From the Office of King-Maceyko Dermatology Associates
Andrew J. King, M.D. Ronald F. Maceyko, M.D.
Gary F. Risko, PA-C

350 Southmont Blvd
Johnstown PA 15905
(814) 536-7045

223 S Pleasant Ave #101
Somerset PA 15501
(814) 443-6918

572 Philadelphia St
Indiana PA 15701
(724) 349-7720

Enclosed are patient information forms. We ask that you **complete these forms at home and bring them with you to your upcoming appointment. The patient completing these forms must be 18 years of age. Even if you have been seen before as a patient you need to complete new forms.**

If you have the following insurance: Medicare**, Security Blue/Freedom Blue, UMWA Funds, Advantra Freedom, UPMC for Life, Anthem Medicare Advantage, or any other Medicare HMO** please fill out the **MEDICARE OR MEDICARE HMO PATIENT INFORMATION** side of the form. Two signatures at the bottom of the form are required.

For all other insurances please fill out the **NEW PATIENT INFORMATION** side of the form. Two signatures at the bottom of the form are required.

Please fill out **both sides** of the **PATIENT HISTORY FORM.**

We are converting our practice from traditional paper medical records to electronic medical records. More time is necessary during the initial stages of conversion. **Even though you may be an *established* patient, updated forms are necessary**. **Please arrive at least 10 minutes before your scheduled appointment time** to assist us in timely processing your paperwork.

Failure to bring *completed* forms with you and *arrive prior* to your appointment time may result in us delaying your appointment time or rescheduling your appointment if there is insufficient time for our office to process the paperwork.

Please bring your most recent insurance card.

Please see additional information on the next page.

We thank you for your cooperation and patience
If unable to keep appointment, kindly give 24 hours notice

King-Maceyko Dermatology Associates Ltd.
Financial Policy

Our office expects payment at the time of service. We accept checks, cash, VISA, Master Card or Discover.

We do participate in various insurance products such as Medicare, Blue Cross/Blue Shield, UPMC, Aetna, Health Assurance/Health America, UMWA/Funds and Penn Highlands to list a few. ***We do not accept any form of Medical Assistance (the Access card or any Commonwealth welfare based HMO).*** It is not possible for our office to know all of the different insurance companies and types of plans available. Plans may have conditions or procedure exclusions, a limited provider panel, deductibles of varying amounts as well as copayment of a flat amount and/or a percent of the bill, which are the responsibility of the patient. It is up to you as the insured or owner of your insurance policy to know what type of contract you have purchased. We will assist you in any way we can to the best of our knowledge but the ultimate responsibility for payment is the patient. We will bill your insurance for you but expect all copayment to be ***paid the day of your visit***.

A parent or legal guardian must accompany minors. If the parent or legal guardian cannot bring the minor the substitute adult must bring written authorization from the parent or guardian to act on their behalf. Minors may not sign forms, enter into financial agreements or make decisions regarding their medical treatment.

Cosmetic Procedures

Patients and physicians are often under the impression that all benign lesions can be removed from the skin and submitted to an insurance plan for payment. This is ***NOT*** the case.

The physician must evaluate skin lesions to determine and document ***medical necessity*** for any procedure billed to an insurance plan. We cannot determine over the telephone if removal of a skin lesion is considered cosmetic or not. Just because a skin lesion is perceived by the patient as unattractive, possibly elevated from the skin surface, itchy, getting caught on clothing/jewelry or occasionally painful does ***NOT*** mean the removal is considered **medically necessary**. This is considered ***cosmetic surgery*** and removal will not be paid for by insurance. Payment is your responsibility at the time the procedure is performed for all procedures deemed to be ***cosmetic***.

We will be glad to remove cosmetic lesions you wish to have removed, if we agree that doing so is in your best interest. We will provide a price quote and have you complete any necessary forms for your method of payment prior to the procedure being performed.

King-Maceyko Dermatology Associates, Ltd.

Patient consent for Use and Disclosure of Protected Health Information

With my consent, King-Maceyko Dermatology, may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to King-Maceyko Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. King-Maceyko Dermatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to King-Maceyko Dermatology, Privacy officer at 350 Southmont Blvd., Johnstown, PA 15905.

With my consent, King-Maceyko Dermatology may call my home or other designated location and leave a message on 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, King-Maceyko 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 as long as they are marked Personal and Confidential.

I have the right to request that King-Maceyko 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 King-Maceyko 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, King-Maceyko Dermatology may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Patient's Name if Signed by Another

_____ _____

Printed Name of Person Signing Form & Relationship Date Signed

King-Maceyko Dermatology Associates, LTD.

NEW PATIENT INFORMATION or ESTABLISHED PATIENT UPDATE

Please Present Insurance cards and Photo ID with completed forms

Please print

Patient Name_____
First *Middle* *Last*

Address: Street_____

City_____State_____Zip_____

Sex_____ Birthday_____ Age_____ Marital Status: Single Married Widowed
M/F *Month Day Year* *(circle one)*

Ethnicity: _____ Non Hispanic or Latino _____ Hispanic or Latino _____ Not Reported

Race: _____Native American Indian _____ African American/Black
_____Alaska Native/Eskimo _____ Asian
_____Native Hawaiian/Pacific Islander _____ White _____ Not Reported

Home Phone_____ Cell Phone_____ Work Phone_____

E-Mail_____ Social Security Number_____

Employers Name & Address_____

Family Physician_____ Referred Yes / No

Referring Physician _____Preferred Pharmacy _____
(If different than family physician)

PARENT/SPOUSE INFORMATION

*(OTHER CONTACT IF **NOT** A CHILD, OR IF AN ADULT **NOT** MARRIED)*

Name_____ Relationship to Patient _____

Address *(If different than above)* Street_____

City_____ State_____ Zip_____

Birthday_____ Social Security Number_____ Marital Status: Single Married Widowed

Home Phone_____ Cell Phone_____ Work Phone_____

Employers Name & Address_____

Patient Name_____ Date_____

King-Maceyko Dermatology Associates, LTD.
NEW PATIENT INFORMATION OR ESTABLISHED PATIENT UPDATE

PRIMARY INSURANCE

Identification Number_____ Group Number_____

Insured's Name_____ Relationship to Patient_____
(Name of who insurance is through-self, parent, spouse) *(mother, father, husband, wife)*

Insured's Birthday_____ Insurance Company Name_____

Insured's Address *(If different)* _____

Employers Name_____
(If insurance is through work)

SECONDARY INSURANCE

Identification Number_____ Group Number_____

Insured's Name_____ Relationship to Patient_____
(name of who insurance is through-self, parent, spouse) *(mother, father, husband, wife)*

Insured's Birthday_____ Insurance Company Name_____

Insured's Address *(If different)* _____

Employers Name_____
(If insurance is through work)

I authorize the release of medical information necessary to process this claim and also authorize payment of medical benefits to the physician.

Signature: _____ Date: _____

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered. We accept payment in the form of cash, check or credit card. If we file a claim with your insurance you are still responsible for any unmet deductible, non-covered services and copayments. Your signature below signifies your understanding and willingness to comply with this policy.

Signature: _____ Date: _____

King-Maceyko Dermatology Associates, LTD.

MEDICARE OR MEDICARE HMO PATIENT INFORMATION

NEW PATIENT OR ESTABLISHED PATIENT UDPDATE

Please Present Insurance cards and Photo ID with completed forms

Please print

Patient Name_____
First *Middle* *Last*

Address: Street_____

City_____State_____Zip_____

Sex_____ Birthday_____ Age_____ Marital Status: Single Married Widowed
M/F *Month Day Year* *(circle one)*

Ethnicity: _____ Non Hispanic or Latino _____ Hispanic or Latino _____ Not Reported

Race: _____Native American Indian _____ African American/Black
_____Alaska Native/Eskimo _____ Asian
_____Native Hawaiian/Pacific Islander _____ White _____ Not Reported

Home Phone_____ Cell Phone_____ Work Phone_____

E-Mail_____ Social Security Number_____

Employers Name & Address_____

Family Physician_____ Referred Yes / No

Referring Physician _____Preferred Pharmacy _____
(If different than family physician)

EMERGENCY CONTACT INFORMATION

Name_____ Relationship to Patient _____

Address *(If different than above)* Street_____

City_____ State_____ Zip_____

Birthday_____

Home Phone_____ Cell Phone_____ Work Phone_____

Patient Name_____ Date_____

King-Maceyko Dermatology Associates, LTD.
NEW PATIENT INFORMATION OR ESTABLISHED PATIENT UPDATE

PRIMARY INSURANCE

Medicare Number *(Include Any Letters)* _____

Medicare HMO Numbers & Company _____

Medicare Supplement Numbers & Company _____

Yes _____No _____ Do you or your spouse work and have insurance coverage through your job?

SECONDARY INSURANCE
(IF THROUGH CURRENT EMPLOYER/PRIOR EMPLOYER OF SELF OR SPOUSE)

Identification Number_____ Group Number_____

Insured's Name_____ Relationship to Patient_____
(name of who insurance is through-self, spouse) *(husband, wife)*

Insured's Birthday_____ Insurance Company Name_____

Insured's Address *(If different)* _____

Employers Name Insurance is through _____
(If insurance is through work)

Yes _____ No _____ Are you coming to this office for an illness or accident that has been covered or is Authorized for coverage from any of the following:

_____Veteran's Administration _____Worker's Compensation _____Federal Black Lung_____Accident

I authorize any holder of medical or other information about me to release to the Social Security 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: _____ Date: _____

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 the above Medigap carrier any information needed to determine their benefits or the benefits payable for related services.

Signature: _____ Date: _____

King-Maceyko Dermatology Associates, LTD

PATIENT MEDICAL HISTORY

In order to provide you with the best possible care possible, we request that you complete all the sections below. All answers are confidential.

NAME: (Please print) _____ **DATE:** ___/___/____

PAST MEDICAL HISTORY (Ever treated for the condition? Clarify in space provided or attach a separate paper.)

Arthritis	O no O yes_____	**Intestinal disease**	O no O yes_____
Heart disease	O no O yes_____	**Diabetes**	O no O yes_____
Blood pressure	O no O yes_____	**Thyroid disease**	O no O yes_____
Stroke	O no O yes_____	**Liver disease**	O no O yes_____
Anxiety	O no O yes_____	**Cancer (non-skin)**	O no O yes_____
Depression	O no O yes_____	**Cancer (skin)**	O no O yes_____
Other mental dis.	O no O yes_____	**Skin disease**	O no O yes_____

Other: _____

INFECTION HISTORY

Tuberculosis	O no O yes_____	**Hepatitis**	O no O yes_____
HIV	O no O yes_____	**STD**	O no O yes_____

SURGICAL HISTORY

Appendectomy	O no O yes_____	**Heart valve**	O no O yes_____
Cancer surgery	O no O yes_____	**Heart pacemaker**	O no O yes_____
Eye surgery	O no O yes_____	**Prostate surgery**	O no O yes_____
Gallbladder	O no O yes_____	**Tonsillectomy**	O no O yes_____
Hysterectomy	O no O yes_____	**Tubes tied** (fem.)	O no O yes_____
Joint replacement	O no O yes_____	**Organ transplant**	O no O yes_____

Other_____

Do you have advance directives? (Documents to define your near end-of-life decisions) O No O Yes

(CONTINUE FORM ON REVERSE SIDE OR PAGE 2)

Patient Name _____ **Date** _____

King-Maceyko Dermatology Associates, LTD
PATIENT MEDICAL HISTORY

FAMILY HISTORY (indicate relationship)

Skin disease	O no O yes_____	**ulcerative colitis**	O no O yes_____
Skin cancer	O no O yes_____	**Crohn's disease**	O no O yes_____
Hair loss	O no O yes_____	**bleeding disorder**	O no O yes_____
Multiple sclerosis	O no O yes_____	**clotting disorder**	O no O yes_____

SOCIAL HISTORY

Tobacco use	O never	O former	O current	# of years used_____
Alcohol use	O never	O social	O heavy	O alcoholic O quit
Illegal drug use	O never	O former	O current	drug(s) of choice_____

MEDICATION HISTORY

Current list of prescription medication(s): (print in the space below)

Current list of nonprescription medication(s) to include supplements, herbal remedies, homeopathic medications:

List your medication allergies below: (include type of reaction) O no allergies

Allergic to latex? O no O yes (If yes, type of reaction) O hives O scaly rash
O swelling O difficulty breathing

I attest that the above information is true to the best of my knowledge:

Signature_____ Date____/_____/_____

I consent to have my medication history retrieved from my pharmacy / pharmacies.

Signature_____ Date____/_____/_____