STUTZ DERMATOLOGY
919 W. UNIVERSITY DR., SUITE 100, ROCHESTER MI 48307
PHONE: 248.651.9500 FAX: 248.651.3366

Health Questionnaire

Legal Name: _____ DOB: _____

Nickname: _____

Primary Care Physician: _____

Reason to be seen: _____

List all medications, over-the-counter and vitamins you currently take. (*List by Medication, Dosage, Frequency*)

Do you take antibiotic's before teeth cleaning? Yes_____ No _____

Are you pregnant, possibly pregnant, trying to get pregnant, or breast feeding? Yes_____ No_____

Please list all medications that you are allergic to. Even if you don't think they concern dermatology.

_____

Personal history of skin problems? Yes_____ No_____ (if yes, please explain)

_____

Family history of skin problems? Yes_____ No_____ (if yes, please explain)

_____

Please check if you have problems with any of the following:

_____ Heart
_____ Liver
_____ Kidney
_____ Diabetes
_____ Seizures
_____ TB
_____ Breathing
_____ Digestion
_____ Arthritis
_____ Bleeding
_____ HIV
_____ Hepatitis
_____ High Blood Pressure
_____ Artificial Joints
_____ Psychiatric
_____ Thyroid
_____ Other _____

Cancer of: _____

Occupation: _____

We offer some cosmetic procedures. Please check if you are interested in obtaining additional information.

_____ Botox Cosmetic _____Fillers

We recommend a full body examination. Please check whether you would like the full exam today or at a later date.

_____ Today _____ Defer

STUTZ DERMATOLOGY **JOSEPH A. STUTZ, M.D.**

Patient Information

Name of Patient _____

Social Security Number _____ M/F _____ Date of Birth _____

Address _____ Apt/Unit # _____

City _____State _____ Zip Code _____

Home Phone (____) _____ Cell Phone (____) _____

Responsible party email address _____

Employer _____ Work Phone (___) _____ Ext. _____

Preferred method of appointment reminders (Circle all that applies) Home Phone Cell Email Text/SMS

Marital Status (check one) Single____ Married____ Divorced ____ Widowed____ Separated____

Is the patient a minor child? _____ If so, name responsible party _____

Emergency Contact: (please use a phone # not listed above)

Name _____ Relationship to Patient _____Phone (____)_____

**Do we have permission to share information with this person? Yes _____ No _____

Primary Insurance Information

Name of Insurance _____ ID# _____

Name of Cardholder _____ Social Security Number _____

Relationship to Patient (circle one) Spouse Parent Other _____ M/F ____ Date of Birth_____

Secondary Insurance Information

Name of Insurance _____ ID# _____

Name of Cardholder _____ Social Security Number _____

Relationship to Patient (circle one) Spouse Parent Other _____ M/F ____ Date of Birth_____

Preferred Pharmacy: _____ **Pharmacy Phone #:** _____

Who may we thank for referring you to our office? _____

I also certify that the above information is correct. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in the information above. If I have included a cell phone above I am giving the office or agent permission to call that phone. I request payment of authorized medical benefits to be made on my behalf to Dermatology Center of Rochester Hills, PC, Stutz Dermatology or Joseph A. Stutz, MD. I authorize any medical information needed to determine benefits payable to be released to my insurance company or its agent. **I understand that I am financially responsible for all charges whether or not paid by insurance**. Further, I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____ _____

Signature of Patient (Parent or Guardian) **Relationship to Patient** **Date**

Privacy Practices Acknowledgement (HIPPA Privacy Rule)
I have read the attached Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____ _____

Signature of Patient (Parent or Guardian) **Relationship to Patient** **Date**

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CONSENT FOR MEDICAL TREATMENT AND INSURANCE AND FINANCIAL RESPONSIBLITY

I understand that medical treatment may be necessary for the patient by **Joseph Stutz, M.D.,** his associates, assistants, of **Dermatology Center of Rochester Hills, P.C** or **Stutz Dermatology.**

Examination Consent:

I understand that the examination procedures will be explained to me, and I hereby consent to a partial or complete dermatological examination of the body areas I choose to present for evaluation. I understand that:

- Examination results will be shared with me, including any medical recommendations. I am responsible for arranging any necessary follow-up examinations for abnormalities identified or treated during this visit. I hereby release the examining physician and staff from all responsibility related to this examination, provided it is conducted in a reasonable and professional manner.

Treatment Consent

I understand and agree that:

- Medical treatment may be necessary, and I consent to any diagnostic or therapeutic treatments considered advisable by the physician.
- No guarantees or assurances have been given as to the outcomes of these treatments.

FINANCIAL POLICY

1. **Payment Due at Time of Service**
   For patients with an office visit copay, without participating insurance, or receiving cosmetic services:
   - Payment is due at the time of service. Accepted forms of payment: cash, checks, credit cards.
   - A $25 fee will apply for returned checks.
2. **Outstanding Balances**
   - Any existing balance on your account must be paid at the time of your appointment.
3. **Insurance Claims**
   - Our office will submit claims to your insurance as a courtesy.
   - You are responsible for knowing your insurance plan's deductible, co-insurance, copay, and covered services. Any amounts not covered by your plan are your responsibility.
4. **Missed Appointments**
   - If you are unable to keep your scheduled appointment, please contact our office 24 hours in advance. Failure to notify us in advance will result in a $50 no show fee.
5. **Follow-up Visits**
   - Medical treatment may require return visits.
   - Each visit involving treatment or procedures will incur additional charges.
6. **Scheduled Surgeries**
   - A down payment will be required for any portion of your deductible that has not yet been met. Our staff will contact you prior to your surgery to discuss what amount will be due.
7. **Managed Care Plans & Referrals**
   - You must review your insurance plan's requirements for referrals.
   - Referrals typically require prior authorization and may take several days; we cannot accommodate last-minute requests.
   - Obtaining referrals is your responsibility; failure to do so may result in out-of-pocket costs.
8. **Minor Patients & Divorced Parents**
   - The parent or guardian accompanying a child is responsible for payment at the time of service, regardless of custody or coverage arrangements.
   - We can provide statements for reimbursement purposes.
9. **Insurance & Financial Questions**
   - Physicians are not insurance experts. Your doctor is here to manage your medical care.
   - Please speak with our business office regarding any financial or insurance concerns.
10. **Financial Hardship**
    - If you are experiencing financial difficulties, please speak with our staff to discuss payment arrangements.
    - Accounts past due more than 60 days may be referred to a collection agency and a service fee of $50 will be added to your unpaid account.

Acknowledgement

I have read and fully understand the information provided above. I agree to the terms and conditions set forth regarding my medical examination, treatment, and financial responsibility.

Patient's Name (Print):_____

Signature of Patient or Guardian: _____**Date:**_____

Relationship to Patient: _____**Witness** _____**Date**:_____