HOLLY FRITCH KIRBY, MD, L.L.C. ***(Please print and bring to appointment along with insurance card. We do not want to leave your information online.)***

LEGAL NAME_____**NICKNAME**_____

ADDRESS_____**CITY**_____**STATE**_____**ZIP**_____

HOME TELEPHONE_____**CELL PHONE NUMBER**_____

SOCIAL SECURITY NUMBER_____

DATE OF BIRTH_____**AGE**___**MALE**____ **Female**____ **MARITAL STATUS**_____

EMPLOYER_____**OCCUPATION**_____**WORK TELEPHONE**_____

REFERRED BY_____**PRIMARY PHYSICIAN**_____

SPOUSE/PARENT NAME_____**ADDRESS**_____

HOME TELEPHONE_____**EMPLOYER**_____**WORK TELEPHONE**_____

IN CASE OF EMERGENCY, NOTIFY_____**TELEPHONE**_____**RELATIONSHIP**_____

SIBLINGS_____

PRIMARY *INSURANCE:* Insurance Co. Name _____

PRIMARY INSURED PARTY NAME_____ **MEMBER ID #**_____

INSURED PARTY SOC. SEC.# _____**D.O.B.**___/___/___**GROUP#**_____

SECONDARY INSURANCE: Insurance Co. Name_____
SECONDARY INSURED PARTY NAME_____**MEMBER ID #**_____

INSURED PARTY SOC. SEC.# _____**D.O.B.**___/___/___**GROUP#**_____

FINANCIAL AGREEMENT AND AUTHORIZATION FOR TREATMENT

I authorize Holly Fritch Kirby, M.D., L.L.C. to treat the person named above and agree to pay for all charges for myself and members of my family at the time of service promptly upon presentment thereof, unless credit arrangements are agreed upon in writing prior to services rendered. Charges shown by statements are agreed to be correct and reasonable unless protested in writing within thirty days of billing date. Checks returned for insufficient funds are subject to a $40 fee. The provision of incorrect insurance information which results in re-filing of the insurance is a non-covered billable fee of $30, or the denial of coverage due to late filing is a non covered billable fee equal to the denial amount and is the financial responsibility of the patient or guardian. Prior authorizations for medications required by your insurance carrier create a non covered billable fee of $50.00 due to our time required to process the authorization. Please notify the office if you wish us to process the prior authorization on your behalf. Your insurance company may still deny the coverage.

If at some point your insurance changes to a HMO & we do not have a referral at the time of service, you will be responsible for the charges incurred. This notice is in effect unless written communication is obtained stating otherwise by the signatory.

It is agreed that payments will not be delayed or withheld because of any insurance coverage or the pending of claims thereon, and all proceeds of insurance are assigned to this office where applicable, but without assuming responsibility for the collection thereof. (A copy of this agreement is as valid as the original.) I also authorize release of any medical information necessary to process my insurance claim. To the best of my knowledge, all the proceeding answers are true and correct. If I ever have any change in health or medications, I will inform the doctor without fail.

SIGNATURE_____**DATE**_____
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MEDICARE LIFETIME CONSENT CERTIFICATE: I request that payment of authorized Medicare benefits be made to me or on my behalf to Holly Fritch Kirby, M.D., L.L.C. for any services furnished to me by that physician. I authorize any holder of medical information about me to release to the CMS and its agents any information needed to determine these benefits or the benefits payable for related services.

SIGNATURE_____**DATE**_____**MEDICARE #**_____
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HIPAA Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree with this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You may revoke this Consent by submitting a written notice. However, such a revocation shall not affect disclosure we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA). **(CONTINUED ON REVERSE)**

In order to be efficient and provide better care, your medical information may be shared with family members or caretakers/babysitters if considered appropriate by Dr. Fritch and staff unless you specifically circle no. The Patient understands that: Protected health information may be disclosed or used for treatment, payment or health care operations. The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice. The Practice reserves the right to change the Notice of Privacy Practices. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon the execution of this Consent.

This consent was signed by: _____ _____ ____/____/____
Print Name (Patient or Guardian) Signature Date

I DO NOT consent: _____ _____ ____/____/____
Print Name (Patient or Guardian) Signature Date

Relationship to Patient:

Witness: _____ _____ ____/____/____
Print Name Signature Date

REASON FOR VISIT_____

ONSET OF PROBLEM_____ **PRIOR EPISODES** _____

PAST OPERATIONS AND ILLNESSES: (CIRCLE POSITIVES)

Tonsillectomy. Appendectomy. Hysterectomy with or without oophorectomy. Ovarian cyst. Sterilization. Cataract surgery. Implants (heart, eye, joint) or stent. Acne, Excessive hair. Hair loss. Glaucoma. Tuberculosis (or positive skin test). Diabetes. Peptic ulcer disease. Hypertension. Heart problems (for example, heart murmur or Rheumatic fever). Easy bleeding. Blood clots. Asthma. Hay fever. Allergies. Hepatitis. Keloid (excessive scar formation). Pernicious anemia. Anemia. HIV positive or at risk. Thyroid disorder. Recipient of blood product(s) (date). Basal cell skin cancer. Melanoma. Malignancy (type, date of diagnosis, treatment with dates). None of the above. Smoker (present or past). Please list other illnesses.

_____

_____

_____

Recent infections_____
(This should include minor infections like cavities, sore throats, sinusitis, and yeast or bladder infections.)

FAMILY HISTORY: (CIRCLE POSITIVES)

Asthma. Hay fever. Allergies. Psoriasis. Diabetes. Keloids. Melanoma. Basal cell skin cancer. Blood clots. Breast cancer. Ovarian cancer. Ovarian cysts. Uterine cancer. Skin problems. Other:_____

_____

LIST PRESENT MEDICATIONS: (Include birth control pills and the dates medications were started as well as dose/frequency) (If you have a new itchy rash, also include soap, shampoo, perfumes, cosmetics, creams and etc., and over-the-counter products such as vitamins, aspirin, or laxatives.)_____

_____

Preferred Pharmacy: (Name, approximate address and phone number_____

LIST MEDICATIONS AT ONSET OF RECENT SKIN PROBLEM:_____

_____

LIST MEDICATIONS USED FOR YOUR SKIN PROBLEMS IN THE PAST: (PLEASE INCLUDE DATES AND EFFECTIVENESS OF MEDICATIONS):_____

_____

LIST ALLERGIES TO DRUGS: (OR STATE "NONE")_____

IF FEMALE, ARE YOU PREGNANT OR NURSING OR ANTICIPATE BECOMING PREGNANT SOON? Yes _____ No

Please STOP your dermatological medications and call/return if you become pregnant. Also, please return for any mole that looks as though it may be changing.
If you consume alcohol, you may increase your risk for bone injury (aseptic necrosis) if treated with steroids.
Specimens will be submitted to an excellent Dermatopathologist for microscopic analysis. Dr. Fritch refuses to send your biopsies/excisions to an HMO (managed care) lab, thereby avoiding risking your life. She has already had such an HMO (managed care) lab miss a melanoma.

FYI: WE ACCEPT CASH AND CHECKS ONLY FOR PAYMENT. NO DEBIT OR CREDIT CARDS. THANK YOU!