



**CENTRAL ILLINOIS DERMATOLOGY, S. C.**  
**Patient Medical Information**

**Patient Name:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**ALLERGIES:** \_\_\_\_\_

**MEDICATIONS Presently Using (oral and topical):** \_\_\_\_\_

**MEDICAL HISTORY:** Select any of the following medical conditions that apply to you

Artificial Joints	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>
Date: _____		Valvular Heart Disease	<input type="checkbox"/>	Organ: _____	
HIV	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	Neurological / Brain Disease	<input type="checkbox"/>	Family History of Melanoma	<input type="checkbox"/>
Lung Disease	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	Take Aspirin or Advil daily	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Cancer	<input type="checkbox"/>
Unusual Scarring	<input type="checkbox"/>	Pregnant (currently)	<input type="checkbox"/>	Type: _____	
Bacterial Endocarditis	<input type="checkbox"/>	Tubal ligation or Hysterectomy	<input type="checkbox"/>	Other:	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	Take Birth Control Pills	<input type="checkbox"/>	_____	

<p>❖ <b>Do you give our office permission to discuss your medical information with any other individual?</b>      <input type="checkbox"/> YES    <input type="checkbox"/> NO</p> <p align="center"><b>If yes, please provide their name, phone number, and relationship below.</b></p>		
_____	_____	_____
Name	Phone	Relationship
_____	_____	_____
Name	Phone	Relationship

**PAYMENT POLICY**

We will file insurance claims on your behalf with insurances we are contracted with. Because your insurance is a contract between you and your health insurance, it is your responsibility to obtain any necessary authorization and/or referrals (if required). Knowing your policy benefits and limitations is your responsibility. If you have any questions regarding coverage, copayments or deductibles, we strongly suggest you contact your insurance company before any services are rendered. Payment of copays, self-pay fees, and non-contracted insurance fees (including Medicare) are expected at time of service, unless prior arrangements have been made. If you are billing a non-contracted insurance, we can provide an itemized statement which will assist you in billing your insurance carrier. This office cannot accept responsibility for collecting your insurance claim or for negotiating a settlement. You are responsible for payment of all charges on your account. It is our policy to make all reasonable attempts to collect outstanding balances should they accrue, including payment arrangements. All payment plans must be negotiated and approved by the billing staff; we ask that you call as soon as possible to initiate a monthly payment arrangement, if needed. Statements are sent out monthly. If your account is over 90 days past due without attempt at payments to be made, your account will be placed in collection hold and payment in full will be due before any further appointments can be made. I have read the above information and understand Central Illinois Dermatology's Payment Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
 Patient/Parent/Legal guardian or (POA) Power of Attorney

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

With my consent, Central Illinois Dermatology, S.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO).

Please refer to Central Illinois Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. I understand the Notice I received explains my rights and contains information to assist me if I should have questions or a complaint. Central Illinois Dermatology, S.C. reserves the right to revise its' Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Central Illinois Dermatology's privacy officer at 5401 N. Knoxville, Ste. #115, Peoria, IL 61614.

With my consent, Central Illinois Dermatology may call or text numbers listed on my patient information sheet for home, work, cellular phone or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and any call pertaining to my clinical care, including laboratory results. By signing below, I agree to any fees or charges that I may incur for incoming calls/messages, and/or outgoing calls/messages to or from any such number given, without reimbursement from Central Illinois Dermatology.

By signing below, I am giving my consent that Central Illinois Dermatology may mail, securely email or fax to me, at my home or other designated location, any items that assist the practice in carrying out TPO, such as appointment reminder notes, patient statements, and any part of my medical record.

The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this form, I am consenting to Central Illinois Dermatology's use and disclosure of my PHI to carry out TPO.

By signing this form, I, or the person signing for me, acknowledge receiving a 'Notice of Privacy Practices' from Central Illinois Dermatology. 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, Central Illinois Dermatology may decline to provide treatment to me.

\_\_\_\_\_  
Signature of Patient or Legal Guardian

\_\_\_\_\_  
Patients' Name (Print Please)

\_\_\_\_\_  
DOB

\_\_\_\_\_  
Date

112 (01/25)