

Dr. Stacy J. Haynes, P.C.
Anniston Dermatology/Haynes Medi-Spa

Birmingham

3825 Lorna Road, Suite 240
Birmingham, AL 35244
205-988-3733 / 205-985-4431 fax

Jacksonville

613 S Pelham Road, Suite 4
Jacksonville, AL 36265
256-435-6200

Oxford

1702 Hillyer Robinson Parkway
Oxford, AL 36203
256-831-8100 / 256-831-8128 fax

NON-COVERED SERVICE AGREEMENT

As your physician, I want to provide you with the best care possible. There may be certain routine services performed during our visit(s), such as:

Shavings
Lab Work

Biopsies
Lesion Removal

Injections
Minor Surgeries

And/or other testing that I feel necessary for the maintenance of your good health and that may NOT be covered by your insurance contract. You will be expected to pay for these services.

(One Signature per Visit)

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

Signature

Date

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New_____ Changes_____ Date_____

Patient's Full Name_____ Date of Birth_____ M_____ F_____

Patient's Social Security #_____ Circle: Marital Status S M W D Separated

Home Address_____ City_____ State_____ Zip_____

Home Telephone_____ Cell_____ Work or Other_____

I wish to be contacted in the following manner:

_____ **OK to leave a message with detailed information at:** HOME WORK CELL

_____ **Leave message with call back number only at:** HOME WORK CELL

_____ **Other**_____ **EMAIL ADDRESS**_____

Name of Relative or Friend Not Living with Patient_____

Patient's Employer_____ Occupation_____ Phone_____

Name of Patient's Spouse_____ Social Security #_____ Phone_____

Spouse's Employer_____ Date of Birth_____ Phone_____

Primary Medical Physician Name_____ Phone_____

If Patient is a Minor please complete the following:

Responsible Party's Name_____ Relationship_____

Address if different than above:_____ City_____ State_____ Zip_____

Mother's Name_____ Phone #_____ Employer_____

Mother's Date of Birth_____ Alt #_____ Social Security_____

Father's Name_____ Phone #_____ Employer_____

Father's Date of Birth_____ Alt #_____ Social Security_____

Insurance Information: PROOF OF INSURANCE IS REQUIRED, NO EXCEPTIONS

Primary Insurance_____ Contract #_____ Group #_____

Name of Subscriber_____ Date of Birth_____ Relationship_____

Secondary Insurance_____ Contract #_____ Group #_____

Name of Subscriber_____ Date of Birth_____ Relationship_____

NOTE: ANY ADULT BRINGING A CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT ON ACCOUNT. IF 18 OR OVER, YOU ARE RESPONSIBLE FOR INCURRED CHARGES.

PATIENT OR GUARDIAN SIGNATURE:_____ **DATE**_____

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HEALTH QUESTIONNAIRE (if you need additional space, please use the back of page)

REASON FOR VISIT _____

MEDICAL HISTORY: (Check box to indicate if you currently have or have had any of the following symptoms or diseases.)

- | | | | |
|--|---|--|---|
| ☐ Alcohol | ☐ Cataracts | ☐ Hepatitis | ☐ Sinus Problems/Nose Bleeds |
| ☐ Asthma | ☐ Chlamydia/Gonorrhea | ☐ Herpes | ☐ Smoking |
| ☐ Allergies | ☐ Coronary Heart Disease | ☐ Hypertension (HBP) | ☐ Stroke |
| ☐ Anemia | ☐ Depression | ☐ Menopausal Symptoms | ☐ Thyroid Disease |
| ☐ Birth Control | ☐ Diabetes | ☐ Mental Illness | ☐ Tuberculosis |
| ☐ Bruise Easily | ☐ Glaucoma | ☐ Migraine Headaches | ☐ Varicose Veins |
| ☐ Cancer | ☐ Heart Murmur | ☐ Phlebitis | ☐ Venereal Disease |

SKIN PROBLEMS: (Check box to indicate if you currently have or have had any of the following symptoms or diseases.)

- | | | | |
|--|--|------------------------------------|---|
| ☐ Abnormal Moles | ☐ Eczema | ☐ Hives | ☐ Recent/Progressive Hair Loss |
| ☐ Acne | ☐ Excessive Scarring | ☐ Psoriasis | ☐ Skin Cancer |
| ☐ Cold Sores/Fever Blisters | ☐ Frequent Sun Exposure | ☐ Rash | ☐ Other _____ |

LIST ALL MEDICATIONS THAT YOU ARE TAKING, INCLUDE ALL OVER THE COUNTER MEDICATIONS

DRUG ALLERGIES _____

SURGERIES: Please include the year _____

FAMILY HISTORY	ALIVE & WELL	DECEASED	FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORIASIS	ECZEMA
FATHER																					
MOTHER																					
BRO/SIS																					
BRO/SIS																					

Patient or Guardian Signature _____ **Date** _____

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

Dr. Stacy J. Haynes, P.C.
Anniston Dermatology/Haynes Medi-Spa

Patient _____ Date of Birth _____

Consent for Treatment/Release of Medical Information/Financial Responsibility

I, the undersigned, consent to treatment necessary for the care of the above named patient. I hereby authorize release of any or all medical records to the referring physicians, my insurance carriers/Medicare/Medicaid and those involved in payment of my account. I further acknowledge full financial responsibility for any services, surgical, or medical rendered by Stacy Haynes, M.D., P.C./Anniston Dermatology/Haynes Medi-Spa whether him/her in person or under his/her supervision and understand that payment of charges incurred in the office is due at the time of service. I also understand that charges not covered by insurance remain my responsibility and assign insurance benefits to Dr. Stacy Haynes, P.C./Anniston Dermatology/Haynes Medi-Spa. I understand that Medicare, PMD-Blue Cross, PMC and other insurance companies may consider durable medical equipment or other services to be a non-covered item and will not reimburse. I agree to assume the financial responsibility for services not reimbursed under my insurance plan. I, the undersigned agree to pay all costs of collection including collection fees (33.3%), attorney fees (and/or court costs, if such be necessary) and hereby waive all rights of exemption under the Constitution of the State of Alabama. If you choose to pay by check and your check is not paid on presentation or dishonored, you agree to pay a bad check charge of \$30 or higher if allowed by law, and we may electronically re-presented for payment. I authorize the undersigned, give Dr. Stacy Haynes, its employees and/or agents "express prior consent" to contact me at any/all phone numbers, including cell phone numbers (by phone call or text message) for the purpose of treatment, insurance and/or payment.

Signature _____ Date _____ Relationship to Patient _____

My protected health information may be released to the following individuals:

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

I, the undersigned, understand that I have the right to change the above information at any time by completing another form.

Signature _____ Date _____ Relationship to Patient _____

Patients age 14 and older must sign for information to be released. Signature _____

Privacy Notice Acknowledgement

I have seen the privacy notice posted in the waiting room of Stacy Haynes, M.D., P.C./Anniston Dermatology/Haynes Medi-Spa and a copy has been made available to me. If you would like a copy of the privacy notice, please check Yes _____ No _____ Initial _____

Prescription Refills

I understand that prescription(s) from other physicians will not be refilled by our physician, PA, or NP. If you HAVE NOT seen our physician within one year, NO refills will be given. Unless there is a true emergency, no messages will be answered after 3:30 pm. Prescriptions are written or electronically scribed the same day as the office visit. When requesting a refill, you MUST have the name of the medication and your pharmacy telephone number before any refills are completed. Questions about medications are addressed on Wednesday. Initial _____ Date _____

PHARMACY PHONE NAME AND PHONE NUMBER _____

Fees for No-Shows, Rescheduling of Surgery, and Medical Records

We always look forward to seeing our patients, therefore your appointment time has been set aside especially for you. A (24) hour notice is required for all cancellations. We accept notice of cancellation on our answering machine or answering services. Cancellations with less than a (24) hour notice, will be charged a fee of \$50. There is a \$25 charge for all forms and letters and a \$25 plus for copying of medical records. Initial _____ Date _____

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PATIENT TEXT MESSAGE CONSENT FORM

Name_____ Date of Birth_____

Mobile Number_____

I hereby give my consent for the office/staff of Dr. Stacy Haynes, M.D., P.C., to send text messages to my mobile number.

Please check which options are authorized:

_____ Appointment Reminders _____ Promotions, Coupons and Specials

If you elect to receive appointment reminders by text and you are not be able to keep an appointment, telephone the office to cancel or reschedule. Responding to the text reminder will not cancel/reschedule the appointment and may result in a No Show Fee.

Signed: _____ **Date:** _____

**Please do not sign if you would like to opt out of all, and not receive any text messages.*

You may receive free promotions, free coupons and specials (i.e. Botox, Laser, Skin Treatments, etc.) through-out the year!! Be the first to know about new procedures and products.

If you change your mobile number, please inform us so that we can update our records.

Dr. Stacy Haynes, M.D.

Due to new requirements from the United States of Health and Human Services, we are requesting that all patients complete our Supplemental Patient Intake Form. We realize that some of the questions may be redundant. We appreciate your patience and apologize for any inconvenience.

Name: _____ DOB: _____ Sex: M _____ F _____

Address: _____ City: _____ St: _____ Zip: _____

Phone: _____ Work: _____ Cell: _____

We are in the process of implementing a Patient Portal to provide a communication option for our patients in compliance with Health and Human Service Requirements. **Please provide a valid email address below:**

**** (REQUIRED)** _____

Ethnicity: ☐ Non-Hispanic ☐ Hispanic ☐ Other _____

Language Preference: ☐ English ☐ Spanish ☐ Other _____

Race: ☐ Caucasian or European American ☐ African or African American ☐ Asian or Asian American
☐ Native American or Native Alaskan ☐ Native Hawaiian or Other Pacific Islander ☐ Other

Smoking Status: ☐ Never smoker ☐ Former smoker ☐ Current every day smoker
☐ Heavy tobacco smoker ☐ Unknown if ever smoker ☐ Current status unknown
☐ Current some day smoker ☐ Light tobacco smoker

Do you take any prescription or non-prescription medications? ☐ Yes ☐ No

If yes, please list each with starting date and dosage: _____

Allergies to Medications: ☐ No ☐ Yes, Please list: _____

Reaction: _____

Severity: ☐ Very Mild ☐ Mild ☐ Moderate ☐ Severe

Onset: ☐ Childhood ☐ Adult ☐ Unknown

Please check if you have a history of the following:

☐ Acne ☐ Herpes Zoster ☐ Psoriasis ☐ Depression
☐ Keloid Scar ☐ Rosacea ☐ Eczema ☐ Skin Cancer
☐ Sunburn ☐ Other _____

HAS YOUR INSURANCE CHANGED SINCE LAST VISIT? ☐ Yes ☐ No

Signature: _____ **Today's Date:** _____

Parent or guardian signature if patient is a minor)

PHARMACY NAME _____ **LOCATION** _____

PHARMACY PHONE NUMBER _____ **Please allow 8 hours for all prescription to be filled**