Patient's Full Name_____ Date of Birth_____ M_____ F_____

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

Home Address_____ City_____ State_____ Zip_____

Cell_____ Home Telephone _____ Work or Other_____

I wish to be contacted in the following manner:

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

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

_____ Other_____

EMERGENCY CONTACT:_____ PHONE:_____ RELATIONSHIP:_____

EMAIL_____

In order to be in compliance with Health and Human Service Requirements, we must ask the following questions:

LANGUAGE PREFERENCE: ☐ English ☐ Spanish ☐ Other_____

RACE: ☐ White/Caucasian/European American ☐ Black/African/African American ☐ ☐ Asian/Asian American

☐ Native American or Native Alaskan ☐ Native Hawaiian or Other Pacific Islander ☐ Other_____

ETHNICITY: ☐ Non-Hispanic ☐ Hispanic ☐ Other_____

EMPLOYMENT: ☐ Employed ☐ Retired ☐ Student Full-time / Part-time ☐ Other _____

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 #_____ Date of Birth_____

Father's Name_____ Phone #_____ Date of Birth_____

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

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_____

PATIENT OR GUARDIAN SIGNATURE:_____ DATE_____

PATIENT NAME: _____ **DATE OF BIRTH**_____

REASON FOR VISIT_____

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

□ Anxiety	□ Breast Cancer	□ End Stage Renal Disease	□ Hypercholesterolemia	□ Prostate Cancer
□ Arthritis	□ Cancer _____	□ GERD	□ Hyperthyroidism	□ Radiation or Chemotherapy
□ Asthma	□ Colon Cancer	□ Hearing Loss	□ Hypothyroidism	□ Seizures
□ Anemia	□ COPD	□ Heart Murmur	□ Leukemia	□ Stroke
□ Atrial Fibrillation	□ Coronary Artery Disease	□ Hepatitis	□ Lung Cancer	□ Thyroid disease
□ Bone Marrow Transplantation	□ Depression	□ HIV / AIDS	□ Lymphoma	□ Tuberculosis
□ BPH	□ Diabetes	□ Hypertension (HBP)	□ Menopausal Symptom	□ Other:_____

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

□ Abnormal Moles	□ Blistering	□ Flaking or Itchy Scalp	□ Precancerous Moles	□ Sun Burns
□ Acne	□ Cold Sores/Fever Blisters	□ Hay Fever/Allergies	□ Psoriasis	□ Squamous Cell Skin Cancer
□ Actinic Keratoses	□ Dry Skin	□ Hives	□ Rash	□ Other: _____
□ Asthma	□ Eczema	□ **Melanoma**	□ Recent/Progressive Hair Loss	_____
□ Basal Cell Skin Cancer	□ Excessive Scarring	□ Poison Ivy	□ Skin Cancer	_____

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

_____

_____

DRUG ALLERGIES:_____

SURGERIES: _____

In order to be in compliance with Health and Human Service Requirements, we must ask the following questions:

HEIGHT:_____ **WEIGHT:**_____ **IV DRUG USE:** _____ **Within last 12 months**_____

SMOKING STATUS: ☐ Never smoker ☐ Former smoker ☐ Current/Every day ☐ Occasional

FEMALES: Are you pregnant or trying to become pregnant? ☐ Yes ☐ No Are you currently breast feeding? ☐ Yes ☐ No

Have you ever had an alcohol related accident and/or injury? ☐ Yes ☐ No

Have you **EVER** (in your lifetime) received a pneumonia vaccination? ☐ Yes ☐ No Yearly Flu Shot? ☐ Yes ☐ No

Do you have a health care proxy in the event you are unable to make your own medical decisions? ☐ Yes ☐ No

Do you have a living will? ☐ Yes ☐ No *(optional) Designee's Name:*_____ *Phone Number:*_____

Which statement best reflects your wishes on advanced care recommendations?

☐ *Do not intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.*

☐ *Do not resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.*

☐ *Full cardiopulmonary resuscitation: I want full cardiopulmonary resuscitation efforts to be made.*

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	DAIBETES	CANCER	ASHTMA	KIDNEY DISEASE	GLAUCOMA	STROKE	MENTAL ILLNESS	ANEMIA	PSORIASIS	ECZEMA	MELANOMA
FATHER																
MOTHER																
BRO																
SIS																

PHARMACY NAME_____ **LOCATION**_____

PHARMACY PHONE NUMBER_____

****All prescriptions will be E-SCRIBED directly to your pharmacy as indicated above. Please allow 24 hours for your prescriptions to be processed/filled. For faster response, please utilize your **PATIENT PORTAL** for refill requests and/or any questions.*

PLEASE COMPLETE FORM IN FULL

CONSENT FOR TREATMENT/RELEASE OF MEDICAL INFORMATION/FINANCIAL/COLLECTION POLICY

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 agree to assume the financial responsibility for services not reimbursed under my insurance plan**. Initial**_____

I, the undersigned agree to pay said fee, including collection agency fees (33.33%), 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**. Initial**_____

If you choose to pay by check, you authorize us to use information from your check to make a one-time electronic fund transfer from your account. Funds may be drawn from your account the same day as your payment, and you will not receive your check back from your bank. If payment is returned unpaid, you authorize EZCheck to debit from your account by a one- time electronic fund transfer a fee of $30.00**. Initial_____**

I **EXPRESS PRIOR CONSENT TO CONTACT CONSUMER BY CELL PHONE** I the undersigned, give Dr. Stacy Haynes, its employees and/or agents "express prior consent" to contact me at any/all phone numbers associated with your account, including wireless phone numbers, which could result in charges to you, for the purpose of treatment, insurance, collections and/or payment. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing device, if applicable. I/We have read this disclosure and agree that Dr. Stacy Haynes, P.C./Anniston Dermatology/Haynes Medi-Spa employees or any agent(s) may contact me/us as described above**. Initial** _____

My protected health information may be released to the following individuals
I, the undersigned, understand that I have the right to change the above information at any time by completing another form. **Patients age 18 and older must sign for information to be released. Initial_____**

Name_____ Relationship to Patient_____

Name_____ Relationship to Patient_____

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. Please check if you would like a copy of the Privacy Notice □ **Initial_____**

FEES FOR NO-SHOWS, RESCHEDULING OF SURGERY AND MEDICAL
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_____**

CONSENT TO OBTAIN ELECTRONIC MEDICATION HISTORY
I understand that my medication history may be obtained utilizing an electronic information exchange and that this protected health information may provide valuable information for my healthcare provider. I hereby authorize Dr. Stacy Haynes and staff access to my pharmacy benefits data electronically. This consent will enable Dr. Stacy Haynes and staff to determine pharmacy benefits, check whether a prescribed medication is covered (in formulary) under a patient's plan, determine if a patient's health plan allows electronic prescribing to Mail Order pharmacies and if so, e-scribe to these pharmacies, e-scribe prescriptions to patient's pharmacy and download a historic list of all medications prescribed for a patient by any provider. Prescriptions are electronically scribed the same day as the office visit and/or within 24 hours of the office visit. **Initial _____**

PRESCRIPTION REFILLS – For faster response, **PLEASE SEND REQUESTS VIA YOUR PATIENT PORTAL.**
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, refill requests require a minimum of 48 hours to be phoned or e-scribed to pharmacy. When requesting a refill, you MUST have the name of the medication and your pharmacy telephone number before any refills are completed. **Initial _____**

PATIENT TEXT MESSAGE CONSENT FOR APPOINTMENT REMINDERS, AND/OR PROMOTIONS.
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_____. I understand I can opt-out at any time. **I Give Consent to Receive Text Messages** □

PATIENT NAME: _____ DATE OF BIRTH_____

PATIENT OR GUARDIAN SIGNATURE: _____ DATE_____

ATTENTION

Each patient is responsible for understanding his/her insurance policy. If your insurance policy requires you to have a referral from your Primary Care Physician (PCP) to see a Specialty Physician, it is your responsibility to obtain that referral from your PCP. Dr. Stacy Haynes is a **Dermatology Specialist.**

Every insurance policy is different and we **do not know** if your insurance requires a referral. If you are seen in our office and your insurance requires a referral and you did not obtain one from your PCP, you may be responsible for your office visit or procedure in full or you may be required to pay a higher copay.

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	Biopsies	Injections
Lab Work	Lesion Removal	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. It is your responsibility to contact your insurance company prior to the procedure to see if procedure(s) are covered.

If you have any questions regarding your insurance policy, contact the number on the back of your card.

Patient or Guardian Signature_____ Date_____