



Patient Name _____ Date of Birth _____

Reason for your visit _____ Location _____

Duration _____ Symptoms _____

Contributing factors (stress, hormones, sun) _____

Prior treatment (biopsy, medications, etc.) _____

LIST ALL ALLERGIES TO MEDICATIONS OR SUBSTANCES _____

LIST ANY ARTIFICIAL JOINTS, PACEMAKER, HEART VALVES REPLACEMENT _____

TO BE COMPLETED BY ALL WOMEN: Please inform the provider should you become pregnant during your treatment.

Are you pregnant or nursing? Yes No

Are you currently planning a pregnancy? Yes No

PERSONAL HEALTH PROBLEMS:

CHECK ALL THAT APPLY (EVEN IF MEDICATED)

SKIN:

- no problems
- abnormal scarring
- poor healing
- other skin conditions _____

HEMATOLOGIC/LYMPH:

- none other _____
- transfusions
- bleeding problems
- enlarged lymph nodes

CONSTITUTIONAL:

- none
- weight loss
- fever
- other _____

EYES/EARS/NOSE/THROAT:

- normal other _____
- glaucoma
- headaches
- plastic surgery _____

CARDIOVASCULAR:

- normal angina
- hypertension
- artificial/mech valve
- pacemaker/defibrillator
- other _____

INTESTINAL/URINARY:

- normal
- colitis
- stomach ulcer
- colon/bladder/kidney CA
- other _____

RESPIRATORY:

- normal
- asthma
- emphysema
- other _____

MUSCULOSKELETAL:

- normal
- arthritis
- artificial joint date _____
- other _____

NEUROLOGICAL:

- normal
- stroke
- seizures
- other _____

PSYCHIATRIC:

- normal depression
- claustrophobic
- anxiety attacks
- other _____

ENDOCRINE:

- normal
- diabetes type I ___ II ___
- thyroid hypo ___ hyper ___
- other _____

INFECTIONS:

- none cold sores
- hepatitis MRSA
- HIV/AIDs TB
- STD _____

PAST HISTORY:

Previous Skin Cancers None Yes _____

Major Illnesses/Hospitalizations None Yes _____

Surgeries No Yes _____

Organ Transplant Recipient No Yes _____

FAMILY HISTORY:

Skin Cancer None Basal cell Squamous cell Melanoma Other skin conditions _____

Relationship: _____

SOCIAL HISTORY:

Occupation _____ Marital status S M D W

Do you wear Dentures Glasses Contact Lenses Hearing aides None

Smoking Never Former/when did you quit _____ Yes/# per day _____

Alcohol No Yes/drinks per week _____ Alcohol or drug addictions No Yes _____

Tanning bed use No Yes/last used _____ Blistering sunburns No Yes

Patient or Parent/Guardian Signature _____ Date _____

Providers Signature _____ Date _____



GENERAL CONSENT TO TREAT

Patient's Name: _____ DOB: _____

1. Consent. I request and authorize medical or surgical treatment as may be deemed necessary and appropriate by the physician and his/her designees and assistants participating in my care. This care may include surgical and laboratory procedures; local anesthesia; therapeutic procedures; medications. I know procedures that have more risk will be explained to me so I can give informed consent for them. I know I can ask my doctor any question(s) I have about my treatment.
2. Release of information. I authorize OSCI, LLC to release pertinent information and/or copies of medical records for treatment, payment, or health care operations purposes. I understand such information may include human immunodeficiency virus (HIV), AIDS related complex (ARC), acquired immunodeficiency syndrome (AIDS), hepatitis, substance abuse, if any. See Notice of Privacy Practices for further information.
3. Human Immunodeficiency Virus (HIV) and Hepatitis B/C Testing. I understand and agree that, in accordance with State law, an HIV, HBV or HCV tests may be performed upon me in the event a health care worker sustains a significant exposure to my blood or body fluids. The results of any test will be treated confidentially.
4. Testing and Disposal of Specimens and Tissue. I authorize OSCI to retain, preserve, or use for research, scientific or teaching purposes, or to dispose of any specimen or tissue remaining after completion of a clinical procedure or treatment.
5. Valuables. I release OSCI from responsibility for all personal articles which I have with me during the time I am at OSCI. I understand that OSCI is not responsible for clothing, eyeglasses, dentures, jewelry, money or other personal articles of value kept in my possession while at OSCI.
6. Payment. I assign and authorize payment from my insurance company directly to OSCI, LLC for any and all services rendered. I agree to pay all charges not covered by my insurance company. I understand that it is my primary responsibility to pay the charges for services rendered irrespective of any disputes or disagreements between myself and insurance companies.
7. Direct Financial Interest. Title 42 CRF 420 requires that a physician notify the patient that the physician has a direct financial interest in a separate diagnostic or treatment agency to which the physician is referring the patient and/or in the non-routine goods or services being prescribed by the physician, and if these are available elsewhere on a competitive basis. We support this law because it helps patients make reasonable financial decisions concerning their medical care. In compliance with the requirements of this law, we have a direct financial interest in the diagnostic or treatment agency or in the non-routine good or services named below. Further, as indicated below, good or services that we have prescribed are available elsewhere on a competitive basis. DIAGNOSTIC OR TREATMENT AGENCY OR NON ROUTINE GOODS AND SERVICES: Ambulatory Surgical Services and Pathology Services. Are these available elsewhere on a competitive basis? Yes – at various hospitals and surgical centers in Franklin County. Mount Carmel East Hospital is the closest location.
8. In accordance with Federal Law, Ohio Skin Cancer Institute is notifying you that it will not honor advanced directives.
9. Under federal law Health Insurance Portability and Accountability Act restricts OSCI from discussing any medical information, unless a release form is signed. Please see the Notice of Privacy Practices Form.

- I have read this form or it has been read to me and I am satisfied that I understand its contents. I further understand that this consent will be deemed continuing and I am free to withdraw my consent at any time.
- I received a copy of the Notice of Privacy Practices and Patient Rights and Responsibilities
- I acknowledge the Direct Financial Interest Disclosure
- I consent to pictures or videos being recorded or televised during my treatment, including appropriate portions of my body, for medical research or educational purposes, as long as my identity is not compromised or released.
- I agree that you may call me on whatever phone numbers I give you, including land lines, cell phones, Skype numbers, or anything else.

Signature of Patient or Authorized Agent

Relationship to Patient

Date



FINANCIAL POLICY

Effective Date: March 24, 2016

Name: _____

DOB: _____

Thank you for choosing OSCI for your care. We appreciate your trust in us and the opportunity to serve you. As part of our practice, we try to offer efficient and helpful billing services. To this end, we ask you to read the following statement of our financial policy. Please sign it prior to any treatment.

- Outstanding fees and co-pays are due at the time of the visit.
- Payment for non-covered or cosmetic procedure must be prepaid in full prior to the time of the visit/procedure.
- We accept cash, check or credit cards.
- 10% service charge will be added to bills over 30 days old.
- We offer an extended payment plan for patients meeting low income or financial hardship criteria.

It is essential that you bring your current primary and secondary insurance card to each visit, so that we have the most accurate and up-to-date information to submit charges to the insurance carrier on your behalf.

MEDICARE: We participate with Medicare and we accept assignment. You are responsible for 20% of Medicare's approved amount unless you provide our office with secondary insurance coverage at the time of service. We will file a claim with your secondary carrier. However, in the event that the secondary does not pay within 60 days, the patient will be billed.

SELF PAY: Payment for all services is due and payable at the time of service. Payment plans are on a case to case basis decided by the provider. We accept CareCredit.

PARTICIPATING PLANS (HMO/PPO): We will be happy to bill insurance plans we participate in. Once we receive correct payment, we will make our contractual adjustment and send you a bill for any balance due. These are due upon the receipt of your bill. If Dr. Ravitskiy or other OSCI medical care provider is a participating provider contracted with your insurance plan; copays are to be paid on the date of service. **It is your responsibility to know your coverage eligibility, deductibles, copays, referral and precertification requirements and whether or not your provider is on your plan.** If the expertise of an outside lab is needed for a portion of your care (biopsy interpretations or second opinions), you may receive a separate bill from that lab for their services.

NON-PARTICIPATING PLANS: As a courtesy to you, we will bill your insurance carrier if you provide us with complete insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account within 30 days, the account will be assessed for payment. You should remit payment within 30 days and contact your insurance company to check on status of claim. Please notify us immediately upon contacting your insurance company or if there is anything we can do to help settle this claim. If you have a non-participating Blue Shield plan which will send payments to you instead of the doctor, we will ask for full payment from you on the day of your visit. Then we will bill Blue Shield on your behalf and Blue Shield will reimburse you directly. When you arrive for your visit, you may be asked to sign a non-contracted waiver form, and you will have an opportunity to speak with our billing staff about the charges.



USUAL AND CUSTOMARY RATES:

Our practice is committed to providing the best care for our patients. Our charges are within the usual and customary charges for our specialty in our area. You are responsible for payment regardless of any non-participating insurance company's arbitrary determination of usual and customary rates.

AUTHORIZATIONS/ACKNOWLEDGEMENTS (For Medicare patient's only)

MEDICARE: I hereby authorize any provider of services to me who file claims to the Medicare Program, its intermediaries or carrier and to Medigap and any plan to which Medicare crossover to release medical or other information about me that is required for the adjudication of a claim submitted for care provided to me. I also assign payment of any health benefits due to me to the party who files an assigned claim to the Medicare program for services provided to me. This authorization is for my lifetime unless revoked in writing by me or my legal guardian or assign.

_____/_____/_____
Signature of Patient or Legal Guardian Relationship to Patient Date

APPOINTMENT CANCELLATION POLICY: Should you be unable to keep your appointment, please contact the office to cancel your appointment. **Failure to contact the office with at least 24 hour advance notice will result in a \$50 fee. Surgical and cosmetic appointments require a 48 hour cancelation notice to avoid \$100 fee.** This fee is not reimbursable by your insurance company.

MEDICAID WAIVER (all forms of Medicaid): OSCI does not accept Medicaid or any forms of Medicaid. I understand OSCI will not bill Medicaid, therefore if I have one of these insurances as my primary insurance I will be responsible for my entire bill at the time of service. I understand that if one of if these insurances is my secondary, I will be responsible for the amount my primary insurance does not cover. At my request OSCI will provide an estimate prior to receiving my services.

**WE ACCEPT MOST MAJOR CREDIT CARDS INCLUDING CARE CREDIT FOR YOUR CONVENIENCE.
There will be a \$35 charge for all checks returned for insufficient funds.**

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

I have read, understand and agree to this Financial Policy.

_____/_____/_____
Signature of Patient or Legal Guardian Printed name Relationship Date



Consent to Obtain External Prescription History

I, _____ (patient name) whose signature appears below, authorize Ohio Skin Care Institute and Its Affiliated Providers to view my external prescription history via the RxHub service.

I understand that the prescription history from multiple other unaffiliated providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years.

My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Signature of Patient or Legal Guardian

Practice Representative

If any prescriptions are written during your visit for convenience purposes we will E-prescribe them directly to the pharmacy.

PHARMACY NAME

ADDRESS/CITY/ZIP

PHONE NUMBER