PATIENT INFORMATION (Please print clearly)

Patient's Name	Marital Status	Sex	Date of Birth	Social Security #
	S M W Div Sep	M F		
Street Address	City and State		Zip Code	Home Phone #
Patient's Employer	Occupation (indicate if student)			Cell Phone #
Employer's Street Address	City and State		Zip Code	Cell Provider ☐AT&T ☐Verizon ☐Sprint ☐T-Mobile ☐Other
Emergency Contact (not living with you)	Relationship			Emergency Contact Phone #
Spouse's Name	Occupation		Spouse Date of Birth	Spouse Contact #
Primary Care Physician	Physician Address			Physician Phone #
Who referred you to this practice?	Email Address			Drivers License Number

IF THE PATIENT IS NOT THE INSURED:

Responsible Party's Name	Marital Status	Sex	Date of Birth	Social Security #
	S M W Div Sep	M F		
Street Address	City and State		Zip Code	Home Phone #
Patient's Employer	Occupation (indicate if student)			Business Phone #
Employer's Street Address	City and State		Zip Code	Relationship to Patient

PRIMARY INSURANCE:

Name of Insurance Co.	Phone # (to verify benefits)	Phone # (for pre-certification)
Address	City and State	Zip Code
Name of Insured	ID #	Group #

SECONDARY INSURANCE:

Name of Insurance Co.	Phone # (to verify benefits)	Phone # (for pre-certification)
Address	City and State	Zip Code
Name of Insured	ID #	Group #

PHARMACY BENEFITS INFORMATION:

Preferred Pharmacy Name	Address or Location	Phone #

AUTHORIZATION TO RELEASE MEDICAL INFORMATION/ASSIGNMENT OF BENEFITS: I hereby authorize Christine D. Brown, M.D. to furnish appropriate and necessary details of medical information to my insurance company. I hereby authorize payment of medical benefits to Christine D. Brown, M.D. for medical services rendered.

Patient Signature: _____ Date: _____

Parent or Guardian: _____ Date: _____

FINANCIAL RESPONSIBILITY STATEMENT

Thank you for choosing our office for your care. We appreciate the opportunity to serve your health care needs and look forward to getting to know you. If you have any questions or concerns, please feel free to discuss these with our staff. Or philosophy is to provide personalized, high quality healthcare in the most cost-effective manner.

This form was developed to explain and clarify our financial policies. Please read this carefully and sign on the next page where indicated. Your signature indicates that you have read and understood our policies and that you will honor the terms. We appreciate your cooperation.

Standard Payment Policy:

Payment for our office visits is due at the time services are rendered. For your convenience, we accept VISA, MASTERCARD, AMERICAN EXPRESS and DISCOVER. We will provide you with an itemization of charges that you may submit to your insurance carrier for reimbursement of fees.

For Medicare patients, our office accepts assignment and files claims with Medicare. Medicare patients are responsible for any coinsurance and deductible amounts. Medicare patients must present their Medicare card at the time of registration. We do file secondary insurance for Medicare patients.

If you are an HMO/PPO (managed care) patient of a plan in which we participate, our office has agreed to accept the plan's fee schedule and file the claim with your insurance company. HMO/PPO patients are responsible for co-pays and deductibles at the time of service. HMO/PPO patients must present their insurance card at the time of registration. HMO/PPO patients are responsible for obtaining a referral number from your primary care physician.

Payment Policy:

Mohs and other surgery patients: We file insurance claims (including Medicare) for all surgery patients. We inform you of estimated deductibles and co-insurance amounts. These amounts are due at the time of service. Any balance due from the patient that is still remaining once insurance has paid its portion will be billed to you.

Insurance Claims:

We make every effort to seek insurance reimbursement on covered services. Filing insurance is a service we provide to you; however, insurance is a contract between you and your carrier. Once your insurance company has paid, you will receive a bill for any remaining balance on the account.

Collection Efforts:

We work with you to make payment arrangements. If these efforts do not result in a resolution of the account, the account may be referred to a collection agency and the local credit bureau. Any collection fees incurred by our office are charged to your account. An 18 percent annual service charge is added to balances over 30 days old.

Returned Checks:
We do not accept checks.

Referrals:

Your physician may have an economic interest in or a business relationship with the company or person who provides the Pharmacy Services. You are not obligated to use the service that your physician refers you to. You are free to use any provider you choose.

Missed or Cancelled Appointments:

If you do not appear for your appointment, or if you cancel your appointment with less than 24 hours' notice, you will be billed a $40.00 "missed appointment" fee.

"Not Medically Necessary" or "Cosmetic" Procedures:

Insurance companies have instituted restrictions on procedures and have designated these as "not medically necessary." Procedures that commonly fall into this category are listed below:

- Removal of benign lesions, including moles, warts, skin tags, cherry or spider angiomas, lentigines (liver spots), cysts, and seborrheic keratoses by any procedure.
- Collagen treatments
- Glycolic acid peels
- Surgery to repair a torn ear (due to earrings)
- Laser surgery for any benign lesion
- Sclerotherapy for leg veins
- Cautery for treatment of dilated blood vessels of the face

If you elect to continue with a procedure in this non-covered category, payment in full is required at the time the service is rendered. There is no reduction in our standard fee schedule for managed care of Medicare patients. Medicare patients will be required to sign a separate acknowledgement statement as required by Medicare guidelines. Our office does not file a claim with your insurance carrier when any of these procedures are performed.

I have read and understand the above and agree to comply with the financial policies of Christine D. Brown, M.D., P.A.

_____

Signature of Patient (or parent) Date

PATIENT INSTRUCTIONS
WAIVER

Please complete the enclosed information form prior to your appointment date and return it to us as soon as possible.

Include a **photocopy of the front and back of your insurance card(s)** and bring BOTH your Driver's License and insurance card(s) with you at the time of your appointment.

If you have an **HMO type plan**, we require **a current referral from your primary care physician**. This will help us ensure that you see Dr. Brown at your scheduled appointment time. If you do not have **a valid referral** by the time of your appointment, **your appointment will be rescheduled**.

The parking garage does have a fee of $2.00 - $8.00 depending on the length of your visit.

Thank you in advance for your assistance in getting the medical information forms to us as soon as possible.

I have read and understand the information provided to me herein.

_____

Signature of Patient (or parent) Date

Patient Preferences Regarding Communication of PHI (Patient Health Information)

Approved HIPAA Contacts

☐ **DO NOT disclose or discuss any information related to my billing account or medical conditions with anyone other than myself, except in an emergency situation.**

Please list any person(s) Dr. Brown and/or her office staff may contact and indicate (by checking the box) if we may discuss any information related to your billing account and/or medical conditions. Also, choose the person you would like us to list as your emergency contact in the event an emergency situation was to take place at our office.

Name	Relationship	Phone Number

☐ Billing Account Information ☐ Medical Condition Information ☐ Emergency Contact

Name	Relationship	Phone Number

☐ Billing Account Information ☐ Medical Condition Information ☐ Emergency Contact

Preferred Method of Communication

☐ **I request that communication regarding my medical conditions to occur only when I am in the office. Please only print and hand me information when I am in the clinic. I DO NOT wish to be notified my any other communications regarding my medical conditions.**
*****If you check the box above, we CANNOT call you, email you, or mail anything to you under any circumstances.**

My preferred contact method regarding my medical conditions is indicated below (check ONE only):

☐ Home Phone ☐ Work Phone ☐ Cell Phone
☐ Mailed Letter ☐ Guardian ☐ Other

Write the number in:
( ) -

If the above method of communication is by phone, please check the appropriate box below:

☐ OK to leave a message with detailed information.

☐ Please leave a message with call-back number only.

Please note that you are responsible for any charges incurred in receiving our communications including charges from your mobile carrier for calls or texts received.

Please let our office know if you have any special directions or requests regarding our communication with you. For example, please let us know if you want us to call you at a different phone number for a particular test result.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed on this form will require my specific authorization prior to the disclosure of any medical information.

Signature of Patient, Parent, or Legal Guardian	Date

Name of Legal Guardian	Relationship to Patient

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
High Blood pressure
HIV/AIDS
High Cholesterol
Hypothyroidism
Hyperthyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke

NONE

Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
Kidney Biopsy (Nephrectomy)
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 (Prostate Removal)
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer

NONE

Joint Replacement within last 2 years
Other _____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	
		NONE

Other _____

Do you wear Sunscreen? Yes No
If yes, what SPF? _____
Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____

Allergies: (Please enter all allergies)
_____
_____
_____

Social History: (Please circle all that apply)

Cigarette Smoking:

Currently Smokes
Has smoked in the past
Never smoked
Former Smoker

Alcohol Use:

EtOH- None
EtOH- less than 1 drink per day
EtOH -1-2 drinks per day
EtOH -3 or more drinks per day

Other_____

Family History:
Skin Cancer _____Yes _____No Relative: _____
Diabetes_____Yes _____No Relative: _____
Heart Disease _____ Yes _____ No Relative: _____
Cancer _____Yes _____No What type:_____ Relative: _____

Preferred Language: _____

Race:_____ Ethnic Group:_____

Preferred pharmacy Name: _____

Phone#: _____

City or Zip code:_____

Patient name: _____

Patient phone #: _____

Patient email address: _____

Referring Physician: _____

Name of Medication Generic or Brand	**Dose to Include: Strength/MG How Many Taken**	**How Taken Pill = Oral Cream = Topical**	**Frequency How Often Taken Daily/Twice Daily/ Etc…**

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

Symptom	Yes	No

Other Symptoms: _____

ALERTS: (please circle all that apply)

Allergy to Adhesive
Allergy to lidocaine
Allergy to topical antibiotics
Artificial heart valve
Artificial joint replacement
Blood thinners
Defibrillator
MRSA
Pacemaker
Require antibiotics prior to a surgical procedure
Rapid heart beat with epinephrine
Are you pregnant or currently trying to get pregnant?

Christine Brown M.D
Review of Systems

Patient Name: DOB:

***Please indicate YES or NO to the following conditions as they apply to you**

	YES	NO
Problems with bleeding		
Anemia		
Clotting Problems		
Problems with healing		
Rash		
Herpes		
Immunosuppression		
Exposure to HIV (AIDS)		
Organ Transplants		
Seasonal Allergies		
Chest Pain		
Heart Murmurs		
Heart Attack		
Shortness of Breath		
Cough		
Wheezing		
Fever or Chills		
Night sweats		
Unintentional weight loss		
Weight change		
Fatigue		
Alcoholism		

	YES	NO
Chemical dependancy		
Thyroid problems		
Excessive sweating		
Hearing difficulty		
Blurry vision		
Vision Loss / Blindness		
Liver Disease		
Bowel problems		
Stomach Problems		
Bladder problems		
Kidney Disease		
Vaginal infections		
Joint aches		
Muscle weakness		
Neck Stiffness		
Headaches tremor		
Seizures		
Anxiety		
Depression		
Mental disorder		

Do you have any of the following:

	YES	NO
Allergy to adhesive		
Allergy to Lidocaine		
Allergy to topical antibiotic ointments		
Allergy to latex		
Artificial heart valve		
Pacemaker		
Defibrillator		
Cardiac / Vascular stent		
Venous filter		
Blood thinners		
Artificial joints within past two years		
MRSA		
Premedication prior to procedures		
Rapid heart beat with Epinephrine		
Pregnancy or planning a pregnancy		
West Africa: Travel or Contact		

You may access the EMA patient portal on your own device by going to the URL www.christinebrownmd.com/patient-resources. Thank you.