

North Valley Dermatology, L.L.C.

PATIENT INFORMATION

Mary F. Fredenberg, M.D. / Theresa T. Magne, M.D.

Diplomates of the American Board of Dermatology / Fellows of the American Academy of Dermatology

Date: _____

Patient Name: _____
(Last) (First) (Middle)

SS#: _____ DOB: _____ Age: _____ Sex: M F

Mailing Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Home Ph. #: _____ Cell Ph. #: _____ Work Ph. #: _____

Marital Status: S M D Widow/Widower Email: _____

Primary Care Physician: _____ Phone: _____
(Last) (First)

Whom may we thank for referring you to our office? _____
(Last) (First)

Emergency Contact: _____ Relationship: _____ Phone: _____

Please Complete if Patient is a Minor

Responsible Party: _____ Relation to Patient: _____

Do we have permission to treat your minor child in your absence? Yes _____ No _____ Signature: _____

INSURANCE INFORMATION

Medicare Under 65? Due to Disability Working

Primary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN #: _____

Policy Holder Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Home #: _____ Work#: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN #: _____

Policy Holder Address: _____ Apt. # _____ City: _____ State: _____ Zip: _____

Home #: _____ Work#: _____

ASSIGNMENT AND RELEASE:

I hereby agree to accept my financial responsibility for all charges incurred in the course of my treatment. In the case of Medicare or other insurance providers that the physicians at North Valley Dermatology have executed and agreement with, **I understand that I am responsible for paying any deductibles or co-payments required under the terms of my insurance plan. Fees start at \$50 for cancelled appointments with less than 24 hours notice.** Should collection procedures become necessary, I agree to pay the collection agency's cost and/or reasonable attorney's fees. I hereby authorize the physicians at North Valley Dermatology to bill Medicare and/or my health insurance plan.

I hereby authorize the release of information acquired in the course of the examination and treatment, should it become necessary to secure payment of benefits.

A photocopy of this authorization is to be considered as valid as the original.

Signature of Patient or Responsible Party: _____ Date: _____

Power of Attorney: _____ Date: _____

Update: Int.: _____ Date: _____



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PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

With my consent, North Valley Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to North Valley Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures. I have received a copy, upon request or laminated in the lobby, of North Valley Dermatology's notice of Privacy Practices.

I have the right to review the Notice of Privacy Practices prior to signing this consent. North Valley Dermatology reserves the right to revise its Notice of Privacy Practice at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to North Valley Dermatology Privacy Officer at 14155 N. 83rd Avenue / Suite 110 / Peoria, AZ 85381.

With my consent, North Valley Dermatology may call my home or other designated location and leave a message or voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, North Valley Dermatology may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements among others.

With my consent North Valley Dermatology may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that North Valley Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to North Valley Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, North Valley Dermatology may decline to provide treatment to me.

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date



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MEDICAL HISTORY

Patient Name: _____

Date: _____

CONFIDENTIAL RECORD: Information contained here is privileged and confidential. This information will not be released except when you have authorized us to do so. The information provided by you will assist your doctor in her diagnosis and treatment.

Do you have or have you had:

Stroke	_____	Migraine Headaches	_____	Nervous Breakdown	_____
Cancer	_____	Hay Fever/Allergies	_____	Anxiety/Depression	_____
Arthritis	_____	Colitis	_____	Bleeding Tendency	_____
Leukemia	_____	Goiter	_____	High Blood Pressure	_____
Bronchitis	_____	Bladder Infection	_____	Rheumatic Heart	_____
Epilepsy	_____	Asthma	_____	Pneumonia	_____
Heart Attack	_____	Diabetes	_____	Stomach Ulcers	_____
Hepatitis	_____	Kidney Disease	_____	Tuberculosis	_____
Tonsillitis	_____	Thyroid Condition	_____	HIV/AIDS	_____

List any serious illnesses you have had: _____

Do you know of any blood relative who has or had any of the above conditions: If yes, please state condition and relationship.

History of Skin Diseases: Eczema _____ Dry Skin _____ Acne _____ Psoriasis _____
Skin Cancers _____ Melanoma _____ Family History of Melanoma _____

Date of last physical exam _____

Do you regularly take aspirin, Bufferin or Anacin? _____ How much? _____

Do you Drink? Yes No Smoke? Yes No Exercise? Yes No Use Sunscreen? Yes No

Circle any of the following medications you are now taking.

Cortisone/Prednisone	Blood Pressure Medication	Iron Supplements	Heart Medication
Cough Medicine	Sleeping Pills	Inhalers	Antibiotics
Headache Medication	Laxatives	Thyroid Medication	Diuretics (Water Pills)
Tranquilizers	Weight Reduction Medication	Medication for Arthritis	Seizure Medication
Birth Control Pills	Hormone Replacement Therapy	Blood Thinning Medication	Shots
Vitamins	Insulin or Diabetes Medication		

Other _____

Name any drugs to which you are allergic: _____



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Your insurance provider does not pay for everything, even some care that you or your Healthcare Provider have good reason to think you need. We expect your insurance provider may not pay for the service below.

SERVICE: Destruction of Skin tags; Seborrheic Keratoses, Warts (may be applied to deductible).

REASON THIS SERVICE MAY NOT BE PAID: Considered cosmetic

ESTIMATED COST: \$110; \$80; \$80

I want my insurance provider billed for an official decision on payment, I understand that if my insurance provider does not pay, I am responsible for payment.

Signature

Date

