Summit Healthcare
DERMATOLOGY

Patient Intake Form

Katrina R. Lynch
MPAS, PA-C

Date: _____

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

Local Address: _____ City _____ State ____ Zip _____

Permanent Address: _____ City _____ State ____ Zip _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Birthdate: _____ Age: _____ Sex: **M F** Marital Status: _____

Ethnicity: _____ Race: _____

Social Security: _____ *(If Using Insurance)* Drivers License: _____ *(If Using Insurance)*

Employer: _____ Occupation: _____

In case of emergency, contact: _____ Relationship: _____ Phone: _____

How did you hear about us? _____ Email: _____

If we are billing your insurance company please complete the following:

Primary Insurance Co: _____ Insurance Phone: _____ ID #: _____

Group #: _____ Employer:

Policy Holder's Name: _____ DOB: _____ SSN: _____

Secondary Insurance Co: _____ Insurance Phone: _____ Policy #: _____

Group #: _____ Employer: _____

Policy Holder's Name: _____ DOB: _____ SSN: _____

_____ _____ _____

Signature of patient/responsible party/legal guardian | Relationship to patient | Date

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Medical/Surgical History

Katrina R. Lynch
MPAS, PA-C

Patient: _____ Today's Date: _____ Height: _____ Weight: _____

Reason for today's visit? _____

Are you allergic to any medications? **YES** **NO** If **YES**, which ones: (RXN) _____

Have you had dental or local anesthesia? **YES** **NO** Any bad reactions? **YES** **NO** (RXN) _____

List all medications vyou are currently taking *(including prescription, over the counter, vitamins and herbals)*:

_____

_____

_____

Pharmacy Name: _____ Pharmacy Phone #: _____

CANCER HISTORY: Have you ever had skin cancer? **YES** **NO**

If Yes, MELANOMA *(body site(s))*: _____

BASAL CELL *(body site(s))*: _____

SQUAMOUS CELL *(body site(s))*: _____

Other Cancers *(Pancreas, Lung, Breast, Colon, Etc.)*: _____

SKIN:

Do you have a history of any specific skin diseases? **YES** **NO** Type? _____

Do you have a problem with healing? **YES** **NO**

Do you develop keloids (scars) after surgery? **YES** **NO**

Do you have skin allergies to: **LATEX** **TAPE** **OTHER** _____

Do you have now, or have you ever had diseases or conditions of:

☐ YES ☐ NO Hepatitis	☐ YES ☐ NO High Blood Pressure	☐ YES ☐ NO Nausea, Vomiting, Diarrhea with pain or antibiotic meds
☐ YES ☐ NO HIV (Aids)	☐ YES ☐ NO Heart Problems	
☐ YES ☐ NO Tuberculosis	☐ YES ☐ NO Phlebitis or Blood Clots	☐ YES ☐ NO Seizures
☐ YES ☐ NO MRSA(STAPH)	☐ YES ☐ NO Fainting	☐ YES ☐ NO Lupus/connective tissue diseases
☐ YES ☐ NO Bleeding Problems	☐ YES ☐ NO Diabetes	☐ YES ☐ NO Mental Disorders
☐ YES ☐ NO Pacemaker	☐ YES ☐ NO Thyroid	☐ YES ☐ NO Dementia
☐ YES ☐ NO Defibrillator	☐ YES ☐ NO Kidney/Bladder	☐ YES ☐ NO Bleeding Disorders
☐ YES ☐ NO Heart Attack	☐ YES ☐ NO Gastrointestinal	☐ YES ☐ NO Immunosuppression
☐ YES ☐ NO Stroke	☐ YES ☐ NO Arthritis	☐ YES ☐ NO Pregnant

Any other significant diseases or cancers? _____

Surgical History: _____

_____

_____

Family History: Has anyone in your family had Melanoma: **YES** **NO**

Social History: Smoke: **YES** **NO** Drink alcohol: **YES** **NO** How Much per ____ day ____ week ____ month

Occupation: _____ Hobbies: _____

Patient *(or parent for minor)* Signature: _____ Date: _____

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Statement of Financial Responsibility

Katrina R. Lynch
MPAS, PA-C

I understand that payment for services, whether cosmetic or not, is solely the responsibility of the patient or their guarantor and as a courtesy Katrina R. Lynch will bill my insurance. I hereby authorize Katrina R. Lynch to bill my insurance company or other third parties responsible for my medical charges. I also authorize Katrina R. Lynch to release any medical information that may be requested by my insurance company to help with the process of my claims. I authorize and request that payment be made directly to Summit Healthcare Dermatology for all medical and surgical services. I understand that I am responsible for any balance not covered by my insurance company.

I hereby acknowledge that I have reviewed the Financial Agreement, the Outpatient Bill of Rights, and the Summit Healthcare Notice of Privacy Practices. I understand that copies are readily available upon my request.

Signature of patient/responsible party/legal guardian	Relationship to patient	Date

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FINANCIAL AGREEMENT

KATRINA R. LYNCH
MPAS, PA-C

General Agreement

I recognize that the practice of medicine and surgery is not an exact science. I understand and accept that fees are paid for performance of the procedure(s) only, and not a guaranteed result. I acknowledge that although a good outcome is expected, and every effort has been made to establish realistic expectations, there cannot be any warranty, expressed or implied, as to the results that may be obtained.

Problems and Complications

I understand and accept that problems relating to or complications of my procedures may result in additional costs to me. These costs may include additional facility fees, hospital costs, dermatologist's fees or other unspecified charges that may not be covered, or only partially covered, by my health insurance.

Revisions and Touch-ups

I understand and accept that on occasion "touch-ups" or revisions of procedures are necessary. I acknowledge that in such cases I am responsible for all additional charges. I am also aware and accept that a dermatologist's fee may also be charged, at my dermatologist's discretion. I understand and accept that the need for, and timing of, revisions and touch-ups will be determined solely by my dermatologist, as will the amount of the dermatologist's fee.

Aesthetic Surgery Payment and Cancellation

A fee of $500 will be collected at the time of booking in order to schedule and secure a date and time. Full payment will be required 14 days prior to the scheduled procedure date.

If, for any reason, I cancel my procedure 14 days prior to the date procedure is scheduled all payments are refundable.

If, for any reason, I cancel my procedure less than 14 days before my scheduled procedure date, my payment will be refunded less my non-refundable scheduling fee. This will be forfeited and retained as a processing fee and not returned to me.

If my procedure must be cancelled because I fail to provide requested pre-operative lab work, X-rays, medical evaluation, history and physical, letter of medical clearance, or other requested medical information, my payment will be refunded less my non-refundable surgery scheduling

Initials _____ **Date** _____

FINANCIAL AGREEMENT
Continued

KATRINA R. LYNCH
MPAS, PA-C

fee. This will be forfeited and retained as a processing fee and not returned to me.

If, for any reason, I fail to show for scheduled procedure without providing notice, my payment will be refunded less my non-refundable scheduling fee, the aftercare fee (if any), 50% of the facility fee, and 50% of the dermatologist's fee. These will be forfeited and retained as processing fees and not returned to me.

If procedures must be rescheduled, all fees will be applied to the new procedure date, and the cost will remain the same, provided it is within 6 months of the original date. After 6 months, fees can still be applied, but there may be additional costs for anesthesia, facility, or surgeon's fees.

If a refund is needed, it will be issued in the form of a check even if a credit card payment was made. Please allow one to two weeks for processing.

DECLARATION

I certify I have read and understand the financial agreement and I accept and agree to all of the above.

Patient signature	Date
Witness signature	Date

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Patient Copy

FINANCIAL AGREEMENT

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Continued

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Patient signature _____ Date _____

Witness signature _____ Date _____

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PRIVACY PRACTICES ACKNOWLEDGEMENT

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_____

Patient Signature

_____

Printed Name

_____

Date

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Content Consent Form

Katrina R. Lynch
MPAS, PA-C

We would like to follow up with our patients after a consultation and/or a procedure performed by this office.

Please indicate your contact preferences below.

May we contact your home phone number?	**YES**	**NO**
May we identify ourselves as being from the office of Katrina Lynch?	**YES**	**NO**
May we leave a message:		
On your answering machine?	**YES**	**NO**
With a family member?	**YES**	**NO**
With a spouse / significant other?	**YES**	**NO**
May we send information to your home or mailing address?	**YES**	**NO**
May we send information via email?	**YES**	**NO**

If yes, please indicate email preference: _____

May we speak with a family member or spous
regarding your care, results, or medications? **YES** **NO**

Name: _____ Relationship _____

_____ _____ _____

Patient's Printed Name | Patient's Signature | Date