

Please PRINT

Karen S. Harkaway, M.D. L.L.C.

PATIENT INFORMATION

Patient's Full Name: _____ Sex: M / F Marital Status: S M D W
Patient's Address: _____ Apt# _____
City: _____ State: _____ Zip: _____
Home Phone: () _____ Cell Phone: () _____ Work Phone: () _____ Ext _____
Date of Birth: ____ / ____ / ____ Age as of Today: _____ Social Security #: _____
Patient's Employer Name & Address: _____
Occupation: _____
If Minor, Mother/ Father Name: _____ Social Security #: _____
Address (if different): _____
Parent's Phone: () _____ Cell: () _____ Work: () _____ Ext _____
Name, Address and Phone of Primary Care Physician: _____

Would you like a report sent to them: **YES / NO**

(If your insurance requires referrals, a report will be sent automatically to your referring physician.)

Emergency Contact: Name (relationship) and Phone: _____

MEDICAL INSURANCE INFORMATION

PRIMARY INSURANCE- Please Provide Card

Insurance Company Name: _____
Group #: _____ Policy #: _____ Co-Pay: _____
Policy Holder's Full Name: _____ Date of Birth: _____
Relationship to Patient: _____ Policy Holder's Social Security #: _____
Policy Holder's Employer: _____
Referral Required: **YES / NO** **If yes, be sure to obtain a referral prior to each visit.**

SECONDARY INSURANCE- Please Provide Card

Insurance Company Name: _____
Group #: _____ Policy #: _____ Co-Pay: _____
Policy Holder's Full Name: _____ Date of Birth: _____
Relationship to Patient: _____ Policy Holder's Social Security #: _____
Policy Holder's Employer: _____
Referral Required: **YES / NO** **If yes, be sure to obtain a referral prior to each visit.**

I herby authorize direct payment to my physician when applicable and the release of medical information to a referring physician or Insurance Company. I understand that I am responsible for any amount not covered by Insurance and will pay within 30 days of notification. I understand that it is my responsibility to obtain the proper referral before each visit and agree to pay for my visit if I fail to do so, for plans that require referrals. I have been given the office financial policy and agree to abide by it.

Signature: _____ **Date:** _____

I herby give my permission to share confidential health care information with a family member/ person I designate.

Name: _____ **Relationship:** _____

I do not wish to designate anyone at this time.



KAREN S. HARKAWAY M.D.
DERMATOLOGY AND DERMATOLOGIC SURGERY

Health History Form

Name _____ Today's date _____

Date of Birth _____ Age as of Today _____

Reason for your visit: _____

Have you been treated for the same reason before? _____ If yes, please briefly explain prior treatment _____

Would you like to have skin care products recommended specifically for you? Yes/ No

Past Medical History: Please check off both past and present issues

- | | | |
|--|--|--|
| <input type="checkbox"/> AIDS/ HIV | <input type="checkbox"/> epilepsy | <input type="checkbox"/> migraines |
| <input type="checkbox"/> anemia | <input type="checkbox"/> gastrophageal reflux disease | <input type="checkbox"/> moles removed |
| <input type="checkbox"/> arthritis | <input type="checkbox"/> glaucoma | <input type="checkbox"/> psychiatric issues |
| <input type="checkbox"/> asthma/ allergies | <input type="checkbox"/> gout | <input type="checkbox"/> rheumatic fever |
| <input type="checkbox"/> bleeding/ clot disorder | <input type="checkbox"/> G6PD deficiency | <input type="checkbox"/> sjingles/ herpes zoster |
| <input type="checkbox"/> cancer | <input type="checkbox"/> heart attack or stroke | <input type="checkbox"/> sickle cell disease |
| <input type="checkbox"/> chemical dependency | <input type="checkbox"/> heart murmur/ valve replacement | <input type="checkbox"/> thyroid trouble |
| <input type="checkbox"/> chicken pox | <input type="checkbox"/> hepatitis A B C D E | <input type="checkbox"/> other: _____ |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> high cholesterol | _____ |
| <input type="checkbox"/> crohn's/ u;cerative colitis | <input type="checkbox"/> chormone disorders | _____ |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> hypertension | _____ |
| <input type="checkbox"/> diverticular disease | <input type="checkbox"/> IBS | _____ |
| <input type="checkbox"/> eczema | <input type="checkbox"/> kidney disease | _____ |

Family History:

- | | | |
|--|---|---|
| <input type="checkbox"/> arthritis | <input type="checkbox"/> psoriasis | <input type="checkbox"/> skin caner, specify type |
| <input type="checkbox"/> asthma/ allergies | <input type="checkbox"/> systemic lupus erythematosis | _____ |
| <input type="checkbox"/> diabetes | <input type="checkbox"/> hematologic disorder | _____ |

Past Surgeries:

Allergies to Medication:

List Medications:(including vitamins, herbals, inhalers, steroids, hormones, birth controls and over-the-counter medications.)

I certify that the above information is correct to the best of my knowledge.

Patient or Parent/ Guardian _____ Date: _____



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Patient Consent Form

Patient Name: _____ DOB: _____

Privacy Policy

By signing this form, you grant consent to Karen S. Harkaway, MD LLC the right to use and disclose your protected health information for the purposes of treatment, payment and health care operations subject to our Privacy Policy and as they may change from time to time. The following is a summary of our Privacy Policy. A complete copy is available as outlined below.

Karen S. Harkaway, MD LLC has developed a Privacy Policy to address the following:

1. We will use and disclose your health care information for the purposes of treatment, payment, and to support other related, defined health care operations.
2. We will keep your health care information confidential, releasing it only according to our policies. In general, we will release your information to others only if we are referring you for care, or if you direct us to do so. However, there are exceptions to that general limitation. (An example would be a release of information that is required by State or Federal law.)
3. You have the right to request to inspect and copy the health care information we keep regarding you, or regarding someone for whom you are the guardian.
4. You have the right to request that we amend the health care information we keep regarding you, or regarding someone for whom you are the guardian.
5. You have the right to request a list of non-routine disclosures to other parties we have made of your health care information, or that of someone for whom you are a guardian.
6. You have the right to request that we limit the disclosures we make of your health care information. We are not required to accept that limit but, if we do so, we will be bound by that agreement.
7. You have the right to request specific confidential communications within our office. Again, we are not required to agree to that limitation but, if we do so, we will be bound by that agreement.

Our Privacy Policy is subject to change from time to time. If we change our policy, you may obtain a copy of the revised notice by contacting us in our office or by calling (856) 461-1400.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent previously granted.

Consent to treatment

I understand that medical treatment will be performed by the physician, physician assistants, or by employees of Karen S. Harkaway, MD LLC.

I consent to such treatment and procedures, and certify that no guarantee has been made as to the results that may be obtained.

Signature Patient/Guardian

Date



KAREN S. HARKAWAY M.D.
DERMATOLOGY AND DERMATOLOGIC SURGERY

Financial Policy

Thank you for choosing us as your dermatologist. Our main concern is that your treatment is successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we require you read and sign prior to any treatment.

- **FULL PAYMENT IS DUE AT TIME OF SERVICE**, including copays. Please check with your plan **PRIOR** to being seen if we are within their network. It is YOUR responsibility to know if we participate with your plan and you will be responsible for any charges incurred if we do not participate with your plan.
- **WE ACCEPT CASH, CHECKS, MAC, or VISA/MASTERCARD.**
- **COPAYS** must be paid at time of service! We cannot bill for copays! A \$30.00 fee will be charged for all returned checks.
- Many insurance plans require patients to obtain a referral from their Primary Care Physician before seeing a specialist or having a study performed.
Please make sure you will provide us with a valid **REFERRAL FROM YOUR PRIMARY CARE PHYSICIAN FOR EVERY VISIT**. We require that all patients be responsible for their own referrals. If you are not sure if you need one, please contact your Insurance carrier **PRIOR** to your appointment. No patients will be seen without the proper referral. Patients arriving to the office without a valid referral will be considered self pay patients. Full payment is expected at the time of visit.
- As a courtesy to you, we will bill your insurance carrier if you provide us with the proper information and mailing address; however, you must recognize that you are ultimately responsible for payment of the bill and/or insurance follow-up.
If you have a specific question about services covered by your insurance plan, refer to the toll free number on the back of your card and contact your insurance company directly.
In the event the procedure billed is deemed non-covered, full contracted payment is not received or deductible has not been satisfied, full payment is expected within 30 days of notification to you.
- Feel free to discuss fees at any time. We want you to understand our charges and be satisfied that they are reasonable and equitable.
If unforeseen financial problems interfere with payment of your medical care, please speak with the billing manager to arrange suitable payment arrangements. Also, any questions regarding your account may be directed to the billing department during the hours of 9:00 am and 5:00 pm Monday through Friday @ 856-461-0909.
- Please note that cosmetic procedures are not reimbursable by medical insurance companies and full payment is expected at the time of visit. Cash, check Visa/MasterCard or debit card are accepted. Also, financing is available through Care Credit for procedures in excess of \$1000.00.
- Returned checks and balances older than 90 days are subject to additional collection fees and/or interest charges. If the account is turned over to a collection agency, that agency has a right to run a credit report when necessary. Any balances not taken care of will be turned over to the National Credit Bureau.
- Advise the front office staff when you come in if any change in your insurance, referring physician, address, phone number, marital status, etc. may have occurred since your last visit.
- **PLEASE CALL TO CANCEL ANY APPOINTMENT YOU CANNOT KEEP AT LEAST 24 HOURS IN ADVANCE.** Unless cancelled, at least 24 hours in advance, our policy is to charge for missed appointments at the rate of \$25.00 per visit. Please help us serve you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy. I understand and agree to this Financial Policy:

Signature Patient/Guardian

Date