PLEASE PRINT

Patient Name: _____ Date of Birth: _____

Quality Measure Questionnaire

The foundation of the Quality Measure Questionnaire is to deliver high-quality patient care. The questionnaire has been developed to gather information on all patients. Using a variety of tools, our providers will report the data according to government regulations and receive valuable feedback about our practices.

1. Have you ever had a melanoma diagnosed and treated? Y N
    a. When was it diagnosed and by whom:_____
    b. How was it treated:_____
    c. Do you have an upcoming Skin check (if so, when)? _____
2. Anyone over the age of 12:
    a. Do you smoke, or have you ever smoked: Current Smoker Never Smoked Former Smoker
    b. If you are a current smoker, have you ever been counseled on the benefits of quitting? ..Y N
3. Anyone over age 65:
    a. Do you have a healthcare proxy in the event you become unable to make your own medical decisions? Y N
    b. Name and contact for appointed Proxy
        i. Name_____
        ii. Contact (phone/Email)_____
    c. Do you have a living will? Y N
4. For Psoriasis patients only:
    a. Are you on a biologic medication for your condition? Y N
    b. Which biologic (name of medication)?_____
    c. How would you rate your itch on a scale of 1 through 10?_____
    d. Have you had a Tuberculin (TB) test in the past 12 months? Y N
    e. When and where was testing done? _____
5. For patients presenting with rash/eczema only:
    a. How would you rate your itch on a scale of 1 through 10?_____

Medical Assistants ONLY: 402:Was handout/counseling provided? Y N

Medical History Form

Please fill out this form and bring it with you to the SkinPros office.

SKINPROS
Your Skin. Our Expertise.

Today's date: / / MD: _____

PATIENT INFORMATION

Patient's last name: _____ First: _____ Middle: _____ Birth date: / /

REASON FOR TODAY'S VISIT

Concern:	Location:	Duration:	Prior Treatments:
Concern:	Location:	Duration:	Prior Treatments:

VACCINATIONS

Have you had your influenza vaccine this year? □ Yes □ No Have you had your pneumonia vaccine this year? □ Yes □ No

PAST MEDICAL HISTORY

Adhesive tape allergy	□ Yes □ No	Abnormal scars	□ Yes □ No
Latex allergy	□ Yes □ No	Poor wound healing	□ Yes □ No
Local anesthetics allergy	□ Yes □ No	HSV / cold sore	□ Yes □ No
Epinephrine sensitivity	□ Yes □ No	Eczema	□ Yes □ No
Bacitracin allergy	□ Yes □ No	Asthma	□ Yes □ No
Neosporin allergy	□ Yes □ No	Hay fever	□ Yes □ No
Anticoagulant treatment	□ Yes □ No	Heart disease	□ Yes □ No
Bleeding disorders	□ Yes □ No	Diabetes	□ Yes □ No
Artificial joint	□ Yes □ No	Kidney disease	□ Yes □ No
Artificial heart valves	□ Yes □ No	Thyroid disease	□ Yes □ No
Pacemaker / defibrillator	□ Yes □ No	Lupus	□ Yes □ No
Mitral valve prolapsed	□ Yes □ No	Arthritis	□ Yes □ No
Immunosuppressed	□ Yes □ No	Psoriasis	□ Yes □ No
Organ transplant	□ Yes □ No	Fainting / syncope	□ Yes □ No
CLL Chronic leukemia	□ Yes □ No	Hepatitis	□ Yes □ No
Pre-op/pre-dental antibiotics	□ Yes □ No	HIV positive	□ Yes □ No
Memory problems	□ Yes □ No	MRSA	□ Yes □ No

MELANOMA HISTORY

Do you have a history of melanoma? □ Yes □ No

Do you have a history of other skin cancer(s)? □ Yes □ No

CURRENT MEDICATIONS

Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:
Medication:	Dose:	Medication:	Dose:

MEDICATION ALLERGIES

Do you have any medication allergies: ☐ Yes ☐ No

List allergies: _____

FOR WOMEN ONLY

Are you pregnant? ☐ Yes ☐ No

Are you breastfeeding? ☐ Yes ☐ No

Are you on birth control? ☐ Yes ☐ No

Do you have regular menstrual cycles? ☐ Yes ☐ No

FAMILY HISTORY OF MELANOMA

Do you have a family history of melanoma? ☐ Yes ☐ No

Do you have a family history of other skin cancer(s)? ☐ Yes ☐ No

Types: _____

SOCIAL HISTORY

Occupation: _____

Do you use tobacco? ☐ Yes ☐ No

Alcohol consumption? ☐ Socially ☐ Moderate ☐ Heavy

Do you use sunscreen? ☐ None ☐ Daily ☐ Occasionally

Tanning bed use? ☐ None ☐ Current ☐ Previous

Do you have any other medical problems or conditions? _____

ADDITIONAL SYMPTOMS

Fever	☐ Yes ☐ No	Shortness of breath	☐ Yes ☐ No	Swollen lymph nodes	☐ Yes ☐ No
Chills	☐ Yes ☐ No	Nausea / vomiting	☐ Yes ☐ No	Joint pain	☐ Yes ☐ No
Fatigue	☐ Yes ☐ No	Abdominal pain	☐ Yes ☐ No	Rash / itch	☐ Yes ☐ No
Unintentional weight loss	☐ Yes ☐ No	Diarrhea	☐ Yes ☐ No	Headache	☐ Yes ☐ No
Eye Irritation	☐ Yes ☐ No	Constipation	☐ Yes ☐ No	Anxiety	☐ Yes ☐ No
Chronic cough	☐ Yes ☐ No	Easy bruising	☐ Yes ☐ No	Depression	☐ Yes ☐ No
		Blood clots	☐ Yes ☐ No		

Patient Registration Form

Please fill out this form and bring it with you to the SkinPros office.

SKINPROS
Your Skin. Our Expertise.

Name _____ Today's Date _____
LAST FIRST M.I.

Mailing Address _____ City _____ State _____ Zip _____
NUMBER, STREET, APARTMENT NUMBER

Age _____ Primary Language _____ Race _____ ☐ DECLINE TO ANSWER

Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Date of Birth / / SS # _____ Marital Status _____ Gender _____

Email _____ Ethnicity: ☐ HISPANIC OR LATINO ☐ NOT HISPANIC OR LATINO ☐ DECLINE TO ANSWER

Would you like to participate in our patient portal to access your records and communicate with the provider? ☐ Y ☐ N

Employer _____ ☐ RETIRED ☐ FULL-TIME STUDENT ☐ PART-TIME STUDENT

Spouse's Name _____ Spouse's Employer _____ Work Phone (___) _____

Person to notify in case of emergency _____ Phone _____
(PLEASE LIST A PERSON *NOT* LIVING IN YOUR HOME)

Referring Doctor _____

Primary Doctor _____

Pharmacy Name/Address _____

May we leave a message on your home answering machine? ☐ Y ☐ N
May we leave a message for you at work to call us? ☐ Y ☐ N
May we discuss your medical condition with another person? ☐ Y ☐ N

If yes, whom? _____ Relationship _____

How did you hear about our practice? _____

Insurance Provider Name _____ Policy # _____ Group # _____

Policy Holder (if different from patient or responsible party) _____

Policy Holder's Date of Birth / / SS # _____

Employer of Policy Holder _____ Work Phone (___) _____

Patient's Relationship to Policy Holder _____

If patient is a minor, please enter responsible party information.
NOTE: We do not bill absent parents. The adult presenting the minor for care is the responsible party.

Name _____ Today's date _____
LAST FIRST M.I.

Mailing Address _____ City _____ State _____ Zip _____
NUMBER, STREET, APARTMENT NUMBER

Age _____ Home Phone (___) _____ Work Phone (___) _____ Cell Phone (___) _____

Assignments of Benefits

ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to *SkinPros*. I authorize *SkinPros* to provide to my insurance company, any information necessary to process claims for services rendered to me.

_____ _____

Signature as it appears on your insurance card Date

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____

Signature as it appears on your insurance card Date

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Signature as it appears on your insurance card Date

☐ Y ☐ N Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?

☐ Y ☐ N Are you covered by any other insurance that Makes Medicare secondary?

Notice of Privacy Rights Receipt Acknowledgment

SKINPROS
Your Skin. Our Expertise.

Please fill out this form and bring it with you to the SkinPros office.

Thank you for choosing Skin Pros for your healthcare needs. We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure our records are accurate, please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice.

_____ _____

Signature of Patient (or Legal Representative) Date

_____ _____ _____

Signature of Staff Member Title Date

Comments

_____

_____

_____

_____

_____

_____

Patient Financial Policy

Please fill out this form and bring it with you to the SkinPros office.

SKINPROS
Your Skin. Our Expertise.

This office has contracts with Medicare and with many managed care plans. Please check with our reception staff to determine whether your plan is one of these.

If we have a contract with your plan, we will file a claim with your insurance company. The amount for which you are responsible (any deductibles, copays, percentages or non-covered services) is required at the time of service.

If you do not have one of the plans with which the practice is contracted, the total cost of your visit is required at the time of service.

If at any time you are concerned about the cost of a procedure proposed by the doctor, you may ask for someone from the business office who will be happy to discuss the cost with you.

For your convenience in paying, this office accepts Master Card and Visa in addition to cash and checks.
Because we make every effort to see patients on time, we do not overbook to accommodate patients who do not keep their appointments. Therefore the practice charges $75.00 for missed appointments not cancelled with at least one business day's notice.

I certify that I have read the financial policy of SKINPros,LLC, and agree to abide by the policy.

_____ _____

Signature Date

SKIN PROS

NOTICE OF PATIENT RESPONSIBILITY FOR NO REFERRAL

In benefit plans that require the issuance of referrals for specialist care, the primary care physician is responsible for coordinating his/her patients' health care. If it is necessary for the patient to see a specialist, other than for direct access services of emergency care, the primary care physician must issue a referral prior to the patient's visit to the specialist. The referral must be for covered benefits under the plan.

If you visit a specialist without a referral, depending on your plan type, you may be responsible for payment for all services rendered or for paying a deductible and coinsurance. You should not return to your primary care physician to request a referral after the service is rendered; primary care physicians cannot issue retroactive referrals.

The referral is not a guarantee of payment. Payment is subject to eligibility on date of service, plan benefits, limitations and exclusions, pre-existing condition limitations, and patient liability under the plan.

I have read the above and understand that I may be liable for any service rendered that is not covered due to not having a referral. This includes any service in which my plan is primary and/or secondary to an auto accident. I understand that I may be billed for my deductible and/or coinsurance applied by that insurance and my current insurance will not cover without a referral.

PATIENT NAME (PRINT) DATE

PATIENT SIGNATURE DATE

1287 North Main Street Providence, Rhode Island 02904

Phone: 401.272.2724 Fax: 401.272.2784 www.skinpros.com