowe Dermatology, the physicians, physician assistants, and other staff may use and share my confidential health information with others in the pursuit of my medical treatment and to arrange for payment of my claim.

_____

Signature of Patient / Other Date Relationship to Patient, if Applicable

_____

Signature of Guarantor, if Applicable Date Patient's Relationship to Guarantor

_____

Signature of Witness Date

Lowe Dermatology

Skin Cancer Screening

Skin cancer prevention is very important those of us who specialize in dermatology. The best way to prevent skin cancer is to be careful about sun exposure. We should wear sunscreen, hats, sunglasses, and appropriate clothing. Tanning beds should be avoided. We want you to enjoy the outdoors, but we also want you to be safe.

If there is a lesion or growth that you or one of your other doctors is concerned about, please point it out to us. In addition, if you have a mole which has grown or changed in color, it should be pointed out as well. Any growth on the skin that itches or has been bleeding should be examined.

Your dermatologist will give you an opinion about your skin lesions. It is important to note that no physician can ever be absolutely sure that any skin lesion is non-cancerous without removing it. Although uncommon, even a skin biopsy can be inaccurate at times. It is important that you participate in the care of your skin by informing your physician of areas of concern or change. We will also do our best to help you by evaluating your skin and pointing out those areas that are concerning to us.

A skin cancer screening is a tool that we recommend to help detect skin cancer on your body. Lesions that are unusual or appear to be cancerous will be pointed out, and may be biopsied. Whenever a lesion is biopsied, it is sent to a pathologist to be examined. Lesions which appear to be benign (non-cancerous) will also be pointed out to you by your dermatologist.

The frequency of your recommended skin cancer screenings is determined by your history. It is recommended that persons who have had a skin cancer in the past be screened regularly. People with a family history of some types of skin cancer should be examined as well. In order to have a skin cancer screening, it is important that you disrobe and wear a gown. Skin cancer screening appointments must be made in advance so that the proper amount of time is available.

WHAT IS A BIOPSY?

When a lesion is biopsied, it is often only sampled. A biopsy is done so that a diagnosis can be made. This means that if the growth is diagnosed as a skin cancer, more work will need to be done to ensure that it has been properly treated. This may involve a second surgery either by your dermatologist, a Mohs surgeon (a subspecialty of dermatology), a general surgeon, or a plastic surgeon. The decision as to who treats your cancer (and how) is a mutual decision that will be made based on what type of cancer you have and where it is located on your body. In some cases, the cancer may also be treated with a chemotherapy cream or radiation.

WHAT IS LIQUID NITROGEN?

Liquid nitrogen is a very cold liquid which dermatologists use to treat several things including pre-cancerous lesions, benign keratosis (age spots), warts, and skin tags. We use this to treat pre-cancers because the liquid nitrogen destroys the pre-cancerous cells and prevents them from turning into a skin cancer. Whenever Liquid Nitrogen is used, the treated area is expected to blister, then scab, then heal. The healing process generally takes a week, but can take as long as 2-3 weeks. After it heals, you may see some discoloration of the skin in the treated area. This is especially true in patients with darker skin and on certain parts of the body, such as the legs. Scarring can also occur. Some lesions need to be treated twice to fully resolve, particularly warts and age spots. If a precancerous lesion is treated with liquid nitrogen and it does not fully heal, or if it comes back, it is important that you let us know.

HEALTH INSURANCE

Most health insurance plans cover evaluation and treatment of skin cancers & pre-cancers.

Initial_____

Lowe Dermatology

Office Policies

We are pleased that you have chosen to trust us with your health care. We take your trust seriously. If you are a new patient, we also know that you may have waited a long time for this visit and we appreciate your patience in so doing. We do our best to ensure that patients who are already in our practice, especially in the case of serious or complicated problems, receive timely care in those times that it is most necessary.

As in any office, your provider may not always run on time. We do our best to stay on schedule, but medicine can be unpredictable and delays do occur. Patients can help by respecting the physician's time during your visit. It also helps when our patients arrive a few minutes early and with paperwork complete when you get to the office. **Please have your insurance card and license or photo ID available when you arrive.**

We schedule your appointment based on the problems described either in your doctor's referral or when you scheduled your visit. Some problems are more complicated and can't be fully explored in one visit. Also, if you have other issues that arise before your appointment time, we may not be able to cover everything at once. In those cases, we will schedule you for a follow-up visit. Some problems also require ongoing care or regularly scheduled appointments and we do our best to accommodate those situations as well.

We understand that emergencies arise and that sometimes appointments must be rescheduled or cancelled. Also, some problems resolve before the appointment occurs. If you need to cancel or reschedule, please provide at least 48 hours' notice so that another patient can use your appointment time. Last minute emergencies do come up, and it is often helpful to have an open slot in the day so that we can better accommodate such situations.

ADVANCE BENEFICIARY NOTICE (ABN)

We all have choices to make about medical care and insurance coverage. Insurance is a means to assist in payment of medical services. Insurance companies are not health care providers. The fact that medical insurance does not pay for services provided or recommended does not mean that said services are not indicated. We recommend treatments, medications, and services based on our experience, knowledge and training in the practice of medicine.

If you have an HMO Insurance and a referral is required for you to see a specialist, it is your responsibility to ensure that you have a valid referral for your visit(s). We have no way of knowing what your plan requires until after we have submitted a claim, meaning you have to keep us informed in advance. Some insurance companies only authorize one visit, others will authorize a designated number of visits or period of time. It is your responsibility to know your plan and you will be responsible for payment if your authorization has expired.

No matter what the situation or process, your insurance provider may choose not to pay for your medications or treatments. This does not mean that the procedure of service was not "coded correctly" by the provider. Many health insurance companies simply make a blanket statement that they will pay for a service if it is "medically indicated." Once a service is provided and a claim submitted, the insurer will review the claim, and at times the records, and decide if payment will be provided on your behalf. This is part of most insurance contracts and is not negotiable.

We have no way of knowing what medications are on your formulary – there are literally thousands of different formularies and they are ever changing and honestly not always logical. Most medications that we prescribe require prior authorization. This is a process by which a member of our office staff must contact your insurance company to explain why a medication has been prescribed for your treatment. We often have to submit several pages of paperwork as well. This process is cumbersome and may take several days to complete. The prior authorization process is initiated at the pharmacy when your prescription is delivered. We cannot rush the process – it is controlled on the end of the insurance company.

In addition, your insurance company may cover a treatment, medication, or office visit, but if you haven't met your deductible, you will be responsible for part of your bill. We will file your claim, which is to your benefit, because your visit (or medication or procedure) is still being obtained at a discounted rate because of our contract with your insurance plan. You still receive a financial benefit from your insurance in that regard. We cannot code something differently to reduce your deductible or change how much you might have to pay.

The insurance system is complicated, frustrating, and always changing. Insurance companies do not notify providers regarding policy changes. We try to keep up with changes as they occur. It is always helpful if a concerned patient takes time to review their own individual health plan and contact their insurance providers regarding questions about fees or coverage.

Lowe Dermatology intends to provide timely invoices, but due to the complexities of medical billing, delays occur. We may spend weeks appealing a denial on your behalf after submitting records for insurance review. Please contact either our office or the billing company if there is ever a concern about your invoice.

We are here to take care of you. To that end, our staff spends an extensive amount of time working with insurance companies to assist in prior authorizations for medications, pre-determinations for procedures, sending records to verify that your services were "medically indicated," etc. We do our best to assist you with this complicated process and our intention is to be honest and transparent. By signing this document you indicate that you understand that your medical insurance may not cover part or all the services provided, recommended, or arranged and that you will be responsible for the bill.

Please also note:

1. **If you have health insurance, you have a contract with your insurance company.**
2. **If we are in your insurance network, we also have a contract with your insurance company.**
3. **We cannot "waive" your co-pay or deductible. Doing so would be a violation of your contract, and our contract, with the insurance provider.**
4. **Your insurance sets the fee schedule that determines the amount that we are paid for your services.** We cannot lower or adjust that amount. We cannot see you and not charge you as that also would violate our contractual agreement with the insurance company. We often cannot tell you precisely how much your insurance company will reimburse us for a procedure that we perform, as they set the fee schedule. If you ever have a question about fees, please call your insurance company directly.

_____

Signature of Patient / Other Date

_____

Relationship to Patient, if Applicable

_____

Signature of Witness Date