



DAWES FRETZIN DERMATOLOGY

We are honored that you have chosen us for your skin care needs, and we promise to provide you with the best care available. This page introduces you to some of our office policies and answers many questions you may have.

Our physicians are all Board Certified by the American Board of Dermatology. They are experts in a broad array of dermatologic problems including medical and surgical management of diseases of the skin, hair, nails, as well as cosmetic services designed to enhance the appearance of your skin. In addition to our physicians, our talented staff includes eight experienced Physician Assistants and our knowledgeable estheticians. For a list of our providers and their specialties visit our website at dawesfretzin.com.

SERVICES

Dawes Fretzin Dermatology proudly offers a variety of dermatologic treatments, including medical and surgical management of diseases of the skin, hair, and nails, as well as cosmetic services to enhance the appearance of your skin. Our Skin Care and Aesthetics Center include, but are not limited to:

- Laser treatments for skin tightening, facial blood vessels, age spots, tattoos, and hair removal
- Botox Cosmetic®, and nearly all the available filler products for facial rejuvenation.
- Platelet Rich Plasma (PRP) is available for hair restoration.
- Chemical peels, Ultrasonic facials, HydraFacial, and Micro-needling

Our Skin Care and Aesthetics Center also has the latest in skin care product lines available for facial skin rejuvenation. Same day appointments for our Esthetician may be available.

For more information visit our aesthetics website at dawesfretzinaesthetics.com

APPOINTMENTS

We strive to give all patients the earliest available appointment. We request 24-hour notice for cancellations, as this will enable us to fill the appointment with another patient. Without proper notice there is a \$50 fee for missed general dermatology appointments, a \$100 fee for any missed surgical, cosmetic, Aesthetics or Blu Light appointments, and a \$150 fee for missed Mohs procedure appointments. All Aesthetics packages will expire 1 year from the date of purchase, and may not be shared between patients.

We also reserve the right to dismiss you from the practice for repeated missed appointments.

WHAT TO BRING

- A complete list of the medications (prescription and non-prescription) you are currently taking.
- Your most recent insurance card(s)
- A photo ID
- A referral from your primary care physician, **if necessary/required** by your insurance plan

PAYMENT FOR SERVICES

By contract, we are required to collect copay **at the time of service**. We accept cash, check and Visa/MasterCard/Discover. A service charge of 3% will be applied to all credit card purchases/payments. We will bill your insurance company, and we do accept assignments from them. Any remaining balance will be billed to you. If you do not have insurance, or do not have your card with you for your visit, full payment will be necessary at the time of service. Accounts referred to by an attorney for collection will incur an additional charge.

PRESCRIPTION REFILLS

Please call our office during regular business hours to request prescription refills. We try to accommodate these requests on the same day, though it is not always possible. Return calls will only occur if there is a problem or question regarding your request; you should call your pharmacy to see if the refill has been called in. Yearly visits are necessary to maintain status as an active patient and to qualify for prescription refills.

TELEPHONE CALLS

We understand how frustrating it is to be stuck in a phone messaging system when you call an office. Below you will find a few extensions that you may dial as soon as the message system is engaged. If you leave a message on the scheduling line, you will receive a call back within 24 hours.

Our phones are on from 7:30am to 4:30pm Mon-Thurs & until 4pm on Fridays.

2	Scheduling/Referrals/Front Desk
3	Nursing (prescription refills, medical questions)
4	Mohs
5	Billing
6	Skin Care and Aesthetics Center

If you have an urgent medical need outside of office hours, dialing our office number will tell you how to reach the doctor on call. Routine prescription refills and lab/pathology results are not available after business hours.

OUR OFFICE LOCATIONS

Indianapolis (Castleton)

7910 N Shadeland Ave
Indianapolis, IN 46250
(317) 516-5000

Anderson

7307 Quality Circle
Anderson, IN 46013
(317) 516-5000

Kokomo

2220 W Alto Rd
Kokomo, IN 46902
(317) 516-5000

Indianapolis (East)

1250 N Post Rd, Suite B
Indianapolis, IN 46219
(317) 516-5000

West Carmel/Zionsville

10801 North Michigan Road, Suite 201
Zionsville, IN 46077
(317) 516-5000

Westfield

17300 Westfield Blvd, Suite 320
Westfield, IN 46074
(317) 516-5000



FINANCIAL RESPONSIBILITY STATEMENT:

If no insurance is to be filed by Dawes Fretzin Dermatology Group, full payment is due at time of service. Should valid insurance be provided to the office after the date of service and denied for timely filing, patient will be responsible for the full balance due. Co-payments, co-insurance, deductibles and non-covered services are due at time of service as well. A \$150.00 fee will be assessed for missed Mohs surgery appointments without 24-hour notice. A \$100.00 fee will be assessed for missed surgical, cosmetic, esthetics and Blu Light appointments without 24-hour notice. A \$50.00 fee will be assessed for all other missed appointments without 24-hour notice and for returned checks.

Patient Initials: _____

The undersigned acknowledges that in the event this account is turned over to collection, I will be responsible for the costs of collection, which includes, but is not limited to, reasonable collection agency fees equal to 33% of the delinquent balance, reasonable attorney's fees, court costs, witness costs and prejudgment interest at 8% per annum. Each party further agrees that the Marion County Circuit, Superior, or Small Claims Court shall be the proper court of jurisdiction and venue. Further, each party waives trial by jury.

AUTHORIZATION TO PAY BENEFITS TO PHYSICIAN AND RELEASE INFORMATION:

I hereby authorize payment directly to the Physician of the Surgical and/or Medical Benefits, if any, otherwise payable to me for his/her services as described, realizing I am responsible to pay non-covered services. I also authorize the Physician to release any information acquired in the course of my treatment necessary to process insurance claims.

CONSENT FOR MEDICAL TREATMENT OF A MINOR:

I (we) the undersigned parent, parents, or legal guardian of a minor do hereby authorize and consent to any medical exam or treatment rendered under the general or special supervision of a duly licensed physician, licensed under the provisions of the laws in the State of Indiana. It is understood that this authorization is given in advance of any specific diagnosis, treatment or medical care being required but is given to provide authority and power to render care, which the aforementioned physician in the exercise of his/her best judgment may deem advisable. It is understood that effort shall be made to contact the undersigned prior to rendering treatment to this patient, but that any of the above treatment will not be withheld if the undersigned cannot be reached.

CONSENT TO TREAT:

I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs, and other services and supplies as are considered necessary or beneficial by my physician 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.

RELEASE OF PROTECTED HEALTH CARE INFORMATION VIA TELEPHONE TO ANSWERING MACHINE OR VOICEMAIL:

I give consent and authorization for the Medical or Billing Staff of my Physician's office to leave Protected Health Information about me or for me on my answering machine or voicemail via the telephone number I have listed. I understand I may revoke this privilege at any time by submitting my request in writing to this office.

I acknowledge a receipt of a copy of Notice of Privacy Practices

Date _____ Account# (office use) _____

Patient Name (print) _____

Patient or Parent/Guardian Signature: _____

***If Patient is a minor please complete the following**

Parent/Guardian Printed Name: _____

Parent/Guardian Date of Birth _____

Relationship to Patient _____

***I hereby give my consent for the above-named patient to be seen without a Parent/Guardian present.** _____ (please initial)

Notice to Patients

Although we are affiliated with Community Hospital Network we do not use, and will not be transitioning to, the EPIC EMR system they use. You will be required to fill out demographic and medical history documentation for Dawes Fretzin Dermatology. We apologize if this causes any inconvenience.

PATIENT REGISTRATION FORM				
First Name:	Nickname:	MI:	Last Name:	
Address:		City/State/Zip:		
Date of Birth:	Gender: Male Female Other:		Social Security Number:	
Home Phone:	Work Phone:	Cell Phone:	E-Mail:	
Marital Status: Single Married Divorced Widowed			Spouse Name:	
Pharmacy Name & Location:			Phone Number:	
Emergency Contact Name & Relationship:			Phone Number:	
Preferred Method of Communication: EMAIL HOME PHONE MOBILE PHONE				
Race		Ethnicity		Preferred Language
Family Doctor:			Family Doctor Phone No.	
Referring Doctor if Different:			Referring Doctor Phone No.	
INSURANCE HOLDER		First Name:	MI:	Last Name:
(If other than patient) Mr. Mrs. Ms.				
Address:		City/State/Zip:		
Home Phone:	Work Phone:	Ext:	Date of Birth:	
Gender: Male Female Other:		Social Security Number:		Relationship to Patient:
GUARANTOR		First Name:	MI:	Last Name:
(If other than patient) Mr. Mrs. Ms.				
Address:		City/State/Zip:		
Home Phone:	Work Phone:	Ext:	Date of Birth:	
Gender: Male Female Other:		Social Security Number:		Relationship to Patient:
OTHER INFORMATION				
Approved Person for Medical Information release:			Relationship to Patient:	
Are you interested in Clinical Research Opportunities? YES NO				

Primary Care Physician/Pharmacy

Who is your Primary Care Physician (PCP)? _____

Did a physician specifically refer you to our office? _____

If yes, what is the name of the referring physician? _____

Pharmacy Name/Location/Phone # _____

Please list the reason(s) for your dermatology visit:**Preferred Method of Contact (please circle):**

Cell Phone

Home Phone

Work Phone

Email

Past Medical History (Please Circle YES or NO)

History of non-melanoma skin cancer (basal cell, squamous cell) YES NO Explain: _____

History of Melanoma YES NO Explain: _____

CARDIOVASCULAR

High Blood Pressure YES NO Explain: _____

Coronary Artery Disease (CHF, Heart Attack) YES NO Explain: _____

Arrhythmia (Irregular Rhythm) YES NO Explain: _____

Valve Disease YES NO Explain: _____

PULMONARY

Asthma/Emphysema YES NO Explain: _____

Tuberculosis YES NO Explain: _____

RENAL/KIDNEY

Renal/Kidney Insufficiency YES NO Explain: _____

LIVER/GASTROINTESTINAL

Hepatitis YES NO Explain: _____

Cirrhosis YES NO Explain: _____

Ulcers YES NO Explain: _____

Ulcerative Colitis/Crohn's Disease YES NO Explain: _____

EYE

Cataracts YES NO Explain: _____

Glaucoma YES NO Explain: _____

NEUROLOGIC/PSYCHIATRIC

Seizures/Epilepsy YES NO Explain: _____

Stroke YES NO Explain: _____

Migraines YES NO Explain: _____

Depression/Anxiety/Other YES NO Explain: _____

ENDOCRINE

Diabetes YES NO Explain: _____

Thyroid Abnormality YES NO Explain: _____

High Cholesterol YES NO Explain: _____

GENERAL

Do you require antibiotics before procedures YES NO Explain: _____

Due to valve or joint replacement? YES NO Explain: _____

Osteoporosis YES NO Explain: _____

Arthritis (Osteo or Rheumatoid) YES NO Explain: _____

AIDS/HIV + YES NO Explain: _____

Sun Sensitivity YES NO Explain: _____

History of any cancer (other than skin) YES NO Explain: _____

Any additional Medical History YES NO Explain: _____

Name: _____ **DOB:** _____ **Height:** _____ **Weight:** _____

SMOKING HISTORY

Current tobacco smoker	YES	NO	If so, when started? _____
Current smokeless tobacco use	YES	NO	If so, when started? _____

If you have no past surgeries, check here: ☐

PREVIOUS SURGERIES:	DATE OF SURGERY:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SIGNIFICANT FAMILY HISTORY (PLEASE CIRCLE):

Adopted (unknown)	YES	NO	Explain: _____
Skin Cancer (non-melanoma)	YES	NO	Explain: _____
Melanoma	YES	NO	Explain: _____
- If yes, any family history of Pancreatic Cancer	YES	NO	Explain: _____
Skin Disease	YES	NO	Explain: _____
Psoriasis	YES	NO	Explain: _____
Autoimmune Disorder (Lupus, RA, Thyroid)	YES	NO	Explain: _____
Eczema	YES	NO	Explain: _____
Cancer, other than skin (Please specify)	YES	NO	Explain: _____

If you take NO medications, check here: ☐

MEDICATION	DOSAGE	PRESCRIBED BY	BAD REACTION?	
1. _____	_____	_____	YES	NO
2. _____	_____	_____	YES	NO
3. _____	_____	_____	YES	NO
4. _____	_____	_____	YES	NO
5. _____	_____	_____	YES	NO
6. _____	_____	_____	YES	NO
7. _____	_____	_____	YES	NO
8. _____	_____	_____	YES	NO
9. _____	_____	_____	YES	NO
10. _____	_____	_____	YES	NO

IMMUNIZATIONS

Have you received the Influenza Immunization in the last year?	YES	NO	EXEMPT
If you are 65 or over, have you received either stage of the Pneumonia Vaccination?	YES	NO	

List any allergies to medication and non-drug allergens.

If you have NO allergies, check here: ☐

ALLERGIC TO:	TYPE OF REACTION:
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____

SOCIAL HISTORY

Do you live alone?	YES	NO	
Do you drink alcohol	YES	NO	
Are you pregnant or planning on becoming pregnant?	YES	NO	N/A
Pregnancy prevention method?	YES	NO	If so, please explain: _____

EMPLOYMENT HISTORY

Do you work outside the home?	YES	NO
Occupation:	_____	
Place of Employment:	_____	