



Kristy R. Kennedy, MD  
 Thomas L. Briscoe, PA-C  
 Donna J. Vial, PA-C  
 Brooklyn Buras, DNP, APRN, FNP-BC

PATIENT INFORMATION			
PATIENT NAME First Last M.I.		DATE OF BIRTH	SEX Female Male
ADDRESS Street		Social Security Number	
City State Zip	Home Phone	Cell Phone	Work Phone
EMAIL		Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Married	
PREFERRED METHOD OF CONTACT <input type="checkbox"/> Text <input type="checkbox"/> Email <input type="checkbox"/> Phone			
RACE <input type="checkbox"/> African American <input type="checkbox"/> Asian <input type="checkbox"/> Hispanic <input type="checkbox"/> Caucasian <input type="checkbox"/> Native American <input type="checkbox"/> Other		ETHNICITY <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic	
EMPLOYER		PATIENTS OCCUPATION	
PHARMACY NAME		PHARMACY PHONE	
HOW DID YOU HEAR ABOUT US <input type="checkbox"/> Community Event <input type="checkbox"/> Patient/Friend/Family <input type="checkbox"/> Employer <input type="checkbox"/> Social Media <input type="checkbox"/> Website or Online <input type="checkbox"/> Insurance <input type="checkbox"/> Magazine or Newspaper <input type="checkbox"/> Physician <input type="checkbox"/> Radio or Television <input type="checkbox"/>			
PERSON RESPONSIBLE FOR CHARGES			
NAME		SOCIAL SECURITY NUMBER	
ADDRESS Street		DATE OF BIRTH	
City State Zip	CONTACT PHONE NO.		
EMPLOYER	EMPLOYER PHONE NO.		
REFERRAL INFORMATION			
PRIMARY CARE PHYSICIAN		NAME OF REFERRING PHYSICIAN	
EMERGENCY INFORMATION			
IN CASE OF EMERGENCY NOTIFY NAME		RELATIONSHIP	PHONE NO.
ADDRESS Street City State Zip			
INSURANCE INFORMATION			
PRIMARY		SECONDARY	
Subscriber Name: _____		Subscriber Name: _____	
Insurance Name: _____		Insurance Name: _____	
Policy ID #: _____		Policy ID #: _____	
Group/Account #: _____		Group/Account #: _____	
Subscriber DOB: _____		Subscriber DOB: _____	
Relation to Patient: _____		Relation to Patient: _____	

I hereby certify the above information is true and correct to the best of my knowledge. I understand that while DCA contracts with many insurance companies, it is my responsibility to verify with my plan that DCA is a participating provider. It is also my responsibility to find out what my coverage options are with my insurance plan. I hereby authorize DCA to submit insurance claim forms along with medical records necessary to obtain payment from my insurance company. I understand that I am responsible for all charges regardless of my insurance coverage. I acknowledge that photo IDs taken are used to assist in patient recognition per HIPPA guidelines.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_



## Privacy and Disclosure Statement

Your treatment, payment, enrollment, or eligibility for benefits at Dermatology Center of Acadiana (DCA) is not dependent upon whether you sign this Privacy and Disclosure statement. You have the right to revoke this Privacy and Disclosure Statement at any time by sending a written notice of revocation to DCA 1245 S. College Bldg 5, Lafayette, LA 70503, Attn: Privacy Officer. Our Practice Manager and front office staff will be glad to discuss these and authorizations with you.

By signing below, I acknowledge that I have received the Notice of Privacy Practices of DCA which explains its legal duties and privacy practices with respect to my protected health information. I understand that if I have indicated my preferred method of contact is by cell phone, I may receive text message communications regarding my scheduled appointments, appointment reminders and missed appointment notifications. I understand that standard message and data rates may apply.

I understand if I choose to opt out of receiving text message reminders, I am responsible for changing my preferred method of contact with DCA.

I hereby agree that DCA may disclose any and all of my protected health information to the following individuals, all of whom are involved in my care, for any purpose related to my treatment or the payment of my care.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Signature of Patient/Patient's Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name of Patient/Patient's Representative: \_\_\_\_\_



## Financial Policy

Dermatology Center of Acadiana (“DCA”) places its patients’ needs first; however, we must be financially responsible to continue to serve.

- I understand that it is my responsibility to know my insurance benefits and plan coverage. My insurance may or may not cover the services provided at DCA. To obtain the most accurate information, please check with your insurance carrier to discuss the benefits provided by your medical plan prior to your visit to fully understand your anticipated out of pocket costs.
- I understand that co-payments, deductibles, co-insurance, and non-covered services are paid at or before the time of service. DCA accepts cash, checks, major credit cards, debit cards and HSA/FSA cards.
- I understand that I may be contacted by telephone regarding my outstanding balance with DCA.
- I understand that if I do not have my insurance, referral, and/or co-payment, my appointment may be rescheduled until such time that I can provide the required documents or payments.
- I understand if my account has a patient responsibility amount that is not paid in full within 90 days, my account may be placed with an outside collection agency. No additional appointments will be made for delinquent accounts until they are brought current unless the appointment is of an urgent nature.
- I understand that a \$35 service fee will be added for any checks returned for any reason and that I will be responsible for payment of this fee in addition to the amount of the returned check. Non-Sufficient Fund checks must be redeemed with certified funds (credit card or cash).
- I understand that I have until 4:00 p.m. the day before my appointment to cancel or reschedule. If I do not show up for my appointment and did not cancel in time, a \$50 no-show fee for medical visits or a \$100 no-show fee for surgical, cosmetic or hormone appointments will be charged to my account.
- I understand that there may be fees associated with medical records requests and completion of forms by a physician. I understand that I may be responsible for these fees.

**Statement of Financial Responsibility:** I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my insurance plan(s). This also applies if I am covered by Medicare, a health maintenance organization (HMO), or any other payer. I have read and I understand the above Financial Policy and I agree to abide by its terms.

Patient or Guarantor Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

**PATIENT PAST MEDICAL HISTORY**

- |   |  |  |
|---|--|--|
| <input type="checkbox"/> Anxiety                | <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Lymphoma            |
| <input type="checkbox"/> Arthritis              | <input type="checkbox"/> End Stage Renal Disease | <input type="checkbox"/> Prostate Cancer     |
| <input type="checkbox"/> Asthma                 | <input type="checkbox"/> GERD                    | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Atrial Fibrillation    | <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Seizures            |
| <input type="checkbox"/> Bone Marrow Transplant | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Stroke              |
| <input type="checkbox"/> Breast Cancer          | <input type="checkbox"/> High Blood Pressure     | <input type="checkbox"/> Thyroid Problems    |
| <input type="checkbox"/> Colon Cancer           | <input type="checkbox"/> HIV/AIDS                | <input type="checkbox"/> Other: _____        |
| <input type="checkbox"/> COPD                   | <input type="checkbox"/> High Cholesterol        | <input type="checkbox"/> None                |
| <input type="checkbox"/> Coronary Disease       | <input type="checkbox"/> Leukemia                |  |
| <input type="checkbox"/> Depression             | <input type="checkbox"/> Lung Cancer             |  |

**PAST SURGICAL HISTORY**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Appendix Removed                       | <input type="checkbox"/> Joint Replacement, Knee (Right, Left, Bilateral) | <input type="checkbox"/> Hysterectomy: Fibroids       |
| <input type="checkbox"/> Bladder Removed                        | <input type="checkbox"/> Joint Replacement, Hip (Right, Left, Bilateral)  | <input type="checkbox"/> Hysterectomy: Uterine Cancer |
| <input type="checkbox"/> Mastectomy (Right, Left, Bilateral)    | <input type="checkbox"/> Joint Replacement within last 2 years            | <input type="checkbox"/> None                         |
| <input type="checkbox"/> Lumpectomy (Right, Left, Bilateral)    | <input type="checkbox"/> Kidney Biopsy (Nephrectomy)                      | <input type="checkbox"/> Other: _____                 |
| <input type="checkbox"/> Breast Biopsy (Right, Left, Bilateral) | <input type="checkbox"/> Kidney Removed (Right, Left)                     | <input type="checkbox"/>                              |
| <input type="checkbox"/> Breast Reduction                       | <input type="checkbox"/> Kidney Stone Removed                             | <input type="checkbox"/>                              |
| <input type="checkbox"/> Breast Implants                        | <input type="checkbox"/> Kidney Transplant                                | <input type="checkbox"/>                              |
| <input type="checkbox"/> Colectomy: Colon Cancer Resection      | <input type="checkbox"/> Ovaries Removed: Endometriosis                   | <input type="checkbox"/>                              |
| <input type="checkbox"/> Colectomy: Diverticulitis              | <input type="checkbox"/> Ovaries Removed: Cyst                            | <input type="checkbox"/>                              |
| <input type="checkbox"/> Colectomy: IBD                         | <input type="checkbox"/> Ovaries Removed: Ovarian Cancer                  | <input type="checkbox"/>                              |
| <input type="checkbox"/> Gallbladder Removed                    | <input type="checkbox"/> Prostate Removed: Prostate Cancer                |   |
| <input type="checkbox"/> Coronary Artery Bypass                 | <input type="checkbox"/> Prostate Biopsy                                  |   |
| <input type="checkbox"/> Mechanical Valve Replacement           | <input type="checkbox"/> TURP (Prostate Removed)                          |   |
| <input type="checkbox"/> Biological Valve Replacement           | <input type="checkbox"/> Spleen Removed                                   |   |
| <input type="checkbox"/> Heart Transplant                       | <input type="checkbox"/> Testicles Removed (Right, Left, Bilateral)       |   |

**SKIN DISEASE HISTORY**

Circle all that apply:

- |                        |                           |              |
|------------------------|---------------------------|--------------|
| Acne                   | Flaking or Itching Scalp  | NONE         |
| Actinic Keratoses      | Hay Fever / Allergies     |              |
| Asthma                 | Melanoma                  | Other: _____ |
| Basal Cell Skin Cancer | Poison Ivy                |              |
| Blistering             | Precancerous Moles        |              |
| Dry Skin               | Psoriasis                 |              |
| Eczema                 | Squamous Cell Skin Cancer |              |

Do you wear Sunscreen?            Yes    No

If yes, what SPF? \_\_\_\_\_

Do you tan in a tanning salon?    Yes    No

Do you have a family history of Melanoma?    Yes    No

If yes, which relative(s)? \_\_\_\_\_

**MEDICATIONS**

Please list all medications you are currently taking below:     None


Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

**KNOWN DRUG ALLERGIES/ALERTS**

Check all that apply:

- Latex
- Adhesive
- Lidocaine
- Topical Antibiotics
- Artificial Heart Valve
- Artificial Joint Replacement
- Blood Thinners
- Defibrillator
- MRSA
- Pacemaker
- Pregnant
- Require Antibiotics Prior to Surgery
- Rapid Heartbeat w/ Epi Other
- None

**SOCIAL HISTORY**

Tobacco:  No  Yes How many packs per day? \_\_\_\_\_ How many years? \_\_\_\_\_  Quit \_\_\_\_\_ yrs ago  
 Alcohol:  No  Yes How much do you drink daily? \_\_\_\_\_  Quit \_\_\_\_\_ yrs ago

**PAST FAMILY MEDICAL HISTORY**

Conditions related to immediate family only:


**PHARMACY**

Please list where you would like to send your prescription:

Pharmacy Name: \_\_\_\_\_

City: \_\_\_\_\_ Zip: \_\_\_\_\_ Phone Number: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Are you currently experiencing any of the following?  check here if unknown

<b>SYMPTOM</b>	<u>Yes</u>	<u>No</u>	<b>SYMPTOM</b>	<u>Yes</u>	<u>No</u>	<b>SYMPTOM</b>	<u>Yes</u>	<u>No</u>
Problems with bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>
Problems with healing	<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
Problems with scarring	<input type="checkbox"/>	<input type="checkbox"/>	Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
Rash	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Immunosuppression	<input type="checkbox"/>	<input type="checkbox"/>	Bloody stool	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain	<input type="checkbox"/>	<input type="checkbox"/>			
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>			
Fever or chills	<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness	<input type="checkbox"/>	<input type="checkbox"/>			
Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>			
Unintentional wt loss	<input type="checkbox"/>	<input type="checkbox"/>	Seizure	<input type="checkbox"/>	<input type="checkbox"/>			