MISSISSIPPI DERMATOLOGY ASSOCIATES

Patient Update Forms

Patient Name: _____

PHARMACY:_____ **CITY:**_____ **LOCATION:**_____

Have you had in the past, or are you presently having a problem with:

Condition	Y	N	Condition	Y	N	Condition	Y	N
Eczema			Psoriasis			Atypical Moles		
Basal Cell Carcinoma			Squamous Cell Carcinoma			Melanoma		

Please list any other history of skin conditions: _____

_____

Any changes in health status since last visit? Yes □ No□

If yes, please list:_____

Have you had surgery in the last three years? Yes□ No□

If yes, please list:_____

Do you have allergies to any drugs, food, ointments, creams, make-up, Jewelry Yes □ No□

If yes, please list:_____

Are you currently taking Aspirin daily? Yes□ No□

Are you currently taking a blood thinner daily? Yes□ No□ If yes, list: _____

Are you taking any other medications daily? Yes□ No□ If yes, please list:

_____ _____ _____ _____

_____ _____ _____ _____

For patients 65 and older:

Have you received a pneumonia vaccination? □ Yes □ No

Do you have a health care proxy in the event you are unable to make your own medical decisions? □ Yes □ No

Do you have a living will? □ Yes □ No

Which statement(s) best reflects your wishes on advanced care recommendations?

□ Do Not Intubate: I do not wish to have a breathing tube, even if it is necessary to save my life.

□ Do Not Resuscitate: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life.

□ Full Cardiopulmonary Resuscitation: I want full cardiopulmonary resuscitation efforts to be made.

1006 Treetops Boulevard, Suite 101
Flowood, MS 39232

601-939-0005
Fax - 601-936-4949

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NAME: _____ DOB: _____

Cell #: _____Text reminders? Yes ❑ No ❑ Voicemail OK? Yes ❑ No ❑

Home #: _____ Voicemail OK? Yes ❑ No ❑

Work #: _____ Voicemail OK? Yes ❑ No ❑

eMail Address: _____ eMail reminders? Yes ❑ No ❑

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION:

I authorize the office of Mississippi Dermatology Associates to release any information regarding my account, insurance information, laboratory results, and medical reports to the following person(s):

_____ _____

Name of person (other than self) authorized to receive information
Example: father, mother, spouse, child, etc.

For security, please list the authorized person's date of birth

If the patient is a minor, the guardian must sign on behalf of the patient and is allowed to receive any information regarding the patient without any other authorization needed.

AUTHORIZATION FOR SENDING SPECIMENS TO OUTSIDE (REFERENCE) LAB(S):

Many tests performed in our office require specimens to be sent to an outside (reference) lab for further assessment. These tests include certain biopsies and special blood tests. Your insurance may or may not pay for these tests. Your signature below reflects your understanding that if your insurance does not pay in full, you will be billed for the balance from our office and/or the outside (reference) lab(s) that performs these additional tests. Also by signing below you are authorizing Mississippi Dermatology Associates, PLLC. to release your medical and demographic information to these outside (reference) labs. This information will be used by these entities to file your insurance for the services they perform.

INSURANCE BILLING AND FINANCIAL RESPONSIBILITY:

I authorize the release of medical information necessary to process a claim on any insurance policy listed. I hereby assign to and authorize payment directly to this clinic of all benefits payable under such insurance policy. I realize that the insurance benefits may not pay all of the bill, and I agree to pay the difference or the entire bill, if necessary. In the event my account is given to an attorney for collection, I shall pay the reasonable attorney's fee, all court costs, and any expense incurred. Should a judgment be rendered against me, I agree to pay all costs of collection, including the reasonable attorney's fee, all court costs, and expenses incurred.

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

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Medical Appointment Cancellation / No Show Policy

Thank you for trusting your skin care to Mississippi Dermatology Associates, PLLC. When you schedule an appointment with one of our providers we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation / No Show Policy below:

- Effective April 1, 2022, any established patient who fails to show, cancel, or reschedule an appointment within **24 hours** of the scheduled appointment date/time will be considered a No Show and charged a **$30.00 fee**.
- A patient may be **dismissed** from Mississippi Dermatology Associates, PLLC practice after a **third** failure to show, cancel or reschedule within 24 hours of the appointment date/time.
- Any **new patient** who fails to show for their initial visit may not be rescheduled.
- The fee is charged to the patient, not the insurance company, and is due at the time of the patient's next office visit.

You may contact our clinic 24 hours a day, 7 days a week at (601) 939-0005. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message. We send courtesy appointment reminders via phone call, text, and email for appointments. If you do not receive a reminder call or message, the Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee.

I have read and understand the Medical Appointment Cancellation/No Show Policy and agree to its terms.

_____ _____

Signature of Patient or Patient Representative **Patient Name**

_____ _____ _____

Description of Personal Representative Authority Date **Patient Date of Birth**