WESSON
DERMATOLOGY

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WESSONDERMATOLOGY.COM

Insurance & Financial Policies

Please know that while we contract with a variety of insurance carriers and work with them on your behalf to utilize the benefits from your specific plan, a coverage determination, prior authorization or certification that is made prior to a service being performed is not a promise for your carrier to pay for the service at any particular rate or amount. Your specific summary plan describes your benefits and governs the amount payable. Every claim submitted is subject to your specific plan provisions, including but not limited to; eligibility requirements, co-insurance, deductibles, exclusions, limitations and applicable state mandates. Please be informed that you are responsible for any balances due to us that your insurance carrier permits us to collect for your treatment.

Copays: Copays are due and payable on the date of service. Any fees related to a deductible or coinsurance will be assessed after the bill is submitted to your insurance company and will become your responsibility upon receipt of the statement. You may be billed separately for any lab work performed by an outside facility.

Referral Requirement: If your insurance plan requires you to obtain a referral from your primary care physician for you to see a dermatologist, it is your responsibility to submit a valid, unexpired referral prior to your visit. Without such referral, you may pay out of pocket or reschedule your appointment. You may incur a $25 missed appointment/re-scheduling fee.

Assignment of Benefits: I authorize payment of any Medicare benefits or commercial insurance claim benefits to Wesson Dermatology, P.C. or the physician indicated on the claim.

Release Information: I authorize Wesson Dermatology to release any information necessary to insurance carriers regarding my illness and treatments in order to process insurance claims generated in the course of examination or treatment.

I have requested services on behalf of myself and/or my dependents, and understand that by making this request, I become fully financially responsible for any and all charges incurred in the course of the treatment authorized.

Cancellation Policy

To reschedule or cancel appointments, please call within 48 hours to avoid being subject to a $25 missed appointment fee. Late arrivals may result in re-scheduling. Refer to additional appointment policies and procedures in this packet.

Skin Cancer Screenings

It is recommended that a dermatologist examine your entire skin surface yearly, thus extending, but not replacing a complete physical examination by your primary care physician. Please inform our staff if you would like to schedule a skin cancer screening exam. Please note that due to the comprehensive nature of this exam, no other procedures are performed during this type of visit.

Pregnancy

Many oral and topical medications are unsafe for use during pregnancy. Please inform the doctor if you are pregnant, breastfeeding, planning or become pregnant at any time while under the care of Wesson Dermatology.

I have read and understand the above-stated policies of Wesson Dermatology, P.C. before signing and will hereby comply in all respects.

Printed Name: _____

Signature: _____ Date: _____

Parent signature, if minor: _____ Date: _____

Patient Information

First _____ Last _____ Date of Birth _____

Sex ☑ Male / ☐ Female Social Security # _____ Marital Status _____

Address _____ City _____ Zip Code _____

Employer _____ Occupation _____

Home Phone _____ Responsible Party:

Work Phone _____ Name _____

Cell Phone _____ Relationship _____

E-Mail _____ Date of Birth _____

Preferred Method of Contact: ☐ Home ☐ Work ☐ Cell Referred By: ☐ Insurance ☐ Friend ☐ Internet

Background Information

Race:
- ☐ American Indian
- ☐ Asian
- ☐ African American
- ☐ Caucasian

Other: _____

Primary Language:
- ☐ Chinese
- ☐ English
- ☐ Hindi
- ☐ Spanish

Other: _____

Ethnicity:
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino

☐ Refuse to Report

Primary Care Physician

Physician _____ Phone _____

Referring Physician

Physician _____ Phone _____

Would you like us to send them a summary of today's visit? ☐ Yes ☐ No ☐ Not Referred

Pharmacy

Prescriptions are sent electronically as mandated by NY State. Please indicate a preferred pharmacy below.

- Please know that due to patient schedules, we process your prescription within 24 hours.
  Refills: Doctor's approval is required. Refill requests are reviewed at 12 PM each day, Monday-Friday.
- Note: Requests received after 12 pm will be processed the next business day.
  Note: This process cannot be expedited as the doctor is with patients throughout the day.
  Note: If the prescribed medication does not resolve the condition in its entirety, or the patient has not been seen within 6 months the doctor will recommend the patient to follow up before refilling a prescription.
  Absolutely no prescriptions will be refilled if a patient has not been seen within 12 months. Certain medications will not be refilled without a follow-up visit.

Name _____

Address _____ City / Zip Code _____

MEDICATIONS

DRUG ALLERGIES

SKIN DISEASE HISTORY

	Y	N
Acne	☐	☐
Actinic Keratosis	☐	☐
Asthma	☐	☐
Basal Cell Skin Cancer	☐	☐
Blistering Sunburns	☐	☐
Dry Skin	☐	☐
Eczema	☐	☐
Flaking / Itchy Scalp	☐	☐
Hay Fever / Allergies	☐	☐
Melanoma	☐	☐
Poison Ivy	☐	☐
Precancerous / Dysplastic Moles	☐	☐
Psoriasis	☐	☐
Squamous Cell Skin Cancer	☐	☐

Other: ☐

	Y	N
Do you wear sunscreen?	☐	☐
Do you visit a tanning salon?	☐	☐

Social History:

Smoking Status
- ☐ Current
- ☐ Former
- ☐ Never

Alcohol Consumption
- ☐ None
- ☐ Less than 1 per day
- ☐ 1 – 2 per day
- ☐ More than 3 per day

REVIEW OF SYSTEMS

	Y	N
Allergy to Adhesive	☐	☐
Allergy to Lidocaine	☐	☐
Allergy to Topical Antibiotics	☐	☐
Blood Thinners	☐	☐
Artificial Heart Valve	☐	☐
Defibrillator	☐	☐
Pacemaker	☐	☐
MRSA	☐	☐
Artificial joints within past two years	☐	☐
Require antibiotics prior to procedures	☐	☐
Rapid heartbeat with epinephrine	☐	☐
Pregnant or planning a pregnancy	☐	☐
Problems with Bleeding	☐	☐
Problems with Healing	☐	☐

	Y	N
Problems with Scarring	☐	☐
Hay Fever	☐	☐
Immunosuppression	☐	☐
Fever or Chills	☐	☐
Unintentional Weight Loss	☐	☐
Thyroid Problems	☐	☐
Sore Throat	☐	☐
Blurry Vision	☐	☐
Abdominal Pain	☐	☐
Muscle Weakness	☐	☐
Joint Aches	☐	☐
Headaches	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Past Medical History

	Y	N		Y	N
Anxiety	☐	☐	Hepatitis	☐	☐
Arthritis	☐	☐	Hypertension	☐	☐
Asthma	☐	☐	HIV / AIDS	☐	☐
Atrial Fibrillation	☐	☐	Hypercholesterolemia	☐	☐
Bone Marrow Transplant	☐	☐	Hyperthyroidism	☐	☐
Benign Prostatic Hyperplasia	☐	☐	Hypothyroidism	☐	☐
Breast Cancer	☐	☐	Leukemia	☐	☐
Colon Cancer	☐	☐	Lung Cancer	☐	☐
COPD	☐	☐	Lymphoma	☐	☐
Coronary Artery Disease	☐	☐	Prostate Cancer	☐	☐
Depression	☐	☐	Radiation Treatment	☐	☐
Diabetes	☐	☐	Seizures	☐	☐
End Stage Renal Disease	☐	☐	Stroke	☐	☐
GERD	☐	☐	Other:		
Hearing Loss	☐	☐			

Past Surgeries

	Y	N		Y	N
Appendix: Appendectomy	☐	☐	Liver: Transplant	☐	☐
Bladder: Cystectomy	☐	☐	Liver: Shunt	☐	☐
Breast: Biopsy	☐	☐	Ovaries: Endometriosis	☐	☐
Breast: Lumpectomy [L / R] Left	☐	☐	Ovaries: Ovarian Cancer	☐	☐
Breast: Mastectomy [L / R] Left	☐	☐	Ovaries: Ovarian Cyst	☐	☐
Colon: Cancer Resection	☐	☐	Ovaries: Tubal Ligation	☐	☐
Colon: Diverticulitis	☐	☐	Pancreas: Pancreatectomy	☐	☐
Colon: Inflammatory Bowel Disease	☐	☐	Prostate: Biopsy	☐	☐
Colon: Colostomy	☐	☐	Prostate: Cancer	☐	☐
Gallbladder: Cholecystectomy	☐	☐	Prostate: TURP	☐	☐
Heart: Biological Valve Replacement	☐	☐	Rectum: APR	☐	☐
Heart: Coronary Artery Bypass	☐	☐	Rectum: Low Anterior Resection	☐	☐
Heart: Heart Transplant	☐	☐	**Skin: Biopsy**	☐	☐
Heart: Mech. Valve Replacement	☐	☐	**Skin: Basal Cell Carcinoma**	☐	☐
Heart: PTCA	☐	☐	**Skin: Squamous Cell Carcinoma**	☐	☐
Joint Replacement: Hip [L / R]	☐	☐	**Skin: Melanoma**	☐	☐
Joint Replacement: Knee [L / R] Left	☐	☐	Spleen: Splenectomy	☐	☐
Kidney: Biopsy	☐	☐	Testicles: Orchiectomy	☐	☐
Kidney: Stone Removal	☐	☐	Uterus: Fibroids	☐	☐
Kidney: Transplant	☐	☐	Uterus: Uterine Cancer	☐	☐
Kidney: Nephrectomy	☐	☐	Uterus: Cervical Cancer	☐	☐
Liver: Hepatectomy	☐	☐	Other: _____		

Family History

	Y	N		Y	N
Adopted	☐	☐	Eczema	☐	☐
Diabetes: Type 1 / 2	☐	☐	Melanoma	☐	☐
Hair Loss: Alopecia	☐	☐	Psoriasis	☐	☐

Relationship (first-degree only): ☐

PATIENT PORTAL GUIDE

PLEASE KEEP THIS SHEET FOR YOUR RECORDS

You will receive an email to activate your patient portal.
(If you do not receive it by the end of the day, please contact our office.)
What can I use my patient portal for?

- **Access biopsy results**
- **Change pharmacy**
- **Update personal health records**

You can contact our medical staff directly regarding:

- **General medication concerns**
- **Medication refill requests**
- **Prior authorizations**

Note: When leaving messages for the medical assistants, be as specific as possible

All messages will be answered by the end of the business day

Biopsy results should be available on the portal within 3 weeks of your procedure. If your biopsy results are not posted, please call the office for further information.

LOGIN INFORMATION:

URL: **wessonderm.ema.md**

USERNAME: The email address that you provided on this intake form.

PASSWORD: _____

HOW TO ACCESS TO TEST RESULTS:
Click on "Visit Info"
Click on "Test and Results"

HOW TO CHANGE PHARMACIES:
Click on "Patient Info"
Click on "Insurance and Pharmacy"
Click on "Add Pharmacy"

HOW TO MESSAGE **MEDICAL ASSISTANTS**:
Click on "Contact Us"
Click on "New Message"

Options:
Prior Authorizations
Medications: Dr. Wesson
Medications: Dr. Brisman

Note: Make sure to indicate the pharmacy as the default pharmacy if you want your medications prescribed there.

HIPAA

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act (HIPAA). This law prohibits any staff member from Wesson Dermatology, P.C. from discussing appointments, medications, treatment plans, or test results with anyone other than the patient unless specified.

I understand that if I ever wish to revoke the right of a personal representative to access my health information on my behalf, I must notify Wesson Dermatology, P.C. in writing that the individual is no longer my representative. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

If you would like to permit someone to discuss your medical condition, biopsy results, and medications or confirm appointments, please indicate their name(s) below.

Name	Relationship

I permit Wesson Dermatology, P.C. to provide my health information, including access to biopsy results and billing information, to the above listed individuals on my behalf:

Patient Printed Name: _____

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
PATIENT ACKNOWLEDGE OF RECEIPT OF NOTICE

I hereby acknowledge that I have received and reviewed Wesson Dermatology, P.C. Notice of Privacy Practices.

Patient Printed Name: _____

Patient Signature: _____ Date: _____