JOHANNA FANGMEYER, CRNP
1101 OPAL COURT, Suite 315A
HAGERSTOWN, MD 21740

Hagerstown DERMATOLOGY & SKINCARE
Experience. Excellence. Expertise.

PATIENT DEMOGRAPHICS TODAY'S DATE: _____

Patient Name: _____ Gender: _____ DOB: _____

Marital Status: ❑ Married ❑ Single ❑ Widowed ❑ Divorced

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone _____ ❑ Preferred Phone
Work Phone _____ ❑ Preferred Phone
Cell Phone _____ ❑ Preferred Phone

Email: _____ SSN: _____

Occupation: _____ Employer: _____

REFERRAL INFORMATION:

Referred to us by (please check one box):

❑ Dr: _____ ❑ Internet/Google ❑ Hospital

❑ Family ❑ Friend ❑ Close to home/work ❑ Insurance Plan ❑ Other_____

Primary Care Physician: _____

RECORDS RELEASE:

I authorize the release of pertinent medical information to my primary care physician or referring provider and to consultants as necessary. I authorize the release of any necessary medical information in an effort to process insurance claims, insurance applications, and prescriptions.

Signature: _____ Date: _____

TELEPHONE INFORMATION & COMMUNICATION RELEASE:
May we leave personal medical information in a detailed voicemail? Yes No
If yes, please check where: HOME CELL WORK
May we use email and/or text messaging for appointment reminders? YES NO
Preferred e-mail and/or text number: _____
Do we have permission to discuss your medical information with any family member? YES NO

Name Phone Relationship to Patient

Patient Signature Date

FINANCIAL DISCLOSURE POLICY

Thank you for choosing Hagerstown Dermatology and Skin Care. In order for us to have complete understanding of our financial policies, we have the following protocols in place. If you have questions, please contact our front desk manager for further assistance. We are committed to providing the best care to you and your understanding of the following protocols is essential to that goal.

- As of December 1st, 2019 Hagerstown Dermatology has terminated all contracts with commercial and government insurance carriers including Medicare. We can no longer bill insurance of any kind. Our practice is now a “cash only” or “self-pay” and all fees will need to be paid on the date of service. The self-pay amounts cover only the professional services provided by Johanna Fangmeyer, CRNP. You are financially responsible for all ancillary services, for example laboratory including biopsies. You will receive a separate bill from the facility that processed your ancillary testing.

- If you have out of network benefits, we can provide you with your receipt of payment and office visit codes to submit for possibly reimbursement. It is the patient responsibility to find out your insurance out of network benefits.

CANCELLATION POLICY

We ask that you give us a 24 hour notice if cancellation is necessary. If you cancel or no show for your appointment less than 24 hours of your scheduled appointment the following will be applied:

- **$25 charge for missed office visits**
- **$100 charge for missed surgery or procedure appointments**

These fees are not covered by your insurance company.

PAYMENT POLICY

- By my signature below, I acknowledge that I have read and understand the above and understand that I am financially responsible for all the charges and will remit payment on the date of services.

Patient’s Name: (First, Middle, Last): _____DOB: _____

Signature: _____ **Date:** _____

Please check here if you are interested in receiving more information about:

☐ Chemical Peels
☐ Skin Care/Anti-Aging Products
☐ Sun Protection/Sunscreens
☐ Treatment of Excessive Underarm Sweating
☐ Wrinkle relaxers (Botox, Dysport)
☐ Spider Veins on the legs (Sclerotherapy)
☐ Wrinkle fillers (Restylane, Juvederm)

What is the reason for today's visit?

What part(s) of the body is/are affected? Describe any associated symptoms (e.g. itching, burning, bleeding, etc.).

For how long? _____ ☐ Year(s) ☐ Month(s) ☐ Day(s)
What treatments have you already tried and what were the outcomes?

Pharmacy Name: _____

Pharmacy Street Address: _____

Past Medical History

SELECT ANY OF THE FOLLOWING MEDICAL CONDITIONS THAT YOU CURRENTLY HAVE. IF NONE, SELECT NONE

☐ Anxiety	☐ Hearing Loss
☐ Arthritis	☐ Hepatitis
☐ Asthma	☐ Hypertension
☐ Atrial Fibrillation (Irregular heart beat)	☐ HIV/AIDS
☐ Blood Clots or Clotting Disorder	☐ Hypercholesterolemia
☐ BPH	☐ Hyperthyroidism
☐ Breast Cancer	☐ Hypothyroidism
☐ Bronchitis	☐ Leukemia
☐ Cancer _____	☐ Lung Cancer
☐ COPD	☐ Lupus
☐ Coronary Artery Disease	☐ Lymphoma
☐ Depression	☐ Prostate Cancer
☐ Diabetes	☐ Radiation Treatment
☐ End Stage Renal Disease	☐ Seizures
☐ GERD/Esophageal Reflux	☐ Stroke
☐ Other _____	☐ None

Patient Name: _____

Past Surgical History

HAVE YOU HAD ANY SURGERIES ON THE FOLLOWING ORGANS? IF NONE, SELECT NONE

☐ Appendix (Appendectomy)	☐ Kidney: Kidney Stone Removal
☐ Bladder (Cystectomy)	☐ Kidney: Kidney Transplant
☐ Breast: Breast Biopsy	☐ Kidney: Nephrectomy
☐ Breast: Lumpectomy (Both Breasts)	☐ Liver: Hepatectomy
☐ Breast: Lumpectomy (Left Breast)	☐ Liver: Liver Transplant
☐ Breast: Lumpectomy (Right Breast)	☐ Liver: Shunt
☐ Breast: Mastectomy (Both Breasts)	☐ Ovaries (Oophorectomy): Endometriosis
☐ Breast: Mastectomy (Left Breast)	☐ Ovaries (Oophorectomy): Ovarian Cyst
☐ Breast: Mastectomy (Right Breast)	☐ Ovaries: Tubal Ligation
☐ Colon (Colectomy): Colon Cancer Resection	☐ Pancreas: Pancreatectomy
☐ Colon (Colectomy): Diverticulitis	☐ Prostate (Prostatectomy): Prostate Biopsy
☐ Colon (Colectomy): Inflammatory Bowel	☐ Prostate (Prostatectomy): Prostate Cancer
☐ Colon: Colostomy	☐ Prostate (Prostatectomy): TURP
☐ Gallbladder (Cholecystectomy)	☐ Rectum: APR
☐ Heart: Biological Valve Replacement	☐ Rectum: Low Anterior Resection
☐ Heart: Coronary Artery Bypass Surgery	☐ Skin: Basal Cell Carcinoma
☐ Heart: Mechanical Valve Replacement	☐ Skin: Melanoma
☐ Heart: PTCA	☐ Skin: Skin Biopsy
☐ Joint Replacement: Hip (Both)	☐ Skin: Squamous Cell Carcinoma
☐ Joint Replacement: Hip (Left)	☐ Spleen (Splenectomy)
☐ Joint Replacement: Hip (Right)	☐ Testicles (Orchiectomy)
☐ Joint Replacement: Knee (Both)	☐ Tonsillectomy
☐ Joint Replacement: Knee (Left)	☐ Uterus (Hysterectomy): Fibroids
☐ Joint Replacement: Knee (Right)	☐ Uterus (Hysterectomy: Uterine Cancer
☐ Kidney: Kidney Biopsy	☐ Uterus (Hysterectomy): Cervical Cancer
☐ NONE	☐ Other: _____

Skin Disease History

HAVE YOU HAD ANY OF THE FOLLOWING SKIN CONDITIONS

☐ Acne	☐ Flaking or Itchy Scalp
☐ Actinic Keratoses	☐ Hay Fever/Allergies
☐ Asthma	☐ Melanoma
☐ Basal Cell Skin Cancer	☐ Poison Ivy, Rashes
☐ Blistering Sunburns	☐ Precancerous Moles
☐ Cold Sores	☐ Psoriasis
☐ Dry skin	☐ Squamous cell skin cancer
☐ Eczema	☐ NONE
☐ Other _____	

DO YOU WEAR SUNSCREEN? ☐ Yes ☐ No

IF YES, WHAT SPF? _____ AND HOW OFTEN? ☐ Daily ☐ Occasionally ☐ Only at the Beach

DO YOU TAN IN A TANNING SALON? ☐ Yes, Currently ☐ Yes, In the past ☐ No, Never

If Yes, for how long and how often? _____

Family History

DO YOU HAVE A FAMILY HISTORY OF SKIN CANCER? ☐ Yes ☐ No

IF YES, WHAT TYPE? ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Melanoma

WHICH RELATIVE? _____

Patient Name: _____

Medications

DO YOU TAKE ANY MEDICATIONS, VITAMINS, SUPPLEMENTS OR BIRTH CONTROL?

☐ YES ☐ No If Yes, please list below

PATIENT MEDICATIONS

Please list medications you take currently, including over-the-counter and prescription medications

Name	Dosage	Route (e.g. by mouth)	Frequency

☐ Check here if medications list attached

ARE YOU ALLERGIC TO ANY MEDICATIONS? ☐ Yes ☐ No
If yes, please list below:

Allergen	Reaction

SMOKING STATUS

☐ Current every day smoker
☐ Current some day smoker (cigarette)
☐ Current some day smoker (tobacco)
☐ Former smoker
☐ Never smoker
☐ Heavy tobacco user
☐ Light tobacco user

START SMOKING _____ QUIT SMOKING _____
MM/DD/YYYY MM/DD/YYYY
NUMBER OF PACKS PER DAY _____
TOTAL YEARS SMOKING _____

SOCIAL HISTORY DETAILS

☐ Not sexually active
☐ Sexually active with one partner
☐ Sexually active with more than one partner
☐ Same sex partner
☐ Drug use
☐ IV Drug use
☐ Other: _____

☐ No alcohol use
☐ Less than 1 drink per day
☐ 1-2 drinks per day
☐ 3 or more drinks per day

☐ Patient feels safe at home
☐ Patient feels unsafe at home

FAMILY HISTORY

Please indicate if you have a family history of any of the following and include which blood relative (mother, son, uncle etc.)

	Relative		Relative
☐ Acne	_____	☐ Lupus	_____
☐ Allergies/Hay fever	_____	☐ Multiple Sclerosis	_____
☐ Eczema	_____	☐ Psoriasis	_____

Patient Name: _____

REVIEW OF SYSTEMS **Are you currently experiencing any of the following? Check yes or no**

Symptom	Yes	No
Problems with bleeding	☐	☐
Problems with healing	☐	☐
Problems with scarring	☐	☐
Rash	☐	☐
Immunosuppression	☐	☐
Hay Fever	☐	☐
Chest Pain	☐	☐
Fever or chills	☐	☐
Night sweats	☐	☐
Unintentional weight loss	☐	☐
Thyroid problems	☐	☐
Sore throat	☐	☐
Blurry vision	☐	☐
Abdominal pain	☐	☐
Bloody stool	☐	☐
Bloody urine	☐	☐
Joint aches	☐	☐
Muscle weakness	☐	☐
Neck stiffness	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Cough	☐	☐
Shortness of breath/wheezing	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Alert	Yes	No
Allergy to adhesive	☐	☐
Allergy to latex	☐	☐
Allergy to lidocaine	☐	☐
Allergy to topical antibiotic ointments	☐	☐
Artificial heart valve	☐	☐
Artificial joints within past 2 years	☐	☐
Blood thinners	☐	☐
Defibrillator	☐	☐
MRSA	☐	☐
Pacemaker	☐	☐
Premedication prior to procedure	☐	☐
Rapid heartbeat with epinephrine	☐	☐
Pregnancy or planning a pregnancy	☐	☐
Currently Breastfeeding	☐	☐

Hagerstown Dermatology and Skincare

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a "friendly" version. A more complete text is posted in the office. What this is all about: specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services at www.hhs.gov.

We have adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, and health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.
2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.
3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.
4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.
5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.
6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods, or services.
7. We agree to provide patients with access to their records in accordance with state and federal laws.
8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.
9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ on _____/____/_____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

Hagerstown DERMATOLOGY & SKINCARE
Experience. Excellence. Expertise.

COSMETIC & ESTHETICIAN SERVICES FINANCIAL POLICY

Because we provide elective cosmetic procedures at Hagerstown Dermatology & Skincare and The Olney Skin Suite these services must be paid in full at the time of service. We will not submit these services to your medical insurance provider. If you have a question about if a service will be billed to your insurance, please ask our staff prior to your treatment.

PAYMENT OPTIONS

Payment for all cosmetic procedures and esthetician services is due at the time of the treatment. For specially packaged or grouped treatments, payment for the entire package is due at the time of the first scheduled treatment. **We require $100 deposit for certain procedures such as filler. In the event a no show occurs, this deposit is non-refundable.**

ACCEPTED FORMS OF PAYMENT

For cosmetic procedures and esthetic services we accept **cash or major credit cards.** We do **not** accept checks or CareCredit. We do accept Cherry, which is a financing option. Please ask the front desk about this option!

CANCELLATIONS

We understand that a situation may arise that could force you to cancel or postpone your treatment. Please understand that such changes affect not only our staff but our other patients as well, and we therefore request your courtesy and concern. If you need to cancel your appointment, please allow 48-24 hours to notify us of the cancellation. A pattern of missed visits without notice may result in discharge from the practice as well as incurring a $100 missed appointment fee. If there is a no show, please be advised you may be asked to put $100 deposit down to reserve your next appointment.

SATURDAY ESTHETICIAN SERVICES PAYMENT POLICY

Johanna Fangmeyer CRNP and the esthetician offers cosmetic appointment times one Saturday each month as a convenience to patients who have scheduling challenges. As these are very desirable appointments, payment in full for the basic service to be provided is due when scheduling your appointment. If additional services or add-ons are decided on at the time of treatment, that amount will be due on the day of treatment.

THERE CAN BE NO REFUNDS FOR SERVICES ALREADY PROVIDED

In the event that a package or series of treatments is initiated, these services will be considered rendered even though the full series may not have been completed. Should you wish to discontinue your treatment before a package is completed, credit for unused treatments at the discounted package price may be extended to be used to purchase other treatments or products. There are no refunds for products or services. Packages must be used within the parameters set forth by the provider to insure optimal results. Package treatments not used according to these guidelines risk forfeiture of remaining treatments in package.

COMPLICATIONS

The practice of medicine is not an exact science, and cosmetic treatments are the practice of medicine. Although favorable results are anticipated, there can be no guarantee or warranty, expressed or implied, by anyone as to your actual results. Occasionally, additional treatments and/or follow-up for complications may be required. This could result in additional charges for which you may be responsible.

MONTHLY SPECIALS, EVENTS, GIFT CARDS, & PRIZES

Monthly specials must be used within 30 days of purchase date unless otherwise noted. Pricing for monthly specials & events is already at a discounted price and may not be combined with other discounts. Payment in full for event pricing is due on the day of the event and monthly specials must be paid for by the end of the month in which the special was offered. Purchased gift cards must be used within one year of the purchase date. Gift cards for prizes won in the office must be used within 4 months of the date issued.

***These Financial Policies are subject to change without notice. If you have any questions or need assistance with any financial matters relating to your treatment, please contact our office for help.**

I agree to the above mentioned policies.

Signature:_____

Date:_____