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**Patient Information**

Patient's Name: \_\_\_\_\_ SS#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone Number: (preferred) \_\_\_\_\_ (cell) \_\_\_\_\_

Appointment Reminders: \_\_\_ Phone Call **OR** \_\_\_ Text Message

Referred by: \_\_\_\_\_ Primary Care Physician: \_\_\_\_\_

Employer Name: \_\_\_\_\_ Tel#: \_\_\_\_\_ Occupation: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Tel#: \_\_\_\_\_ Relationship: \_\_\_\_\_

Personal Email address: \_\_\_\_\_

\*\*\*Please provide your email address to access your own personal **patient web portal**. This will give you the opportunity to view your medical records via the internet as well as reminders for any future appointments.

How did you hear about us? Referred \_\_\_ Internet \_\_\_ Friend \_\_\_ Phone Book \_\_\_ Insurance Company \_\_\_ Other \_\_\_

**Pharmacy Information**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

Address/Location: \_\_\_\_\_



## **REASON FOR TODAY'S VISIT:**

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❖ **Have you had or do you currently have any of the following medical conditions:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Lung Cancer          |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> Hearing Loss        | <input type="checkbox"/> Lymphoma             |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> MRSA                 |
| <input type="checkbox"/> Atrial Fibrillation    | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> HIV/AIDS            | <input type="checkbox"/> Prostate Cancer      |
| <input type="checkbox"/> Breast Cancer          | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Colon Cancer           | <input type="checkbox"/> Thyroid Disorder    | <input type="checkbox"/> Seizures             |
| <input type="checkbox"/> COPD                   | <input type="checkbox"/> Heart attack        | <input type="checkbox"/> Stroke               |
| <input type="checkbox"/> Heart Disease          | <input type="checkbox"/> Immunosuppression   | <input type="checkbox"/> Heart Valve Replaced |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Diabetes            | Other: _____                                  |

Are you currently: Pregnant: Yes / No Planning Pregnancy: Yes / No Breast Feeding: Yes / No

Have you had any surgeries? (including joint replacement and heart valve surgeries)

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Medications: (including over the counter)

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Drug Allergies: (including reaction)

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Do you have or have had any of the following skin conditions?

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Acne                    | <input type="checkbox"/> Eczema                 | <input type="checkbox"/> Precancerous Moles             |
| <input type="checkbox"/> Actinic Keratosis       | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Psoriasis                      |
| <input type="checkbox"/> Basal Cell Carcinoma    | <input type="checkbox"/> Hay Fever/Allergies    | <input type="checkbox"/> History of Blistering Sunburns |
| <input type="checkbox"/> Squamous Cell Carcinoma | <input type="checkbox"/> Melanoma Skin Cancer   | <input type="checkbox"/> Dry Skin                       |

Do you have a family history of melanoma or other skin cancers? \_\_\_Yes\_\_\_No

If yes, which relative? What type of skin cancer? \_\_\_\_\_

Smoking Status:

- Current Every Day Smoker  
 Current Some Day Smoker  
 Former Smoker  
 Never Smoked

Alcohol Consumption:

- None  
 Socially  
 Moderate  
 Daily



## Information and Assignment of Benefits

As a courtesy to you, we will file your insurance claims on your behalf. We encourage everyone to understand the coverage your insurance provides for professional services. We will do our best to estimate what your insurance company will pay based on information provided by you and your insurance company. Estimates are **NOT GUARANTEED**. Payments for services rendered are expected upon checking out today.

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original. I hereby authorize Dr. Adam S. Pritzker to apply for benefits on my behalf for covered services rendered by him or by his order. I request that payment from my insurance company be made directly to Dr. Pritzker. I certify that the information I have reported with regard to my insurance coverage is correct. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

**Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_



**Acknowledgement of Review of  
Notice of Privacy Practices**

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

\_\_\_\_\_  
**Signature of Patient or Personal Representative**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Name of Patient or Personal Representative**

\_\_\_\_\_  
**Description of Personal Representative's Authority.**



\*\* I authorize Savannah Dermatology Clinic, P.C. to disclose my health care and diagnostic information to the **person** (relative, caregiver or friend) listed below:

**My medical records (e.g. biopsy results) may be released to:** \_\_\_\_\_

**Signature of Patient:** \_\_\_\_\_

**Date:** \_\_\_\_\_



## Patient Financial Policy

We regard your complete understanding of your financial responsibilities as an essential element of your care and treatment. Please review and carefully read the policies outlined below. Read each line, to assure that you are familiar and understand our policy in full. If you have any questions, please discuss them with a member of our staff.

1. Unless other arrangements have been made in advance, full payments of co-pays, coinsurance, and deductibles are **due at the time of service**. This includes, but not limited to, your office visit and any additional procedures that were done at the time of service (e.g. biopsies, removal/treatment of benign lesions, surgeries and cosmetic procedures, etc.). In the event we over collect, we will voluntarily refund your overpayment.
2. This office participates with a number of health insurance providers. To see if your plan is listed among these, please contact our office staff. If we are out of network with your particular plan, **you will be responsible for payment in full** and we can provide you with a form so that you may file a claim with your insurance carrier.
3. All insurance plans are not the same and do not cover the same services. In the event your insurance plan determines the service to be "not covered," **you will be responsible in full for the remaining balance**. Any disallowed charges are due upon receipt of a statement from our office. If you are unsure of your plan benefits, please contact your insurance company.
4. If your insurance company requires a **referral**, you must obtain this from your primary physician prior to your appointment. This is a requirement of your insurance carrier and we must follow these rules to ensure that you get the full benefits to which you are entitled. If you have any questions regarding the regulations your carrier has, contact your employer's human resources department or your insurance carrier directly.
5. **Collections**: Failure to pay balance in full or arrange payment on your account for a period of 90 (ninety) days will result in your account being turned over to an outside collection agency. Additional collection costs/fees will be added to your account in this instance and you will be financially responsible for additional collection fees.
6. If your insurance company sends you a check for services provided by Pritzker Dermatology, P.C., you must turn over the check to our office or pay us immediately. If there is no receipt of payment, your account will go to an outside collection agency.

**By signing below, I agree that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I am providing consent to participate in Text2Pay for outstanding patient balances. I also understand and agree that such terms may be amended periodically by this practice.**

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**Signature of Patient  
(or responsible party if a Minor)**

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**Date**



### Credit Card on File Authorization

Pritzker Dermatology, P.C. DBA Savannah Dermatology Clinic, P.C. **offers** a Credit Card on File program as a convenient method of paying for the portion of your services that are patient responsibility such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure. **This program is optional.**

**I (we), the undersigned, authorize and request that Pritzker Dermatology, P.C. DBA Savannah Dermatology Clinic, P.C. charge my credit card for the balance due that my health plan has identified as my financial responsibility.** This authorization relates to all charges not covered by my insurance company for services provided to me by Pritzker Dermatology, P.C. DBA Savannah Dermatology Clinic, P.C.. My card will remain securely stored for future use by Open Edge via EClinicalWorks, a secure credit card processor affiliated with Global Payments Merchant's Services that partners with Pritzker Dermatology, P.C. DBA Savannah Dermatology Clinic, P.C. to collect payments. This authorization will remain in effect until revoked by me in writing.

Patient's chart # \_\_\_\_\_ Patient's name: \_\_\_\_\_ DOB: \_\_\_\_\_

By signing below, I agree to keep my credit card on file and charge my account to pay for charges not paid by my insurance plan.

Charge limits: Balances exceeding \$\_\_\_\_ require verbal authorization from me. Charges under this amount require no further authorization.

**Patient/Guardian signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

*Credit card information:*

Card type: Amex Visa Mastercard Discover

Is this card a Flexible Spending/Health Savings card? Yes No

Card number ending in(last 4 digits) : \_\_\_\_\_ Expires: \_\_\_\_\_

Cardholder name: \_\_\_\_\_

Card's bill to address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Contact phone: \_\_\_\_\_

Transaction type: AUTHORIZATION

Email receipt to \_\_\_\_\_ @ \_\_\_\_\_ or  mail receipt

Authorization received by: \_\_\_\_\_ Date: \_\_\_\_\_



## **Credit Card on File Policy**

Pritzker Dermatology, P.C. DBA Savannah Dermatology Clinic, P.C offers a Credit Card on File program as a convenient method of paying for the portion of your services that your insurance policy requires you to pay such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure. This policy has been implemented to simplify and enhance your patient experience, and to simplify our business operations.

### **Q & A about Credit Card on File**

**How does this work?** At patient registration we will ask you to sign a credit card on file agreement. As part of the agreement you will be able to set a maximum to be charged to your card. Charges that exceed this maximum require verbal authorization from the card holder prior to processing payments. At checkout, fees due at the time of service will be paid using the card on file unless you elect to pay by an alternative method.

**What are the benefits to me?** You can use your credit card on file to pay for copays, coinsurance, and deductibles at future visits. It will make checkout easier, faster, and more efficient.

**What if I don't have a credit card?** It is our policy that payment is due at the time of service. You may also keep your Health Savings Account (HSA) or Flex Spending Account (FSA) credit cards on file. If you do not have either of these types of cards, then you can use a debit or credit card. We accept Visa, Mastercard, American Express, and Discover.

**How can I be assured that my credit card information will remain safe?** We are under the strict rules and guidelines of Payment Card Industry (PCI) Compliance, and HIPAA Compliance to protect patient privacy and credit card information is considered protected health information. Open Edge, our credit card processing vendor, will store your information on a secure and encrypted site, which will enable us to run bank card transactions on our computer system. Our employees will not have access to your bank card.

**Is it required?** This policy has been implemented to simplify and enhance your patient experience, and to simplify our business operations. This is an optional program and it is not required to store a card on file. Although this is not required, it is our policy that all copay's, co-insurance and deductibles are collected in full at the time of service.

Effective 3/2024