GREENWOOD DERMATOLOGY

Larry J. Buckel, M.D. • Thomas J. Eads, M.D. • Laura T. Stitle, M.D.

Thank you for choosing Greenwood Dermatology for your Dermatologic needs.

Dermatologists are the experts in the diagnosis of skin, hair, and nail conditions, and are specially trained to provide the highest quality of medical, surgical and cosmetic treatments.

Enclosed you will find the paperwork that you will need to fill out and bring with you when you come in for your appointment.

Please arrive **15 minutes** before your scheduled appointment time.

You will need to bring with you:

1. **Completed paperwork.**
2. **Insurance Card or Cards**
3. **Photo ID (If minor, we will need parents ID)**

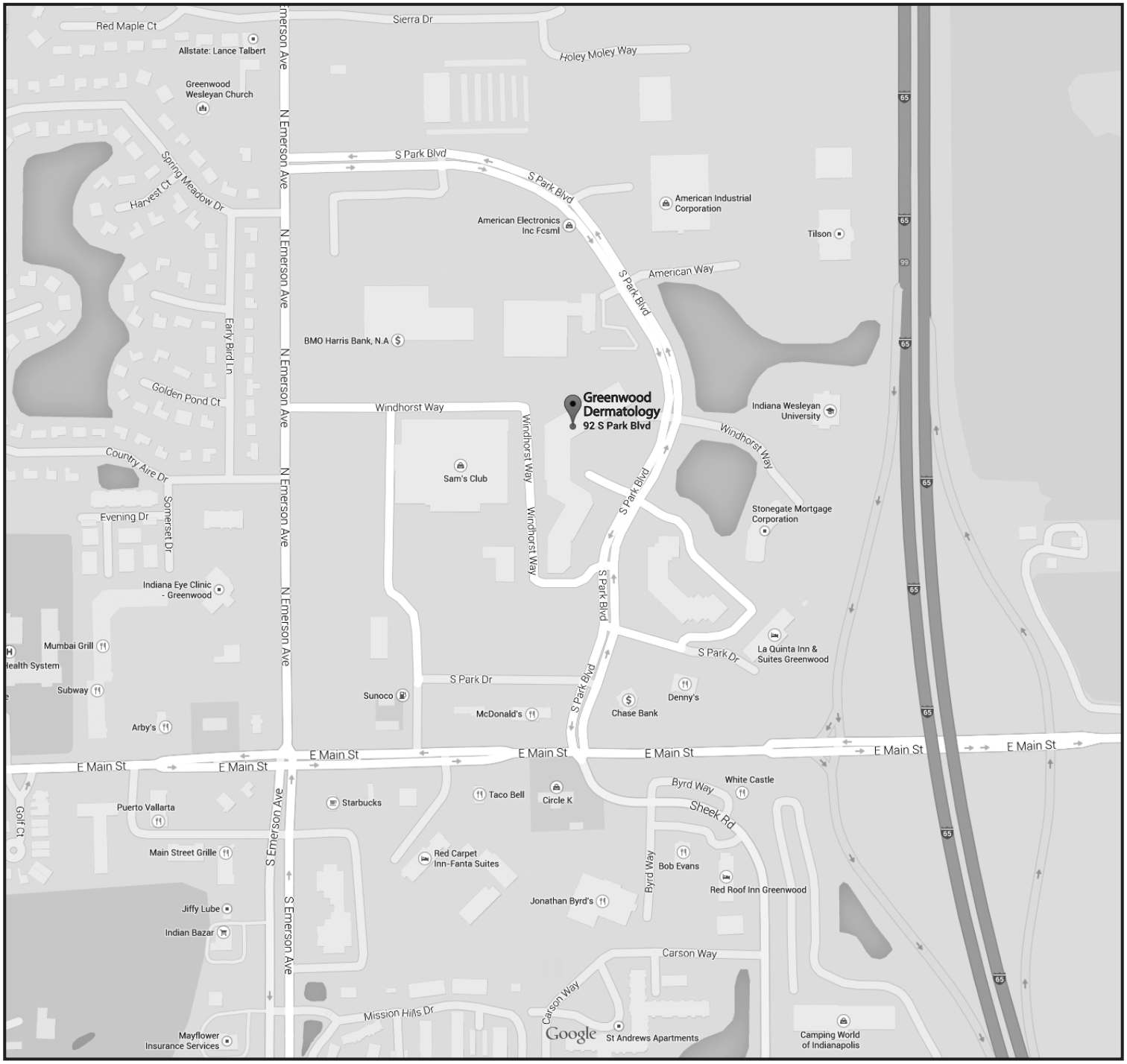
We recommend that you check with your insurance plan to be sure the doctor is in your network.

Our address is, 92 South Park Blvd, Greenwood, IN 46143.

Map on the reverse side of this page.

We look forward to helping you with your dermatological care.

Sincerely,
Larry Buckel MD
Thomas Eads MD
Laura Stitle MD
& Staff



We are located off I-65 at Exit 99 (Greenwood Exit)

Go West on East Main St. to South Park Blvd. (McDonald's & Chase Bank are at the corner of South Park and East Main St.)

Go North (Right) on South Park Blvd.

We are the first building on the West side (Left) of the street past McDonald's (Same side of the road as the McDonald's)

Patient Information

Today's Date: _____/_____/_____

Name: _____
Last First M.I.

Date of Birth: _____/_____/_____ Age: _____ Sex: ❑ Male ❑ Female Soc. Security #:_____

Address:

Mailing Address: _____

City:_____ State:_____ Zip Code:_____

Home Phone: ( ) _____ Cell Phone: ( ) _____

May we email personal medical information ❑ Yes ❑ No Email: _____

With my consent, Greenwood Dermatology may mail to my home or call my home or designated locations any items that assist the practice in carrying out treatment, payment, and healthcare operations such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. Greenwood Dermatology has my permission to leave a message. **Signature:**_____

Place of employment:_____ Phone: ( ) _____

Spouses place of employment:_____ Phone: ( ) _____

Emergency Contact Information

In case of Emergency, who should be notified? _____ Phone ( ) _____

Relationship to patient: _____

Parent, Spouse or Responsible Party ***(if different from patient)***

Name: _____ Date of Birth: _____/_____/_____
Last First M.I.

Address: _____
City State Zip Code

Home Phone: ( ) _____ Work Phone: ( ) _____

Physician Information:

Family Physician_____Address:_____

Were you referred by a physician? _____ If yes, who is the referring physician:_____

Address or phone number of referring physician:_____

Insurance Information:

Primary Insurance Carrier: _____

Policyholder's Name: _____ SSN# _____ Birthdate _____

Relationship to Patient: _____

Secondary Insurance Carrier: _____

Policyholder's Name: _____ SSN# _____ Birthdate _____

Relationship to Patient: _____

Please sign so we may have your insurance authorization on file

I authorize any holder of medical and/or other information about me to be released to the above insurance company(s), and any information needed for this or a related insurance claim. I hereby assign to the physician all payments for medical services rendered to my dependents or myself. I understand that I will be billed and I am responsible for any amount that is not covered by my insurance.

Date:_____/_____/_____ Signature: _____

Please present your insurance card(s) and a photo ID to the receptionist.

(Over)

DERMATOLOGY HISTORY FORM

Name_____ Date of Birth _____ Date_____

1. How were you referred to us?
   ____ Friend ____Doctor _____ Internet _____ Yellow Pages _____Other
2. Primary reason for today's visit?_____
3. How long have you had the problem?_____
4. What treatment have you tried both nonprescription and/ or prescription?
   _____
5. Do you have or have you ever had any of the following: Review of Systems: (ROS)

LUNG

Yes	No	
___	___	Bronchitis
___	___	Emphysema
___	___	Asthma
___	___	Do you smoke
_____		When was your last Flu shot?

VASCULAR

Yes	No	
___	___	High Blood Pressure
___	___	Heart Attack
___	___	Heart murmur/Rheumatic Fever
___	___	Palpitation/Irreg. or fast heart beat
___	___	Heart disease, angina or chest pain
___	___	Artificial Pacemaker/Defibrillator
___	___	Stroke

SYSTEMIC

Yes	No	
___	___	Diabetes
___	___	Thyroid trouble
___	___	Kidney or bladder problems
___	___	Stomach or bowel problems
___	___	Hepatitis, jaundice, liver disease
___	___	Convulsions or epilepsy
___	___	Fainting
___	___	Glaucoma
___	___	Alcoholism
___	___	Hepatitis B Exposure
___	___	AIDS or HIV Exposure
___	___	Cancer
___	___	Blood Transfusion
___	___	Do you drink alcohol?

If yes,
How many:____per day, ____per week

For Office Use
Reviewed by:

(1) _____ Date Signature
(2) _____ Date Signature
(3) _____ Date Signature
(4) _____ Date Signature
(5) _____ Date Signature
(6) _____ Date Signature
(7) _____ Date Signature
(8) _____ Date Signature
(9) _____ Date Signature
(10) _____ Date Signature
(11) _____ Date Signature
(12) _____ Date Signature
(13) _____ Date Signature
(14) _____ Date Signature
(15) _____ Date Signature
(16) _____ Date Signature
(17) _____ Date Signature
(18) _____ Date Signature
(19) _____ Date Signature
(20) _____ Date Signature

6. Current medication and dosage, include over the counter, and vitamins_____
   _____
   _____
   _____
   (If you need additional space please check with the receptionist)
7. Do you have any medication allergies? Yes _____ No _____
   List: _____
8. Other Medical Conditions or Surgeries not already listed?_____
   _____
9. Any personal history of skin cancer? ____Yes ____No
   If yes, Type (If you know) _____
10. Any personal history of other skin disease? ___Yes ___No
    If yes, What _____
11. Any family history of skin cancer? ____ Yes ____ No
    If yes, What _____
12. Any family history of skin disease? ____ Yes ____ No
    If yes, What _____
13. Do you have any scarring tendencies after surgery? ____Yes ___No
    _____
14. Women Only: Are you pregnant? ___Yes ___No If yes, Due Date _____
    When was your last menstrual period? _____

Completed By: ___ Patient ___Parent/ Guardian _____
Signature

Greenwood Dermatology
92 South Park Blvd
Greenwood, IN 46143
317 889-7546

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Greenwood Dermatology to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). (Greenwood's Notice of Privacy Practices provides a more complete description of such uses and disclosures.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Greenwood Dermatology reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Greenwood Dermatology, 92 South Park Blvd, Greenwood IN 46143 Attn: Office Manager.

With this consent, Greenwood Dermatology may call my home or alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, Greenwood Dermatology may mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards, lab results, and patient statements.
With this consent, Greenwood Dermatology may e-mail to my home or alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

You may have the following right with respect to your PHI:
The right to request that Greenwood Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. The right to reasonable request to receive confidential communication of PHI by alternative means or at alternative locations. The right to inspect and copy your PHI. The right to amend your PHI. The right to obtain a paper copy of this notice from us upon request. The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.
If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure. You must submit your request in writing to the office manager.

Do you give our office permission to discuss your medical information with a family member or care giver:
_____Yes ____No Please list name:

Name:_____Relationship:_____

Name:_____Relationship_____

By signing this form, I am consenting to Greenwood Dermatology's use and disclosure of my PHI to carry out TPO. 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, or later revoke it Greenwood Dermatology may decline to provide treatment to me.

_____ _____
Signature of Patient or Legal Guardian Date

_____
Please print patient name.

Payment Policy:

The doctor appreciates the confidence you have shown in choosing us to provide for your healthcare needs. The service you have elected to participate in implies a financial responsibility on your part. As a courtesy, we will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. The patient or legal guardian is responsible for all fees incurred for office medical services regardless of insurance coverage. This includes any amount the insurance does not cover for office visits and in the unlikely event of complications from treatment, the patient is responsible for fees charged by other physicians or hospitals. Any amount that insurance does not pay will be billed directly to you. Any co-payments that you are liable for with your policy, as well as any medications, charges for noncovered services, products you may purchase at the office, and cosmetic services are due at the time of the visit.

Electronic recording is prohibited within the office.

The Adult/Guardian who brings in the child will be responsible for all copayments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

If we receive payment from the primary insurance, we will file a claim with your secondary. If we do not receive payment from your primary carrier, you will be billed for the entire amount.

It is ultimately the patient's responsibility to verify that the physician is in your network, and to obtain any referrals your insurance may require.

If insurance does not pay your claim within 90 days, you will be responsible for the amount in full. It is your responsibility to make sure that these claims are paid in a timely manner.

I understand that should my account become past due it may be placed with a collection agency. **If it is, I am aware that I am responsible for all collection agency fees (33 1/3%) of my account balance), attorney fees and court cost.**

No Show / Late Cancellation: In order to provide timely care for all of our patients, we have a no show / late cancellation fee. A twenty-four hour cancellation of your appointment must be given to avoid being assessed a $25.00 charge for a missed appointment. If you miss a scheduled surgery appointment there will be a $100.00 fee. These fees are not covered by your insurance.

There will be a $25.00 charge for any returned checks.

Signature: _____ Date:_____/_____/_____