KLINGER & MARSHALL
DERMATOLOGY
MEDICAL • SURGICAL • COSMETIC

PATIENT INFORMATION

PATIENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ E-MAIL ADDRESS* _____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
SOCIALSECURITY# _____ RACE: CAUCASIAN/AFRICAN AMERICAN/ASIAN/OTHER
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART
REFERRED BY _____

SPOUSE/PARENT INFORMATION

SPOUSE/PARENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ SOCIAL SECURITY # _____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART

RESPONSIBLE PARTY

_____ SELF _____ SPOUSE _____ PARENT _____ GUARDIAN _____ OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP _____
CONTRACT# _____
GROUP # _____
INSURED'S NAME _____
INSURED'S EMPLOYER _____
INSURED'S SS # _____
INSURED'S D.O.B. _____

SECONDARY INSURANCE

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP _____
CONTRACT# _____
GROUP # _____
INSURED'S NAME _____
INSURED'S EMPLOYER _____
INSURED'S SS # _____
INSURED'S D.O.B. _____

PRIMARY CARE PHYSICIAN (if applicable)

NAME _____ PHONE _____
FULL ADDRESS _____

IN CASE OF EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____

**By providing your email address, you are giving us permission to send email correspondences to you pertaining to our office's news, updates, specials and events. If at any time you would like to unsubscribe from receiving future emails, we include unsubscribe instructions at the bottom of each email blast. We will never share your email address with others.*

AUTHORIZATION

I. **GENERAL CONSENT TO TREATMENT**: I AGREE AND CONSENT TO A PHYSICAL EXAMINATION BY KLINGER AND MARSHALL DERMATOLOGY, DR. STEPHEN KLINGER OR DR. DANA MARSHALL. I UNDERSTAND THAT ADDITIONAL DIAGNOSTIC PROCEDURES AND TREATMENT MAY BE RECOMMENDED BY THE PHYSICIAN AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARANTEES, EXPRESSED OR IMPLIED, AS TO THE RESULTS OF ANY PROCEDURES OR MEDICAL TREATMENT.

II. **RELEASE OF INFORMATION**: I AUTHORIZE PHYSICIANS PROVIDING SERVICES ON BEHALF OF THE PATIENT TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICABLE) TO PHYSICIANS OR INSTITUTIONS PROVIDING FOLLOW-UP CARE, THE SOCIAL SECURITY ADMINISTRATION, MEDICARE, MEDICAID (OR THEIR VARIOUS INTERMEDIARIES), AND THE INSURANCE COMPANY, EMPLOYER, PERSON ACTING ON BEHALF OF A PREFERRED PROVIDER ARRANGEMENT OR THIRD PARTY NAMED ON THIS PATIENT INFORMATION FORM (OR ANY OF THEIR AGENTS OR REPRESENTATIVES), WHEN SUCH INFORMATION IS REQUESTED FOR PAYMENT, WORKERS' COMPENSATION, UTILIZATION REVIEW, OR COVERAGE DETERMINATION PURPOSES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THIS PHYSICIAN'S OFFICE.

III. **ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE**:

A. I AUTHORIZE ANY THIRD PARTY PAYOR TO PAY DIRECTLY TO THE PHYSICIAN PROVIDING SERVICES TO THE PATIENT, ALL BENEFITS DUE PAYABLE AS A RESULT OF SERVICES RENDERED.
B. I AUTHORIZE ASSIGNMENT TO THE PHYSICIAN WHO HAS PROVIDED SERVICES TO THE PATIENT THE INSURED'S RIGHTS TO PENALTIES AND ATTORNEY'S FEES IN THE EVENT THAT THE INSURER FAILS TO TIMELY PAY SUCH BENEFITS IN ACCORDANCE WITH LOUISIANA LAW (LA. R.S. 22:657).

IV. **ACKNOWLEDGEMENT OF RESPONSIBILITY TO PAY FOR SERVICES**: I ACKNOWLEDGE AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY ANY CHARGES WHICH, FOR ANY REASON, ARE NOT PAID BY ANY THIRD PARTY PAYOR UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN THE PHYSICIAN AND THE PAYOR. I ACKNOWLEDGE THAT THIS FEE IS INCURRED ON OPEN ACCOUNT FOR PROFESSIONAL MEDICAL SERVICES, IN ACCORDANCE WITH R.S. 9:2781. I ACKNOWLEDGE THAT IF I FAIL TO PAY THE BALANCE DUE ON THIS OPEN ACCOUNT WITHIN THIRTY (30) DAYS AFTER WRITTEN DEMAND, AND IN THE EVENT JUDGMENT IS RENDERED AGAINST ME, IN ADDITIONAL TO THE PRINCIPAL BALANCE DUE, I SHALL BE LIABLE FOR REASONABLE ATTORNEY FEES, LEGAL INTEREST FROM DATE OF JUDICIAL DEMAND, UNTIL PAID, PLUS COSTS OF COURT.

IV. **INSURANCE PATIENTS**: I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO KLINGER AND MARSHALL DERMATOLOGY FOR ANY SERVICES FURNISHED TO ME BY KLINGER AND MARSHALL DERMATOLOGY, DR. STEPHEN KLINGER OR DR. DANA MARSHALL. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

V. **COSMETIC PATIENTS**: I UNDERSTAND THAT COSMETIC SERVICES ARE NOT COVERED BY HEALTH INSURANCE AND ALL PAYMENTS ARE DUE AT THE TIME OF SERVICE.

_____ _____

DATE PATIENT OR GUARDIAN SIGNATURE

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Reason for today's visit? _____

Please list your current medications (including over-the-counter medicines, nutritional supplements, and herbal remedies):_____

_____

_____

_____

Please list any drug allergies (including local anesthetic and adhesives):_____

_____

_____

Please list any previous surgical history: _____

_____

_____

If we perform a test, our office will need to contact you with results. Please give us the phone numbers you would like us to use. Home:_____ Cell:_____ Work:_____

YOUR PAST MEDICAL HISTORY			
Have you ever had any of the following medical problems? *Please circle any that apply.*	**YES**	**NO**	*Please give us any details.*
Melanoma/ Skin Cancer / Unusual (dysplastic) Moles			
Other cancer (If so, what type?)			
Psoriasis / Eczema / Other skin rash			
Asthma / Hay Fever / Hives			
A skin rash in reaction to food or medication			
Heart disease / Angina / Chest pain			
Mitral valve prolapse / Heart murmur			
Pacemaker / Defibrillator			
Do you take antibiotics before dental procedures?			
High blood pressure / high cholesterol			
Diabetes / Kidney disease / Organ transplant			
Thyroid disease / Anemia / Blood transfusions			
Pneumonia / Tuberculosis / Other respiratory condition			
HIV / AIDS / Hepatitis / Liver disease			
Poor wound healing / Skin ulcers / Keloid scarring			
Prolonged bleeding during surgery / Blood clots			
YOUR SOCIAL HISTORY			
Do you smoke or have you ever smoked?			If so, how long?
Do you drink?			If so, how often?
FEMALE PATIENTS: Are you pregnant or trying to become pregnant?			If so, how far along?

YOUR FAMILY HISTORY			
Has any close relative had any of the following?	**YES**	**NO**	*Please give us any details.*
Melanoma / Skin cancer			
Psoriasis / Other skin disease			
Lupus / Connective tissue disease			
Severe acne			

REVIEW OF SYSTEMS			
Are you currently experiencing any of these symptoms? *Please circle any that apply.*	**YES**	**NO**	*Please give us any details.*
CONSTITUTIONAL			
Fever / Chills / Night sweats / Unplanned weight loss / Feeling ill			
ALLERGY / IMMUNOLOGY			
Seasonal allergies / Allergies to food			
ENM&T			
Hearing problems / Nose bleeds / Dry mouth / Trouble swallowing			
EYES / HEAD			
Vision problems / Dry eyes / Headaches / Dizziness			
RESPIRATORY			
Shortness of breath / Cough / Wheezing			
CARDIOVASCULAR			
Chest pain / Swelling of legs / Fainting or passing out			
GASTROINTESTINAL			
Abdominal pain / Nausea / Vomiting / Diarrhea			
MUSCULOSKELETAL			
Joint pain / Swelling / Stiffness / Muscle weakness			
HEMATOLOGICAL / LYMPHATIC			
Swollen glands / Easy bleeding / Easy bruising			
NEUROLOGICAL			
Seizures / Epilepsy / Stroke / Numbness / Tingling			
GENITOURINARY			
Pain or burning on urination / Vaginal or penile discharge			
ENDOCRINE			
Feeling unusually hot or cold / Extreme thirst or hunger			
PSYCHIATRIC			
Depression / Anxiety / Psychiatric condition			

To the best of my knowledge, I have answered the questions on this form accurately. I understand that it is important that my doctor have correct information to make the best decisions for my health. In any future visits, I will inform the doctor of any changes in my medical status.

Your signature: _____ Date: _____

I have reviewed the above information with the patient.

Physician signature: _____

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No Show / Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of health care to other patients, some of whom are quite ill.

A "no-show" is missing a scheduled appointment. A "late cancellation" is canceling an appointment without calling us to cancel 24 hours in advance of an office or procedure visit.

We understand that situations such as medical emergencies occasionally arise when an appointment cannot be kept and adequate notice is not possible. These situations will be considered on a case by case basis.

A charge of $35.00 will be assessed for each "no show" or "late cancellation" office visit appointment if less than 24 hours notice is given.

A charge of $50.00 will be assessed for each "no show" or "late cancellation" procedure appointment if less than 24 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

_____ _____

Date Signature

2600 Belle Chasse Highway · Suite 202 · Gretna, LA 70056 · 504-393-7393

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RECEIPT AND ACKNOWLEDGEMENT

NOTICE OF PRIVACY PRACTICES

I hereby acknowledge receipt of the Notice of Privacy Practices provided by Klinger & Marshall Dermatology.

I have read and thoroughly understand the Notice of Privacy Practices and agree to them as described.

I further understand that the Notice of Privacy Practices represent guidelines by which the practice will operate. I realize that I may obtain or review my medical records at any time.

Klinger & Marshall Dermatology reserves the right to deny any amendment to a medical chart which is determined to be inappropriate.

_____

Patient's Name (Please Print)

_____ _____

Patient's or Guardian's Signature Date

I give consent to Drs. Klinger and Marshall and office staff to speak to the following person(s) regarding my medical care (ex: spouse, parents, legal guardian, etc.):

Name Relationship

_____ _____

_____ _____

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Cosmetic Interest Questionnaire

Name: _____ Date of Birth: _____

Please check all that apply

☐ Skin Care Advice	☐ Facial Veins
☐ Skin Care Products	☐ Facial Redness
☐ Facial Fine Lines/Wrinkles	☐ Brown Spots/Age spots/Freckles
☐ Facial Injectables/Fillers	☐ Mole Removal
☐ Thin Lips	☐ Neck Wrinkles
☐ Length/Fullness of Eyelashes/Eyebrows	☐ Unwanted Hair
☐ Blotchy Skin (Uneven Skin Tone)	☐ Dullness
☐ Chemical Peels	☐ Texture of Skin/Pore Size
☐ Scar Revision	☐ Leg Veins
☐ Double Chin	☐ Aging Hands

☐ I am not interested in any additional services at this time.

Are you interested in a Cosmetic Night Out? Yes No

How did you hear about us:

Newspaper Billboard Radio Phone Book

Sign Out Front Friend Family Employee Facebook Ad

Our Practice Website Physician Referral

Other: Please Specify _____

Current at home maintenance program _____

_____

_____