Cosmetic Laser Surgery
Dermatologic Surgery
Adults and Children

Westerville Dermatology

Kevin B. Karikomi, D.O.
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235 W. Schrock Rd.
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Ph. 614-895-0400
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Welcome To Our Practice

APPOINTMENT DATE: ______________________________ AM PM

□ **Kevin Karikomi, D.O.** □ **Rosina Lin, M.D.**

□ **Heidi Bermudez, P.A.** □ **Julie Fetch, P.A.**

We have enclosed the initial paperwork that needs to be completed for a new or previous patient. Please fill this out. You can then mail or fax ahead of time or you can bring with you when you come for your appointment. Please arrive 15 min ahead of your appointment time and allow to be here approximately an hour for your entire visit.

- **REMEMBER TO BRING YOUR INSURANCE CARD WITH YOU; WE WILL NEED TO PHOTOCOPY IT.**
- **CALL YOUR INSURANCE TO MAKE SURE THE DOCTOR YOU ARE SCHEDULED WITH IS A PARTICIPATING MEDICAL PROVIDER WITH YOUR PLAN.**
- **REMEMBER TO CHECK YOUR INSURANCE PLAN AND IF IT REQUIRES A REFERRAL, YOU WILL NEED TO GET ONE FROM YOUR PRIMARY CARE DOCTOR. IF WE DO NOT HAVE ONE ON FILE WHEN YOU COME IN YOU MUST SIGN A REFERRAL WAIVER THAT STATES THAT IF YOU DO NOT HAVE ONE, INSURANCE WILL NOT COVER YOUR VISIT.**
- **IF PATIENT IS UNDER 18 YEARS OF AGE, A PARENT OR LEGAL GUARDIAN MUST BE PRESENT FOR THE VISIT.**
- **ALL FEES ARE PAYABLE AT THE TIME OF THE VISIT UNLESS YOU ARE WITH A CONTRACTING INSURANCE.**
- **ALL DEDUCTABLE AND COPAYS ARE DUE AT THE TIME OF SERVICE. WE ACCEPT CASH, CHECK, VISA, MASTERCARD AND DISCOVER.**

DIRECTIONS:

Our address is 235 W. Schrock Rd. Westerville, Oh. 43081

Our office is located on the south side of Schrock Rd., it is the only **driveway** between the traffic lights for Brooksedge and Parkmeadow.

FROM THE WEST: Take 270 E. to **Cleveland Ave. North**. Go to the 2nd. traffic light **(Schrock Rd.)** turn right. Go thru the 3rd traffic light for Parkmeadow. You want the next **driveway** on your right. Our building is immediately on the right near corner.

FROM THE EAST: Take 270 W. to **State St exit (Route 3).** Turn right as you come off the ramp. Go to the 3rd. traffic light **(Schrock Rd.)** turn left. Once on Schrock Rd, go thru the 2nd. traffic light for Charring Cross. After going thru this light you will want to be in the left lane as you will need to get in the turn lane. You will be making the next left into our **driveway**. Our building is immediately on the right near corner.

Patient Legal Name: ______________________________ Date of Birth: ______________

Patient Street Address: ______________________________ Social Security: ______________

City: ______________________ State: __________ Zip Code: ______________

Telephone Number: ______________ Sex: *M or F* Marital Status: *S, M, W, SEP, D*

Current Employer: ______________________________ Occupation: ______________

Work Phone Number: ______________ Ext: __________ Employed: ☐ Full Time ☐ Part Time

Have we seen any other family members? ☐ *Yes* *or* ☐ *No*
If Yes, name and relationship: ______________________________

My Primary Care Physician is: (please give first and last name) ______________________________
Were you referred by your P.C.P.? ☐ Yes or ☐ No

If not referred by your P.C.P. please indicate how below.

☐ Other: ______________________________.

☐ My friend referred me . Hospital recommended ☐ Yellow pages

☐ Office is close to my home or work . Participate in my health care plan ☐ Lecture/Open house

Primary Insurance Co. Name: ______________________________ Plan: ______________

Subscribers Name: ______________________________ Group Number: ______________

ID Number: ______________ Relationship: __________ Employer: ______________

Social Security Number: ______________________ Date of Birth: _____/ _____/ _____

Subscribers Street Address: ______________________________

City: ______________________ State: __________ Zip Code: ______________

Secondary Insurance Co. Name: ______________________________ Plan: ______________

Subscribers Name: ______________________________ Group Number: ______________

ID Number: ______________ Relationship: __________ Employer: ______________

Social Security Number: ______________________ Date of Birth: _____/ _____/ _____

Subscribers Street Address: ______________________________

City: ______________________ State: __________ Zip Code: ______________

I authorize my insurance benefits to be paid directly to Westerville Dermatology. I authorize the release of any information to my insurance company pertinent to my health insurance claim. I understand that I am financially responsible for this account unless other arrangements have been made. I understand that services rendered to me may not be eligible for benefits under Medicare, Medicaid or other insurances or payors. Non-covered services may include those my physician determines medically necessary but are later deemed unnecessary by my insurance plan. I understand that I am responsible for payment of any non-covered service. I also understand that any co-payment or co-insurance is also my responsibility to be paid.

Date: ______________ **Signature:**______________________________

Area below to be used in office by staff.

1. ______________________ **4.** ______________________

2. ______________________ **5.** ______________________

3. ______________________ **6.** ______________________

Past Medical History

1. Chief complaint. Tell me about your problem. ____
____

2. History.
Present location of problem. ____
Where on your skin did it begin? ____
How did it begin? (i.e. red spot, itch, blister, bite, injury, dryness, etc.) ______________________
____
When did it begin? ____

3. What have you **previously** applied or taken for it? Please include cosmetics, soaps and treatment medications prescribed by your physician.

	Medication	*Frequency*	*Date Started*	*Date Stopped*
1.	______________	______________	______________	______________
2.	______________	______________	______________	______________
3.	______________	______________	______________	______________

List current medication intake, either prescription or non-prescription. (include aspirin, laxatives, nerve pills, birth control pills, etc.)

	Medication	*Frequency*	*Date Started*	*Date Stopped*
1.	______________	______________	______________	______________
2.	______________	______________	______________	______________
3.	______________	______________	______________	______________

4. **List ANY Drug Allergies**: ____

5. Personal History. Have you ever had:

☐ Diabetes	AIDS/ARC	High blood pressure
Tuberculosis	HIV positive	Bleeding disorders
Heart Disease	Hepatitis	Mitral valve prolapse
Glaucoma	Bowel Disease	Asthma/ Hayfever
Epilepsy	Ulcer Disease	Respiratory Allergies
Organ Transplant	Pacemaker	Artificial implants

If yes to any of the above, please describe. ____
____
Are you now pregnant? yes or no.

6. Have you ever had skin cancer? yes or no. If yes what type (basal or squamous cell, malignant melanoma)____
How and when was it treated?____

7. Do you have a family history of melanoma? yes or no. Other internal malignancies? yes or no.

8. List past surgeries and dates? ____
____
____

9. History of keloid (raised , thickened or hard scar) formations? yes or no.

10. List any previous hospitalizations. ____
____
Do you smoke? yes or no. Do you drink? yes or no. How much?______________

11. Additional comments or concerns: ____

Date: ____________________ **Signature:** ______________________________________

Westerville Dermatology Office Policy

In order to better serve you, please find our policies in writing

***1.* Missed Appointment Policy:**	We require 24 hr. notice of a cancellation or there will be a $25.00 no show fee. If you miss an appointment 3 times without prior notification, you will be dismissed from our practice.
***2.* Prescription Policy:**	All prescription refill requests need to be made through your pharmacy. Please call them and ask them to fax us a request at 614-895-2911. Please be aware that this may take up to 48 hrs. so you may want to plan your refills a week in advance. This policy also applies to walk in requests.
***3.* Referral Policy:**	If a referral is required by your insurance it is your responsibility to obtain it and make sure it is effective for any upcoming visits. If you do not have a current referral you will be required to sign a responsibility waiver.
***4.* Insurance Policy:**	You will need to have your insurance card with you for each visit as we may ask to see it to verify current insurance. Even though we may contract with your insurance, you are responsible for your charges and account.
***5.* Minor Policy:**	If the patient is under 18 yrs. old, they must be accompanied by a legal guardian or have the proper consent filled out by a legal guardian present in our office and kept on file.

Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Westerville Dermatology may use and disclose **Protected Health Information (PHI)** about me to carry out **Treatment, Payment and Healthcare Operations (TPO).** Please ask to see the Notice of Privacy Practices for a more complete description of such uses and disclosures. With my consent, Westerville Dermatology may call or send information as indicated below to carry out TPO, such as appointment reminders, insurance items pertaining to my clinical care, including laboratory results among others.

With my consent Westerville Dermatology may:

Call me at my home?	**□ yes**	**□ no**	
May we leave a message on a machine at home?	**□ yes**	**□ no**	
Call me at my work?	**□ yes**	**□ no**	**□ retired**
May we leave a message on voice mail at work?	**□ yes**	**□ no**	**□ retired**

With my consent Westerville Dermatology may give results of test and/or surgery to family members listed below:

Name:	**Relationship:**
1.____	____
2.____	____

By signing this form, I AM CONSENTING to Westerville Dermatology's use and disclosure of my PHI to carry out TPO. and confirming that I have read the office policies.

Print Patient Name: ____________________________________ Date: ___________________

Signature of Patient or Legal Guardian: ____

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Our office and you in regards to HIPAA
(Health Information Portability and Accountablility)

Due to new Federal regulation known as "HIPAA" we must change and update our filing policy and records. We need and appreciate your patience with this.

Due to this law, you will be asked to fill out new update forms and sign a new consent form and a Privacy Statement. By law, we cannot treat you unless these forms are completed and signed. Likewise without proper consent we would be unable to bill your insurance.

Our patients have always had control about who has access to information contained in their record. This information is referred to as **Protected Health Information (PHI)**, and the disclosure of PHI will be governed by this law.

The new consent form will ask for specific information regarding whom we can speak with about you and your PHI. If you do not fill this in we will not be able to give information to anyone or leave a message with anyone in your family including a spouse.

Please keep in mind that if you do not accept the privacy law we will not be able to file claims with your insurance, call you with appointment reminders or send you statements.

In regards to minors, if you intend to send your child for future treatments without a legal guardian being present, a specific minor consent must be signed by you in our office. This form cannot be sent or faxed to you. It also does not cover surgical procedures. A legal guardian must be present during any surgical procedure.

Our employees have been instructed about these policies and should be able to answer any questions you may have about HIPAA or the forms.

If you would like a copy of this notification, please ask the receptionist.

We appreciate your cooperation.