_____ NEW PATIENT _____ UPDATED/20____

# PATIENT REGISTRATION FORM


## Dermatology Center of Loudoun, PLC

19455 Deerfield Avenue, Suite 311, Lansdowne, VA 20176

**PH: 703.723.9751 FAX: 703.723.9752**

**Jane T. Nguyen, MD** **Smeena Khan, MD** **Khoa Tran, MD**


**PATIENT INFORMATION** (Please Print) **DATE** __________________

Patient's Name (Last) ______________________________ (First) ________________________ (MI) _____

Nickname ___________________________ Email __________________________________________

Address _____________________________________________________________ Apt # ______________

City __________________ State, Zip _______________ Sex M / F Date of Birth _____/_____/_______

Home Phone __________________ Cell Phone _________________ Work Phone _________________

What is the best daytime number to reach you? ___________________________________________

Marital Status M/ S / D / W (please circle) Spouse's Name ________________________________

Emergency Contact ___________________________________ Phone Number __________________

May we discuss your medical condition with another person? Y N

If yes, whom ________________________________________________ Relationship _________________

Referring Physician Name & Phone # _______________________________________________________

Preferred Pharmacy _____________________________ Location ___________________________

How did you hear about us? ________________________________________________________________

**RESPONSIBLE PARTY** (Note: We do not bill absent parents; the adult presenting the minor for care is the responsible party.)

Guarantor's Name __________________________________ Relationship to Patient ________________

Address: ____________________________________ City, State & Zip: _____________________________

Guarantor's Employer: _____________________________________________________________________

Employer's Address: ________________________________ City, State, Zip: ________________________

Guarantor SS #: __________________ Guarantor Date of Birth: _____ / ______/ _______ Sex: M / F

**PRIMARY INSURANCE**

Name of Insurance Co: ______________________________ Policyholder: _________________________

Relationship to Patient: _______________________ Policyholder Date of Birth: _____/_____/______

Employer: ___________________________________________ Policyholder SS #: ____________________

**SECONDARY INSURANCE**

Name of Insurance Co: ______________________________ Policyholder: _________________________

Relationship to Patient: _______________________ Policy Holder Date of Birth: _____/_____/______

Employer: ____________________________________________ Policyholder SS #: ___________________

Patient's Signature (or Responsible Party) _______________________________ Date: _______________

## CONSENT TO TREATMENT

**Dermatology Center of Loudoun, PLC**
**Jane T. Nguyen, MD** **Smeena Khan, MD** **Khoa Tran, MD**

I, the undersigned, hereby consent to dermatologic evaluation to determine the best treatment course. After discussion with physician and acceptance of treatment(s), I authorize the administration and performance of medically necessary treatment(s); the administration of any needed anesthetics; the performance of any procedures as may be deemed medically necessary or advisable; the use of prescribed medications; the performance of diagnostic procedures; the taking and utilization of cultures and performance of other medically accepted laboratory tests, all of which, in the judgment of the physician, are considered medically necessary or advisable. I also reserve the right to refuse treatment at any time during the evaluation and take full responsibility, holding the physician harmless, for refusing recommended treatment.

Signature of Patient/Responsible Party___________________________________________

Printed Name ________________________________________ Date__________________

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**Dermatology Center of Loudoun, PLC**
**Jane T. Nguyen, MD** **Smeena Khan, MD** **Khoa Tran, MD**

Thank you for choosing Dermatology Center of Loudoun, PLC for your healthcare needs.

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, please sign this form and fax or return it to our office to acknowledge that you have been provided with a copy of our Notice.

Signature of Patient/Legal Representative _______________________________________

Printed Name _______________________________________ Date __________________

________________________________ ______________________ ____________________
Signature of Staff Member Title Date

## INSURANCE AUTHORIZATION

**Dermatology Center of Loudoun, PLC**
**Jane T. Nguyen, MD     Smeena Khan, MD     Khoa Tran, MD**

**ALL INSURANCES EXCEPT MEDICARE**
I certify the information I have provided with regard to my insurance coverage is true and correct. I authorize my insurance company to pay benefits on my behalf directly to Dermatology Center of Loudoun, PLC. I authorize Dermatology Center of Loudoun, PLC or any holder of medical or other information about me to provide to my insurance company any information necessary to process claims for services rendered to me. I permit a copy of this authorization to be used in place of the original.

_______________________________________________     ________________
Signature as it appears on insurance card     Date

**MEDICARE**
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_______________________________________________     ________________
Signature as it appears on Medicare Card     Date

**MEDIGAP**
If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

_______________________________________________     ________________
Signature as it appears on MEDIGAP Card     Date

Y   N Are you covered by any other insurance that makes Medicare secondary?

# PATIENT FINANCIAL POLICY

**Dermatology Center of Loudoun, PLC**
**Jane T. Nguyen, MD        Smeena Khan, MD        Khoa Tran, MD**

This practice has contracts with Medicare and with many managed care plans. Please check with our reception staff to determine whether your plan is one of these.

As a courtesy to our patients, if we have a contract with your plan, we will file a claim with your insurance company upon receipt of a current insurance card. In addition, we will file secondary insurance for Medicare patients only. You are responsible for any and all charges that your insurance company does not cover (deductibles, co-pays, percentages, or non-covered/cosmetic services), which are **due at the time of service**. If your claim is denied, you will be billed and payment in full is due upon receipt of the bill.

If you do not have one of the plans with which the practice is contracted, the **total cost** of your visit is due at the time of service. To assist you in obtaining reimbursement for covered charges, we will provide you with an itemized statement, which you may then submit directly to your insurance carrier.

For HMO participants, in order for your insurance company to pay for your visit, it is **your** responsibility to obtain a referral from your primary care physician prior to **each** visit with us. If a referral is not obtained and your claim is denied, you will be responsible for the full balance upon receipt of the bill.

For your convenience in paying, this office accepts Discover, Master Card and Visa, in addition to cash and checks. There is a **$25.00 charge** for returned checks. If two checks are returned, you will no longer be able to write checks to our office.

If you fail to meet your financial obligation to Dermatology Center of Loudoun, PLC and it becomes necessary to take action to collect on your account, you agree to pay for any and all costs and expenses incurred in the collection of your account, including attorney and collection agency fees.

Because we make every effort to see patients on time, we do not overbook to accommodate patients who do not keep their appointments. Therefore, the practice charges **$25.00** for missed office visit appointments and **$50.00** for missed surgery appointments not cancelled with at least **one business day's notice**. Insurance will not pay for these charges.

I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I certify that I have read and understand the financial policy of Dermatology Center of Loudoun, PLC and agree to fully abide by the policy.

Signature of Patient/Responsible Party__________________________________________

Printed Name ______________________________ Date____________________