# PATIENT REGISTRATION FORM

## Patient Information

| First Name | Middle Initial | Last Name |
|---|---|---|

| Preferred Name | Date Of Birth | Gender |
|---|---|---|

| Address | Apt # | City | State |
|---|---|---|---|

| Zip Code | Home Phone | Cell Phone |
|---|---|---|

Email

Preferred Method of Contact   Home Phone ☐   Cell Phone ☐   Text Message ☐   Email ☐

| Primary Care Provider | Referring Provider |
|---|---|

## Guarantor Information (For Minors, Patients Over 18 Will Be Considered Their Own Guarantor)

| First Name | Middle Initial | Last Name |
|---|---|---|

| Date Of Birth | Relationship to Patient |
|---|---|

| Address | Apt # | City | State |
|---|---|---|---|

| Zip Code | Home Phone | Cell Phone |
|---|---|---|

Email

## Insurance Information

| **Primary Insurance** | Policy ID # | Group # |
|---|---|---|

| Eff. Date | Insured's Name | Insured's Birthdate |
|---|---|---|

| **Secondary Insurance** | Policy ID # | Group # |
|---|---|---|

| Eff. Date | Insured's Name | Insured's Birthdate |
|---|---|---|

## In Case Of Emergency

| Emergency Contact Name | Relationship |
|---|---|

| Home Phone | Cell Phone |
|---|---|

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize this office or insurance company to release any information required to process my claim.

Patient / Guardian Signature ____________________   Date ____________________

# PATIENT REGISTRATION FORM

______ Initials

**CONSENT FOR TREATMENT:** I authorize this office and its personnel to provide ongoing medical care, treatment and procedures (skin biopsies, routine surgical procedures, etc.) as ordered by the physicians and/or other healthcare professionals. Some tissue and cultures are sent to outside laboratories. If your insurance carrier requires a specific facility, please let our team know at the time service is rendered. I acknowledge that no guarantee can or will be made as the results of the care, treatment and medication prescribed.

______ Initials

**CONSENT FOR RELEASE OF INFORMATION:** I authorize this office to release to my insurance carrier(s) including Medicare, Medicaid and any other reimbursing agency information about my identity, treatment, diagnosis, prognosis and/or services rendered as permitted by state and federal law which may be required or requested, thus releasing this office from any liability for furnishing such information. Information may also be sent to other physicians involved in your care. I understand information may be released through electronic or paper media.

______ Initials

**NOTICE OF HEALTH INFORMATION PRACTICES:** I acknowledge that the Notice of this office's Privacy Policy is on file and I may access it at any time.

______ Initials

**ELECTRONIC CONSENT:** I agree to receive communication via email or text message regarding my appointment.

______ Initials

**UNACCOMPANIED MINORS:** After the initial visit, I authorize this office and its personnel to provide any healthcare deemed necessary for the treatment and/or diagnosis of my child as follows:

- ☐ Without any adult present.
- ☐ With the following adult(s) present, who may consent to the treatment of my child and may receive health information related to my child:

| Name | DOB | Relationship |
| --- | --- | --- |
| ______ | ______ | ______ |
| ______ | ______ | ______ |

- ☐ My child may NOT receive care in my absence. I will accompany my child to all visits.

______________________ Patient / Guardian Signature

______________________ Date

# HEALTH HISTORY FORM

| ☐ New Patient<br>☐ Annual Update | Last Name | First Name | MI | Date Of Birth |
|---|---|---|---|---|
| Primary Reason For Today's Visit? | | | | Date |
| Additional Details | | | | |

**Medical History Review of Systems**

Please circle all conditions that apply. Check "No" if none apply.

| System Review | Circle all that apply (presently) | No | Comments |
|---|---|---|---|
| **Constitutional** | Fevers, chills, night sweats | | |
| **Skin** | Color changes, infections, masses, open sores, hair changes, rash, itching, eczema | | |
| **Ears, Nose, Throat** | Loss of hearing, trouble swallowing, nosebleeds, hoarseness,earache, nasal polyps, ear ringing | | |
| **Eyes** | Visual loss or change, trauma, contacts, cataracts, blurred vision, glaucoma | | |
| **Respiratory** | Shortness of breath, asthma, difficulty breathing, emphysema,bronchitis, tuberculosis | | |
| **Cardiovascular** | Heart attack, irregular heartbeat, heart murmur, chest pain, high blood pressure | | |
| **Gastrointestinal** | Ulcer, hepatitis, weight changes, bowel changes, weight gain, weight loss, liver problems, intestinal disorders, reflux | | |
| **Genitourinary** | Painful urination, difficulty urinating, blood in urine, renal disease/failure, frequent urination, kidney problems | | |
| **Musculoskeletal** | Arthritis, weakness, back pain, joint pain, cramps, stiffness, osteoporosis | | |
| **Neurologic** | Seizures, stroke, balance changes, numbness/tingling, headaches, dizziness, migraines, myasthenia gravis | | |
| **Psychological** | Eating disorder, mood changes, sleep changes, domestic abuse, substance abuse, anxiety, depression, mental disorders, nervousness | | |
| **Endocrinology** | Intolerance to cold/heat, thyroid disease, growth changes, low energy, excessive fatigue, diabetic | | |
| **Hematologic** | Blood clots, anemia, bleeding problems, hepatitis, blood transfusions, platelet disorder | | |
| **Immunologic/Allergic** | Dermatitis, latex allergy, hives, rash, asthma, hay fever, diabetes | | |
| **Other Medical Problems** | Such as: Cancers, infectious disease, HIV, autoimmune disease, etc. | | |

| Current Medical Conditions (Check Any That Apply) | | | | | | |
|---|---|---|---|---|---|---|
| Hepatitis ☐ | Leukemia ☐ | Cancer ☐ Type: | Last Hemogloin A1c: | | Kidney Disease ☐ | HIV/Aids ☐ |
| Anxiety ☐ | Diabetes ☐ | Lymphoma ☐ | Atrial Fibrillation ☐ | Hypertension ☐ | Strokes ☐ | Seizures ☐ |

| Past Surgeries (Check Any That Apply) | | | | | | |
|---|---|---|---|---|---|---|
| Appendix ☐ | Breast ☐ | Heart ☐ | Gallbladder ☐ | Liver ☐ | Skin: Squamous Cell ☐ | Skin: Melanoma ☐ |
| Bladder ☐ | Colon ☐ | Joint ☐ | Kidney ☐ | Prostate ☐ | Skin: Basal Cell ☐ | |
| Additional Surgery Details: | | | | | | |

**Skin History**

| Skin Cancer | | |
|---|---|---|
| Have You Ever Had Skin Cancer? ☐ Yes ☐ No | What Type? | When? |

# HEALTH HISTORY FORM

| Other Skin Conditions (Check Any That Apply) | | | | | |
|---|---|---|---|---|---|
| Acne ☐ | Eczema ☐ | Poison Ivy ☐ | Rosacea ☐ | Hay Fever/Allergies ☐ | Actinic Keratosis ☐ |
| Dry Skin ☐ | Psoriasis ☐ | Blistering Sunburns ☐ | Flaking or Itchy Scalp ☐ | Precancerous Moles ☐ | |
| Other(s): | | | | | |
| Additional Skin History Details: | | | | | |

| Sun Exposure History | |
|---|---|
| Do you use sunscreen? If no, why? ☐ Daily ☐ Sometimes ☐ Only Outside ☐ No | |
| What SPF Do You Use? | What is Your Favorite Sunscreen? |
| Do you use an indoor tanning bed? ☐ Current ☐ Past ☐ No | |

| Family History - Skin Cancer | |
|---|---|
| Do You Have a Family History of Skin Cancer? ☐ Yes ☐ No | Which Relatives? |
| Do You Have a Family History of Melanoma? ☐ Yes ☐ No | Which Relatives? |

| Medications and Allergies |
|---|
| Current Medications:<br><br>______ Please initial if you give us permission to access your medication records from your pharmacy. |
| Blood Thinners: ☐ Yes ☐ No ☐ Aspirin ☐ Coumadin ☐ Plavix ☐ Xarelto ☐ Pradaxa ☐ Vitamin E ☐ Fish Oil ☐ Garlic |
| Drug Allergies: |
| Any Other Details We Should Know: |

| Additional Questions | | |
|---|---|---|
| Smoking Status (Choose One) ☐ Every Day ☐ Sometimes ☐ Former ☐ Never ☐ Unknown | Do You Drink Alcohol? (Choose One) ☐ Yes ☐ No Drinks Per Day ______ | |
| Are You Planning On Getting Pregnant? ☐ Yes ☐ No | Is Your Menstrual Cycle Regular? ☐ Yes ☐ No | |
| Have You Ever Taken Accutane? ☐ Yes ☐ No | How Long? | When? |
| Have You Had Your Pneumonia Vaccine? ☐ Yes ☐ No | Do You Have a Health Care Proxy? ☐ Yes ☐ No | Do You Have a Living Will? ☐ Yes ☐ No |
| Any Additional Pertinent Medical History For Immediate Family Members? | | |

**Patient Signature:** ______________________________ **Date:** ______________________

The health care provider signature below indicates this entire form was reviewed to include:
past medical history · family history · social history · surgical history · review of systems

**Provider Signature:** ______________________________ **Date:** ______________________

# FINANCIAL POLICY FORM

Welcome and thank you for choosing us for your dermatologic care. We are committed to providing you with the highest quality care in an efficient, timely and cost-effective manner. Please take a moment to review our financial policy so that you understand your responsibility regarding the charges for the services rendered to you by this office.

**Insurance:** When making an appointment with one of our physicians or providers, it is your responsibility to confirm with our office and your insurance company that the physician or provider is currently contracted with your plan.

**Patient Balance:** If your insurance does not respond to or pay your claim within 45 days, any remaining balance that was not collected at time of service will be billed to patient.

**Co-payment:** All co-payments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Co-payment and co-insurance are determined by your insurance. We accept cash, check, Visa, MasterCard, American Express, Discover and Care Credit. Please be prepared to pay any balance due prior to seeing a physician or provider.

**Deductible:** An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay. Payment for any deductible, co-insurance and non-covered service will be required at the time of service. A $35 fee will be assessed on any and all returned checks.

**Referrals:** If your insurance company requires a referral from your Primary Care Physician (PCP), it is your responsibility to obtain one. If the referral is not sent to us prior to your scheduled appointment you may be asked to reschedule the visit until we have a valid referral on file. It is also your responsibility to ensure that your PCP is listed correctly with your insurance company. If the PCP is not correct at the time of service, you will be responsible to pay for the cost of services rendered.

**Treatment of Minors:** Patients under the age of 18 must be accompanied by a parent or legal guardian to their first appointment to meet the clinician and complete all necessary paperwork. A signed authorization from the parent or guardian allowing our clinician to provide medical treatment is available for subsequent visits. All co-pays or monies due are expected to be paid at the time of each service.

**Determining Guarantor:** The guarantor is the responsible party held accountable for this patient's bill. The guarantor is always the patient if they are over the age of 18. The guarantor for a minor child is the parent that presents the child for care at the time of the initial visit.

**Non-Payment:** If your account is 90 days past due, we will refer your account to an external collection agency. The collection vendor may report your delinquency to a credit bureau and may file litigation in efforts to collect the total balance due. Any litigation fees will be applied to the collection balance.

**Medical Necessity:** I understand that I am responsible for all charges incurred. If my insurance policy determines/denies my procedure as NOT MEDICALLY NECESSARY, I am responsible for payment in full.

**Missed Appointments:** If you are unable to keep your appointment please notify our office at least two business days in advance. Failure to provide two-business-day notice and/or excessive missed appointments could result in additional fees or dismissal from the practice.

**Credit Card on File:** For continuity of care with our practice, we offer the ability to maintain a valid credit card in our PCI compliant secure database. We understand your concerns with providing us this confidential information but assure you that this information is kept confidential.

**Patients Without Insurance (Self-Pay):** Full payment is due at the time of service. Please note, if you have a procedure, your specimen may be sent out for tissue processing which could generate additional fees from the laboratory/pathologist.

**Medicare Payment Policy:** We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-insurance. We do file with secondary supplemental carriers. However, in the event that the secondary does not pay the patient will be responsible for the remaining balance.

**Cosmetic Procedures & Cosmetic Products:** Payment in full for non-covered services and products is required at your visit and is non-refundable. Please come prepared with the proper payment for your treatment, CASH or CREDIT CARD. Cosmetic procedures including, but not limited to skin tag removal, varicose veins, Botox, fillers, laser surgery, hair removal, photorejuvenation, chemical peels, and microdermabrasion treatments are not covered by insurance and claims will not be filed for them. If there is a medical balance due at the time you check in for a cosmetic service, the balance must be paid in full before you can be seen for the cosmetic service.

**Assignment of Benefits:** In consideration of the services provided, with your signature below, this practice is given all rights, title and interest to the medical reimbursement in accordance with the terms of the patient's insurance policy or other health benefit, including Medicare. You are responsible for any unpaid balances not covered by insurance.

We require payment at time of service for every patient's cost share. Our office will review your insurance eligibility and benefits to determine an estimate of your cost share that will include any remaining deductible, co-payment, and/or co-insurance. This amount will be due upon every visit.

We also require that all patients leave a credit card on file. If you are a general dermatology patient you may opt to leave a $150 deposit in lieu of leaving a credit card on file.

A singular statement will be mailed for any remaining balance due for services provided. If payment is not received within 28 days of the statement date, we will charge the remaining balance to your credit card on file.

I grant ______________________________ permission to charge my card on file for all outstanding balances and email me a receipt.

### Credit Card Information

Name on card: ____________________ Last 4 digits: __________ Exp: __________ CVV: ________

**Deposit (General Dermatology Patients):**

☐ I will deposit $150 in lieu of leaving a credit card on file. The deposit will automatically be applied to my account balance. I will receive a statement for any remaining balance and I will pay the outstanding balance within 30 days of receipt.

**I have read and understand this financial policy. I hereby acknowledge receipt of services, authorize this office to bill the credit card I have provided above to keep on file for such services, and agree to take all further actions required to pay the charges in full and to perform obligations set forth in my agreement with my credit card issuer. By signing I agree, in full with the terms and conditions set forth in this financial policy.**

**Patient/Guarantor Printed Name** ______________________________

**Patient/Guarantor Signature** ______________________________ **Date** ______________