Michael J. Redmond, M.D
Renata T. Brindise, D.O.
Patient Information

Patient's Full Name _____ Sex _____

Street Address _____

City, State, Zip _____

Phone (home) _____ (work/cell) _____

Employer _____

Email Address _____

Date of Birth _____ Marital Status _____

Referred By _____

**Due to Health Care Reform this information is now required for reporting purposes.*

Ethnicity _____ Race _____ Preferred Language _____

Insurance Information – Please present your insurance card

Primary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birthdate _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone _____

Secondary Insurance Name _____ Relationship _____

Cardholder's Name _____ Birthdate _____

Cardholder's SSN _____ Is this an HMO? _____

Cardholder's Address (if different from Patient) _____

Cardholder's Employer and Phone _____

I understand that regardless of my insurance status I am ultimately responsible for the balance of my account. I have read all of the information on BOTH sides of this sheet and have completed the above information. I certify this information is true and correct to the best of my knowledge. Michael J. Redmond, M.D., Renata T. Brindise, D.O. have permission to contact me by email. I further understand that if I consent to the photographing of skin conditions these may be used for educational, training and patient awareness purposes. Additionally, I hereby authorize the release of any protected health information necessary to process claims for medical services performed on me. I also request that payment be sent to the provider of services at Michael J. Redmond, M.D., Renata T. Brindise, D.O.

*** 24-hours is required for cancellations to avoid $25 collection fee ***

Signature _____ Date: _____

Updated _____ Date: _____

Updated _____ Date: _____

Michael J. Redmond, M.D
Renata T. Brindise, D.O.

About Financial Arrangements

We are committed to providing you with the best possible care. If you have medical insurance we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding of our payment policy.

Payment for service is due at the time services are rendered unless we are aware you have insurance coverage for this particular visit. It is the patient/subscriber's responsibility to submit claims covered under any Master/Major medical policy, unless prior arrangements have been made with the office staff. Returned checks and balances older than 30 days may be subject to additional collection fees.

We participate with various insurance plans, accepting assignment of benefits. Please check with your insurance company to verify that the doctor you are seeing is a participating provider. Copayments, coinsurances, and deductibles remain your responsibility. It is the responsibility of the patient/subscriber to obtain any necessary referral forms or authorization numbers. If you fail to obtain these necessary forms/numbers you will be held responsible for your balance. Please be advised that our office takes, CASH, CHECKS, VISA, MONEY ORDER, MASTERCARD.

We are happy to process other insurance plans. You must realize however, that:

1) **Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract.**
2) **Our fees are generally considered to fall within the acceptable range by most companies and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies which pay a percentage (such as 50% or 80%) of "U.C.R.". U.C.R. is defined as "Usual, Customary, and Reasonable" by most companies. This is a "schedule of fees" which bears no relationship to the current standard and cost of care in the area.**
3) **Not all services are a covered benefit on all contracts. Some insurance companies arbitrarily select certain services they will not cover.**

We must emphasize that as medical care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is a courtesy that we extend to our patients, all charges are your responsibility from the date services are rendered. Should problems arise affecting your timely payment of this account, we encourage you to contact the billing office promptly for assistance in working this out.

If you have any questions regarding the above information, please do not hesitate to ask us. We are here to assist you.

Medical History Information Form

Patient Demographics -
Name:
Gender: M / F DOB (age):

LIVONIA OFFICE –
Provider:
Date of Service:

REASON FOR TODAY'S VISIT:_____

_____

_____

REVIEW OF SYSTEMS (ROS) FOR GENERAL HEALTH:	NO	YES
Changes in overall health?	☐	☐
Yellowing of the skin or eyes?	☐	☐
Enlarged lymph nodes?	☐	☐
Seizure or stroke?	☐	☐
New confusion or mood change?	☐	☐
Changes in vision?	☐	☐
Muscle or joint pains?	☐	☐
Fevers, chills or night sweats?	☐	☐
Weight loss or fatigue?	☐	☐
Shortness of breath or leg swelling?	☐	☐
Blood in the urine or bleeding problems?	☐	☐
Cough or mouth sores?	☐	☐
Other problems elsewhere on the skin?	☐	☐
Skin problems with medicine, food, plants?	☐	☐
-> If yes, do you get:		
rash?	☐	☐
sun sensitive?	☐	☐
itching?	☐	☐
pain?	☐	☐
other?	☐	☐
Difficulty with healing, scarring, or keloids?	☐	☐
Do you pass out with medical procedures?	☐	☐

ALLERGIES:	NO	YES
Lidocaine:	☐	☐
Latex:	☐	☐
Topical products:	☐	☐
Other:	☐	☐

Past Medical History:	NO	YES
Females: are you pregnant/nursing?	☐	☐
Last menstrual cycle day?_____		
Skin cancer?	☐	☐
Type -> Basal cell or Squamous cell (v10.83) / Melanoma (v10.82) / Merkel Cell (MCC, v10.91) / other:_____		
Other skin conditions?	☐	☐
Other cancer? If yes, type?_____	☐	☐
Diabetes?	☐	☐
High Blood pressure?	☐	☐
Pacemaker/defibrillator?	☐	☐
Joint replacement? If yes, when?_____	☐	☐
Blood problems?	☐	☐
Exposed to HIV/AIDS?	☐	☐
Blood transfusion?	☐	☐
Hepatitis? If yes, type?_____	☐	☐
Problems with immune system?	☐	☐
Any history of mental illness?	☐	☐
Crohns or Ulcerative Colitis?	☐	☐
Other conditions?	☐	☐

Current Medications:	NO	YES
Blood thinners? If yes, type?	☐	☐
Immune suppressors? If yes, type?	☐	☐
Antibiotics? If yes, type?	☐	☐
Other medications?	☐	☐

_____

_____

_____

_____

_____

Primary Care Provider Information:
Name:
Contact Info:

Social History:	NO	YES
Do you smoke?	☐	☐
Do you drink alcohol?	☐	☐
Ever use tanning beds?	☐	☐
Your occupation:_____		
Do you have any siblings?	☐	☐

Family history:	NO	YES
Anyone with skin cancer (v16.8)?	☐	☐
-> If yes, melanoma? (circle if unsure)	☐	☐
Eczema? If yes, who?	☐	☐
Asthma? If yes, who?	☐	☐
Hay Fever? If yes, who?	☐	☐
Other conditions?	☐	☐

If applicable, would you be interested in learning about cosmetic services we offer (please circle)? YES / NOT TODAY

Patient Signature:_____ Date: _____

Provider Signature:_____ Date: _____

Michael J. Redmond, M.D.

Notice and Acknowledgement

Acknowledgement:

I acknowledge that I have received the attached Notice of Privacy Practices.

_____ _____

Patient or Personal Representative Signature Date

_____

If Personal Representative's signature appears above, please describe Personal Representative's relationship to the patient:

Michael J. Redmond, M.D.

Individual Patient Authorization

This form is provided to confirm your authorization to use or disclose your protected health information for a special purpose.

Patient Name: _____

Date of Birth _____

I give my permission for my protected health information to be given to the person or persons listed below and as indicated in the Privacy Notice, which has been given to me. The information to be given is including, but not limited to labs, test results, diagnosis and/or information about my condition and/or treatment.

My information can be given only to the person or persons listed below:

Name _____

Relationship_____ **Phone** _____

Name _____

Relationship_____ **Phone** _____

Name _____

Relationship_____ **Phone** _____

I understand that I may revoke this authorization at any time by giving a written notice to the Privacy Officer at this office. However, I understand that I may not revoke this authorization for any actions taken prior to receipt of my written notice to revoke this authorization.

I have had a chance to read and think about the content of this authorization form and I agree with the statements made in this authorization. I understand that by signing this form I am confirming my authorization for use and/or disclosure of the protected health information described in this form with the people and/or organizations named in this form.

Signature _____

Date _____