ALEKSANDAR KRUNIC, M.D. S.C.
Innovative Dermatology
3000 N. Halsted Street, Ste # 620
Chicago, IL 60657
Phone (773) 871-7000 Fax (773) 871-4344

NEW PATIENT INORMATION **DATE:**_____

Last Name: _____ First Name: _____ M:_____

Street Address: _____

City:_____ State:_____ Zip Code: _____

Home Phone ( ) _____ Work Phone ( ) _____ Ext:_____

Cell Phone ( ) _____ E-mail Address:_____

Gender: Male Female (circle one) Marital Status: **S M W D**

Age: _____ Date of Birth: _____/_____/_____ SS#: _____-_____-_____
MM DD YEAR

EMERGENCY CONTACT: _____ Relationship:_____

Home Phone: ( )_____ Cell Phone ( ) _____

Spouse's Name: _____ Office Phone ( ) _____

PROTECTED HEALTH INFORMATION

Name of individual(s) who may receive test results/medical record/prescription information on your behalf:

_____

Relationship(s): _____ Phone (if different from patient's): _____

May we leave a message on your voicemail/answering machine? **Y N HOME CELL WORK EMAIL**

Please specify (circle) information to be released: **Biopsy Results** **Blood Test Results** **Culture Results**

Current Medications **Information Related to Medical Procedures**

Treatment for Sexually Transmitted Diseases **HIV/AIDS Related Treatment**

Mental Health Notes **Alcohol/Drug Usage**

Signature: _____ Date: _____

INNOVATIVE DERMATOLOGY

INSURANCE INFORMATION

Insurance Company Name: _____

Policy Holder's Name: _____

Social Security # of Policy Holder: _____ Date of Birth _____/_____/_____
MM DD YEAR

ID #: _____ Group #: _____

Primary Care Physician: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: ( ) _____ Fax: ( ) _____

Pharmacy: _____ Phone: ( ) _____

Address: _____ Fax: ( ) _____

Name of Employer: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Referred By: Doctor Patient Yellow Pages Other (circle one)

Name: _____ Phone: ( ) _____

I HAVE RECEIVED AND I UNDERSTAND THE INNOVATIVE DERMATOLOGY OFFICE POLICIES AND PRIVACY PRACTICES REGARDING THE PRIVACY OF MY MEDICAL INFORMATION AND RECORDS.

_____ _____ _____
Patient or Authorized Person Signature Relationship Date

_____ _____
Witness Signature Date

INNOVATIVE DERMATOLOGY
MEDICAL HISTORY

Patient name: _____ Date: _____
Reason for today's visit: _____
Are you allergic to any medications? ☐ **YES** ☐ **NO**
1._____ 2._____
Have you ever had dental anesthesia (Novocaine) ☐ **YES** ☐ **NO** Any bad reaction? ☐ **YES** ☐ **NO**
List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins,and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____
Do you have now, or have you ever had diseases or conditions of: (Please check **YES** or **NO**)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
-Inflammation of vein	☐	☐
-Blood clots	☐	☐
Pacemaker	☐	☐
Artificial valve	☐	☐
Heart valve disease	☐	☐

Other Systemic:	**YES**	**NO**
* *Diabetes*	☐	☐
-Excessive thirst/hunger	☐	☐
- Amputation	☐	☐
**Thyroid*	☐	☐
**Kidney*	☐	☐
-Dialysis	☐	☐
**Bladder*	☐	☐
- Frequency/burning	☐	☐
**Gastrointestinal*	☐	☐
- Stomach absorptive disorder	☐	☐
- Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
*Yeast infection when taking antibiotics	☐	☐
**Arthritis/Joint Deformity*	☐	☐
**Arthralgia*	☐	☐
**Limited motion*	☐	☐
*Artificial joint	☐	☐
*Convulsion, Epilepsy or Seizures	☐	☐
*Fainting	☐	☐

List any other diseases or conditions: _____
List any surgical procedures you have had in the last 2 years: _____
Skin: Have you ever had skin cancer? ☐ **YES** ☐ **NO**
Has anyone in your family had skin cancer? ☐ **YES** ☐ **NO**
Do you have a history of any specific skin disease? ☐ **YES** ☐ **NO**
Do you have problems with healing? ☐ **YES** ☐ **NO**
Do you develop keloids (scars) after surgery? ☐ **YES** ☐ **NO**
Do you bleed easily? ☐ **YES** ☐ **NO**
Do you develop skin rashes due to: ☐ Medication ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin ☐ Other

Social history:
Do you drink alcohol? ☐ **YES** ☐ **NO** if **YES** _____ drinks per day
Do you use IV drugs? ☐ **YES** ☐ **NO** if **YES**, what? _____ How often? _____
Do you smoke? ☐ **YES** ☐ **NO** if **YES**, how much? _____
Have you had or have you been exposed to HIV (AIDS)? ☐ **YES** ☐ **NO**
Please answer the following questions:
(Woman) Are you pregnant? ☐ **YES** ☐ **NO** Due Date: __/__/____
What is your occupation? _____ Hobbies? _____
Completed by: ☐ Patient ☐ Medical Assistant _____ _____ __/__/____

Initials Signed by patient Date

HIPAA CONSENT
PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

INNOVATIVE DERMATOLOGY

The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

Our Notice of Privacy Practices provides information pertaining to the use and disclosure of protected health information (PHI). Innovative Dermatology complies with HIPAA guidelines in regards to patient treatment, payment, and healthcare operations. You have the right to review our Notice of Privacy Practices prior to signing this consent. Innovative Dermatology reserves the right to revise its Notice of Privacy Practices at any time. If we change our Notice, you may obtain a revised copy by contacting our office.

By signing this form, you consent to our use and disclosure of your protected health information for treatment, payment and health care operations. You have the right to revoke this consent by submitting a written request. However, such a revocation shall not affect any disclosures we have already made in compliance with your prior consent. Innovative Dermatology shall provide this form, which complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) if requested.

The patient or patient guardian understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- The patient/guardian may request a copy of the Innovative Dermatology Notice of Privacy Practices.
- Innovative Dermatology reserves the right to change the Notice of Privacy Practices.
- The patient or guardian may revoke this consent in writing at any time and all future disclosures will then cease.

With my consent, Innovative Dermatology may call my home or other designated location and speak with me, or leave a message in reference to any items that assist the practice in carrying out TPO (Treatment, Payment, Operations), such as appointment reminders, insurance related information, and information pertaining to patient clinical care, including laboratory results, ect.

With my consent, Innovative Dermatology may forward to a designated address, any items that assist the practice in carrying out TPO, such as patient statements, collection letters and any other correspondence or related material.

The Practice is not required to agree to my requested restrictions, but if an exception is made, it is bound by this agreement.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Innovative Dermatology may decline to provide treatment.

By signing this form, I am consenting to Innovative Dermatology's use and disclosure of patient's PHI to carry out TPO.

_____ _____

Patient's Name (print please) **Date**

_____ _____

Signature of Patient or Legal Guardian **Relationship**

INNOVATIVE DERMATOLOGY OFFICE POLICIES

We would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office. In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients in a prepaid plan applicable co-payments and deductibles will be collected at time of visit. Biopsies, cultures and blood tests, if applicable, will be billed to your insurance company. We are currently contracted with many PPO insurance carriers including: Aetna, Blue Cross, Cigna, Harkin, Humana, Land of Lincoln, Medicare, PHCS, Unicare, and United Healthcare. We are also contracted with Advocate HMO, St. Josephs Health Preferred HMO and Union Health HMO.

- The patient understands that all charges for services in this office are ultimately his/her responsibility.
- If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. You will be responsible for the annual deductibles, co-payments, coinsurances, and charges for non-covered or cosmetic services. You are also responsible for obtaining a valid referral, as per your insurance carrier. In the event of a scheduled procedure, you will be asked to pay for the procedure at this time, if you do not have a HSA account or if your deductible has not yet been met. In the event that we are not aware of a charge that is not covered by your plan, you will be billed for the balance after we obtain an explanation of benefits from your insurance carrier. Payment in full is required within 60 days of claim adjudication, payment plans will be ½ of the balance the first month, and the reminder paid the next month.
- Office visits/Refunds: If we cannot verify your benefits at the time of service, or we are not contracted with your insurance provider, you must pay for the visit on the day of your appointment. If your payment results in an overpayment after your insurance paid its portion of the charge, a refund will be issued to you in a timely manner.
- Refill policy: Patients are given enough medication to sustain them until their next visit. A follow-up visit is required for prescriptions that were written over a year ago. Depending on the situation the patients may be given a one time refill to carry them over until their follow-up visit. We have your permission to contact you via email or text message regarding your prescription status, unless otherwise stated. Account balances must be paid in full to obtain a refill.
- Cancellation policy: Patients are required to cancel 24 hours prior to their appointment. As a courtesy the office attempts to remind you of your appointment, but ultimately it is the patients' responsibility to remember their scheduled appointment. The fee for late cancellations (less than 24 hours) or a missed appointment is $30.00 for a routine visit, and $50.00 for a surgical or cosmetic/laser appointment.
- Transfer of records charges to patient or another physician: $25.00-$35.00 for small charts and $40.00-$50.00 for charts over 15 pages. Payment is due before the chart can be copied and sent. Account balances must be paid in full to obtain medical records.
- Patient communication: I understand that if I request/send information, documents, results, receipts, etc., from/to the office via email, text, or fax, my information may not be encrypted, and therefore understand that the information may not be kept confidential. I agree not to take action against the corporation regarding this breach of security.
- Co-pay rebilling charges: As many patients are presenting old insurance cards displaying incorrect co-pay amounts, there will be a service charge of $20.00 if additional billing is required, due to the fact that patient co-pay wasn't paid in full at the time of your visit. Please make sure your insurance card is current.
- Insurance rebilling charge: If your insurance claim requires a second submission because of incorrect insurance policy information, there will be an additional $25.00 charge which will be the responsibility of the patient, and not the insurance company. If the correct insurance information is not obtained before the claim filing deadline of your insurance company, the patient will be responsible for the entire cost of the visit.
- Patients will be subject to a $30.00 processing fee for returned checks.
- There will be a service charge of $50 if your account is turned over to collections.

We hope you will understand the necessity for implementing these office policies. By signing below, the patient/guardian acknowledges the notification.

_____ _____

Patient/Guardian Signature Date

ALEKSANDAR L. KRUNIC, M.D., S.C.

5140 N. California Ave #660
Chicago, IL 60625
Phone: 773-907-8454
Fax: 773-907-6336

Thank you for choosing Innovative Dermatology as your dermatology provider. We always strive to treat you with courtesy and to provide the finest medical care. Changes in health care laws have made it essential to collect full payment for all services in a timely manner in order to continue to provide the quality of care you have come to expect from us.

Payments due at time of service: Payment of copays are required at time of service prior to your appointment. All charges for services not covered by insurance are also due at time of service. In addition, amounts due for deductibles in which the amount due can be determined, are also due at time of service. We accept credit cards, debit cards, Care Credit, and cash.

Other payments: You will be required to provide a credit card number at time of service to be used for forgotten payments, missed appointments and any amount your insurance company indicates is your responsibility per your explanation of benefits statements. You authorize Innovative Dermatology and our billing service, Physician Billing Solutions, to charge this credit card for these amounts due. You will receive a receipt for all payments.

Cancellation policy: A cancellation fee will be charged for cancellations with less than 24 hours' notice. Late cancellations of non-surgical appointments are $25.00, $40.00 for surgical and laser appointments. A no-show fee of $30.00 will be charged for all non-surgical appointments, $50.00 for surgical and laser appointments. These fees are not covered by your insurance, and you authorize us to charge your credit card for this fee.

Past due balances: If you have a balance which is over 30 days past due, you will receive a notice/phone call giving you 30 days to pay the full amount, or to find care at another dermatology practice. If payment in full is not received during this 30 day period, you will not be able to receive care from our doctors until payment has been made. Amounts greater than 60 days past due will be turned over to collections and a $50.00 collection fee will be added to your account.

Insurance: Insurance claims will be submitted to your insurance company as a courtesy, however, you are fully responsible for all amounts due which are not paid by your insurance. If we are not a provider in your insurance plan, or if you have an HMO and do not have a valid referral, which is required by your insurance, you will be responsible for full payment of all charges at the time of service or claim adjudication.

I authorize Aleksandar L. Krunic, M.D., S.C, dba Innovative Dermatology to provide dermatological services and agree to abide by the above policies.

Signature: _____ Date: _____

Name on Credit Card: _____

Credit Card #: _____

Expiration Date: _____ CVV Code: _____ Billing Zip Code: _____