Integrative Dermatology, Anti-Aging, & Rejuvenation

Vindhya L Veerula MD, FAAD

(Fort Wayne Integrative Medicine [FWIM] & VeerulaMD,LLC)

www.drvskin.com -- www.fwimed.com

Patient Information:

FULL NAME: First _________________________ Last _________________________ MI _____ Marital Status: S M D W

SOC SEC NUMBER: _________ - ______ - _________ DATE OF BIRTH: ______ / _______ / ________

EMPLOYER: __________________________ How did you hear about us? (facebook, friend, prior patient, other) ______________

ETHNICITY: NON-HISPANIC _____ HISPANIC _____ PREF LANGUAGE: _____________ RACE ____________ GENDER: M F

ADDRESS: ____ HOME PHONE: ________________________________

____ WORK PHONE: ________________________________

____ CELL / MOBILE PHONE: ________________________________

EMAIL ADDRESS: ____ IS IT OK TO EMAIL YOU? Y N

Would you like to receive our newsletter? Y N. PREFERRED PHARMACY ____
(NAME, ADDRESS, PH) ____

PROVIDER INFORMATION:

PRIMARY CARE PHYSICIAN: ______________________________ REFERRING PHYSICIAN: ________________________________

Guarantor Information (If patient is under 18 years old):

GUARANTOR NAME: ____ RELATIONSHIP TO PATIENT: ________________

ADDRESS:____

Insurance Information:

PRIMARY INSURANCE NAME: ____ INSURANCE FROM AN EMPLOYER? Y N

IF YES, INSURED's EMPLOYER? -____ INSURED DOB: ____________________

INSURED FULL NAME: ____INSURED's SSN: __________________

INSURED's ADDRESS (if different): ____HOME PH:_____________________

POLICY# / RID#: _______________________________________

GROUP#: ____ EFFECTIVE DATE: ______________________________

SECONDARY INSURANCE NAME: ____ INSURED DOB ______________________

INSURED FULL NAME: ____INSURED's SSN: __________________

INSURED's ADDRESS (if different): ____HOME PH:_____________________

POLICY# / RID#: ____

GROUP#: ____ EFFECTIVE DATE: ______________________________

Emergency Contact Information:

NAME: ____

ADDRESS:____ MOBILE ___________________________

PHONE: ________________________________ RELATIONSHIP TO PATIENT: ____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION & ASSIGNMENT OF INSURANCE BENEFIT

X__________I authorize the release of any medical information necessary to process my insurance claim(s) and assign all medical and/or surgical benefits including major medical benefits, FWIM & VeerulaMD,LLC & Vindhya Veerula, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as an original. Even though I have provided all of my insurance information, I understand that I may be financially responsible for any balance not covered by my insurance. I agree to provide my most current insurance information and if any bills are not paid by insurance because of outdated or inaccurate information, I agree to pay my entire bill in full – even though the bill might have been paid by insurance had I provided the correct information. I understand that holistic treatments are not a substitute for medical diagnosis and treatment, and no medical claims are made regarding these treatments. (March 1, 2018)

FINANCIAL AGREEMENT

X__________All FWIM & VeerulaMD,LLC's account balances are due at the time of service. I understand and agree that, (regardless of insurance coverage), I am ultimately responsible for any professional service rendered. I certifiy that this information is true & correct to my best knowledge. I will notify you of any changes in my insurance coverage, address, or health status. I accept this statement as notice from you that my insurance plan may not pay for any service that you provide to me because the service or procedure may not be covered by the plan or may not be considered medically necessary by the plan. I agree that all services and procedures that I receive from you have been requested by me with full knowledge that my insurance plan may not cover them.

COSMETIC TREATMENTS

X________I also agree that certain treatments are not covered by insurance and are considered cosmetic. These will not be billed to insurance. These require payment IN FULL at the time of, or prior to the procedure. I understand that Dr. Veerula sends all specimen's to pathology for verification, and this fee is separate from the removal fee.

LATE PAYMENTS

X________All past-due account balances may be assessed a LATE PAYMENT FEE equal to 18% per annum on the delinquent balance. A LATE PAYMENT FEE can be avoided by paying the account balance within 30 days of the mailing of the patient statement. Subject to such limitation as may be imposed by applicable law, if I have not made payment on my account as required, my account may be sent to an attorney or collection agency for collection, I will pay the reasonable fees of such attorney or collection agency, and all court costs to the extent provided by law as well as my total outstanding bill. No waiver by Fort Wayne Integrative Medicine or FWIM & VeerulaMD,LLC or any default hereunder shall constitute a waiver of any other default. The construction and enforcement of this Agreement shall be governed by the State of Indiana. Any provision of this agreement that may be prohibited by law shall be ineffective only to the extent of such prohibition. From time to time, FWIM & VeerulaMD,LLC may amend this Agreement by giving of such notice, if any, as may be required by applicable law. FWIM & VeerulaMD,LLC may assign the Agreement, or it's right hereunder, without notice to me.

NO SHOW/CANCELLATION POLICY:

When you make an appointment, we are reserving time in our clinician's schedule that is no longer available to other patients. If you are unable to make it to an appointment, VeerulaMD,LLC requires that you cancel (or re-schedule) your appointment at least 24 hours in advance (excluding weekends and holidays). If you cancel an appointment with less than 24-hour notice or fail to appear in a timely fashion for an appointment, VeerulaMD,LLC will charge the patient $60.00. This applies to new patients as well. Failure to show for your appointments (or violation of this cancellation policy) on two or more than two consecutive occasions can be grounds for discharge from the clinic. Note that the cancellation fee may be waived in special circumstances, determined on an individual basis (eg: medical emergency- patients may be asked to provide documentation for the same).

CONSENT TO CARE

X_______ I request and give consent to Dr.Veerula, the nurse practitioners, their associates and assistants who may provide me medical care to perform such medical-surgical care, tests, procedures, and other necessary services as well as provide drugs and supplies as they consider necessary or beneficial for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me. In addition, I understand there may be adverse effects or complications from some treatments/procedures/drugs, etc.

Check all that apply: I agree to be contacted at: ______Home ______Work ______Cell ______EMAIL

Signature of Responsible Party: ____ Date__________

FOR MEDICARE PATIENT ONLY:
STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO PROVIDER, PHYSICIANS AND PATIENTS

I request that payment of authorized Medicare benefits be made either to me or on my behalf for any services furnished me by Vindhya L Veerula, MD, FWIM, & VeerulaMD,LLC., including physician, nursing or lab services. I authorize any holder of medical or other information about me to release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or benefits for related services.

Signature ____Date_____________________

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT

Date: Month ________ Day _______ Year ________ # __________

FWIM & VeerulaMD,LLC's "Notice of Privacy Practices" has been offered to me. It is available from the front desk of the FWIM & VeerulaMD,LLC as well as on the website (*WWW.FWIMED.COM*) I understand I have the right to review the "Notice of Privacy Practices" prior to signing this document. By signing this document, I acknowledge my receipt of and my agreement with and understanding of the above mentioned privacy practices.
Fort Wayne Integrative Medicine reserves the right to change the privacy practices that are described in the Notice of Privacy Practices.
Updated "Notice of Privacy Practices" is available at the front desk or on the website.

____
Printed Name of Patient OR Printed Name of Patient Representative

____
Signature of Patient OR Signature of Patient Representative

_________________ _________________________________
Patient Date of Birth Description of Personal Reps. Authority

☐ Check if the patient is a minor

I authorize the following individuals to have access to my Protected Health Information (PHI):

Name	Relationship	Date of Birth	Phone Number

Patient Signature: ____
For authorization to release PHI to the above listed individuals.

OFFICE USE ONLY
The above named patient or personal representative of the patient was given FWIM & VeerulaMD,LLC's Notice of Privacy Practices on the date indicated, but either refused to sign the acknowledgement or did not return the acknowledgement.

____ __________
Signature and Title of person providing the "Patient Notice of Privacy" DATE

HISTORY & REVIEW OF SYSTEMS QUESTIONNAIRE:

Reason for visit:
____

____

Rate your pain 1-10: _______ How long have you had this?_________________________________

What makes condition better or worse:
____

____

____Does stress make it worse? Y N

What treatments have you tried? ____

____

PAST MEDICAL & PAST SURGICAL HISTORY:

Have you ever had?
___ Asthma/Hay Fever ____Arthritis ___Bleeding problems ____Diabetes ___Cancer ___Heart Disease
____Hepatitis ___Hormonal conditions ___Hives ____Heart murmur ___ Xray /radiation
____ Eczema ___ Fainting spells ___Pregnancy ____ Back injuries ___Cold Sores/Fever Blisters
___ High blood pressure ___ Tuberculosis ___Autoimmune conditions (lupus, RA, thyroid other)

Please list any other history (including surgeries) ____

____

____

Have you had a knee or hip replacement? When? ______________________________________

When you seen last see a dermatologist? ___ Never ___ 6 months ___1 year ___2 years

Who did you see? ____

List any prior biopsies, excisions, light treatment, chemo cream, botox, fillers, lasers, or peels here:____

____

____

List any oral or topical medications, birth control, and supplements you are currently taking:
LIST MEDICATION, DOSE, & FREQUENCY
____

____

____

Allergies: List allergies to anesthesia, steroids, or antibiotics.
____

Have you taken oral or IM steroids? Y N How long ago? ________________________________

Do you take NSAIDS (Aspirin, Motrin, Ibuprofen, Excedrin) Y N How much_____________

Tylenol Use? _________ how often?________ Acid blocking drugs (zantac, prilosec,etc? Y N

Pacemaker or defibrillater or spinal implant? Y N <u>Are you pregnant?</u> Y N How many weeks?

Do you need to take preoperative antibiotics before a dental procedure? Y N

Have you taken Accutane Y N How long ago & for how long? ____________________________

Do you form keloids or hypertrophic scars Y N

Do you smoke? YES_____ NO____ How long?________ Packs per day_________

Do you drink alcohol? YES____ NO____ How many drinks per week?__________

Do you use recreational drugs? YES____ NO____ If yes, what kind?_________________________

Family History (cancers or skin conditions)____

<u>SKIN QUESTIONNAIRE:</u>

What skin concerns bother you? ___Wrinkles ___Dark Circles ____Pores ___ Scars

___Red spots ___Brown Spots

___New or changing moles? Where?

Do you choose organic products? Y N Do you use essential oils? Y N

Do you sunbathe? Y N How often? Do you use a tanning boothe? Y N How often?

Do you use sunscreen? Y N SPF: History of blistering sunburns? Y N How many?

Have you had an allergic or irritant reaction to skin care products? Please list.

Any pets? ____

<u>Nutrition</u>

Do you currently follow any of the following special diets or nutritional programs? *List below. (Vegan, vegetarian, organic, gluten free, ketogenic, low carb, high fat, none, etc)*

Do you have sensitivities to certain foods? Y N If yes, list food and symptoms:

____

____

____

Do you have any food allergies? Y N If yes, list foods: ____

Are there any foods that you crave or binge on? Y N

If yes, what foods? ____

Do you eat 3 meals a day? Y N If no, how many meals per day do you eat? ____________

Any lifestyle or other barriers to healthy eating? Y N

If yes, please explain: ____

Cans of soda per day (regular or diet) ______

Number of glasses of water per day: ☐ 1-2 ☐ 3-4 ☐ 5-6 ☐ 7-8 ☐ >8

Stress

Do you feel you have an excessive amount of stress in your life? Y N

Do you feel you can easily handle the stress in your life? Y N

How much stress does each cause on a daily basis: *(Rank on scale of 1-10, 10 being highest)*

Work_____ Family_____ Social_____ Finances_____ Health_____ Other_____

Do you use relaxation techniques? Y N If yes, how often?______________________________

Which techniques do you use? ___Meditation ___Breathing ___Tai Chi ___Yoga ___Prayer

Other:____

Have you ever sought counseling? Y N

Have you ever been abused, a victim of crime, or experienced a significant trauma? Y N

What are your hobbies or leisure activities?____

Do you have any pets or farm animals? Y N If yes, do they live: ___Inside___Outside ___Both

What kind of pet(s):____________________________________

Review of Systems:

Do you CURRENTLY have? (IF YES, CHECK APPROPRIATE BOXES)

GENERAL

☐ Fatigue
☐ Fever
☐ Weight Gain >10 pounds
☐ Weight Loss >10 pounds

SKIN

☐ Nail Changes
☐ New Lesions
☐ Rash
☐ Skin Color Changes

HEENT

☐ Double Vision
☐ Eye Pain
☐ Eye Redness
☐ Decreased Hearing
☐ Earache
☐ Ear Ringing
☐ Nose Bleeds
☐ Dry Mouth
☐ Hoarseness
☐ Oral Ulcers
☐ Sore Throat

NECK

☐ Neck Pain
☐ Swollen Glands

RESPIRATORY

☐ Chronic Cough
☐ Decreased Exercise Tolerance
☐ Difficulty Breathing
☐ Coughing Up Blood
☐ Sputum Production
☐ Wheezing

BREAST

☐ Breast Mass
☐ Breast Pain
☐ Nipple Discharge
☐ Skin Changes

CARDIOVASCULAR

☐ Chest Pain
☐ Leg Pains with walking
☐ Leg Swelling
☐ Night Awakening due to trouble Breathing
☐ Palpitations
☐ Shortness of Breath

GASTROINTESTINAL

☐ Abdominal Pain
☐ Change in Bowel Habits
☐ Constipation
☐ Diarrhea
☐ Nausea
☐ Vomiting
☐ Rectal Bleeding
☐ Trouble Swallowing

GENITOURINARY

☐ Vaginal Discharge
☐ Menstrual Irregularities
☐ Difficulty Starting/Stopping urinary Stream
☐ Painful Urination
☐ Change in Urinary Stream
☐ Increased Frequency
☐ Blood in Urine
☐ Loss of Bladder Control
☐ Nighttime Urination
☐ Urinary Retention
☐ Urethral Discharge
☐ Impotence
☐ Penile Lesions
☐ Testicular Mass
☐ Testicular Pain

MUSCULOSKELETAL

☐ Decreased Range of Motion
☐ Joint Pain
☐ Joint Redness
☐ Joint Swelling
☐ Joint Stiffness
☐ Muscle Wasting
☐ Muscle Weakness
☐ Muscle Aches/Pains

NEUROLOGICAL

☐ Loss of Bowel Control
☐ Dizziness/Vertigo
☐ Headaches
☐ Numbness/Tingling
☐ Passing Out
☐ Seizures
☐ Tremor

PSYCHIATRIC

☐ Anxiety
☐ Change in Sleep Pattern
☐ Depression
☐ Hallucinations
☐ Suicidal Thoughts

ENDOCRINE

☐ Appetite Changes
☐ Cold Intolerance
☐ Increased Thirst
☐ Increased Urination
☐ Hair Changes
☐ Sexual Dysfunction

HEMATOLOGY

☐ Easy Bruising
☐ Enlarged Lymph Nodes
☐ Prolonged Bleeding

Patient's Signature ___________________________________ Date __________________

Print Name ____

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