# PATIENT REGISTRATION FORM

Dermatology Center of Loudoun, PLC
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**Patient Information**(*Please print in **BLACK** ink*) Date_____

Patient's Name (*Last*) _____ (*First*) _____ (*MI*) _____

Nickname _____ Email _____

Sex: ☐ M ☐ F Date of Birth _____/_____/_____ SS #_____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone _____ Cell _____ Work _____

Primary Language* _____ Marital Status: M / S / D / W (*please circle*)

Race* _____ Ethnicity*: Hispanic or Latino / Not Hispanic or Latino (*please circle*)

**Requested under federal guidelines for "Meaningful Use" to optimize patient-specific treatment and counseling.*

Emergency Contact _____ Relationship _____ Phone _____

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

If yes, whom _____ Relationship _____

Did a doctor refer you to us? If yes, Doctor _____ Phone _____

Preferred Pharmacy _____ Location _____

How did you hear about us? _____

**Responsible Party** (*complete only if the patient is a minor/dependent*)

Guarantor Name _____ Relationship to Patient _____

Home Phone _____ Cell Phone _____ Work Phone _____

Address _____ City, State & Zip _____

Guarantor SS # _____ Guarantor DOB _____ / _____/ _____ Sex: ☐ M ☐ F

**We do **not** bill absent parents; the adult presenting the patient for care is the responsible party.*

**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 # _____

**I hereby certify the above information to be true and correct to the best of my knowledge.**

Signature of Patient/Responsible Party _____ Date _____

# PATIENT FINANCIAL POLICY

**Financial Policy**

You are responsible for any and all charges that your insurance company does not cover. All out-of-pocket costs, including **high deductibles, co-pays, co-insurances, and non-covered/cosmetic fees, will be collected at the time of service.** If your claim is denied, you will be billed and payment is due in full upon receipt of the bill. Please check with your insurance company or our reception staff prior to your appointment if you have any questions regarding your insurance coverage or treatment costs.

**Insurance Participation**

This practice has contracts with Medicare and with many managed care plans. 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.

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.

**Referral Requirements**

For HMO and POS 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.

**Payment Options**

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.

**No-Show Policy**

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 days' 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.*
** Do not sign this form unless you positively understand the consequences of your visit and the charges you may encounter.*

Signature of Patient/Responsible Party _____

Printed Name _____ Date_____

## CONSENT TO TREATMENT

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_____

## PATHOLOGY CONSENT

I, the undersigned, understand that **any and all tissue removed from my skin as part of a medically necessary or a cosmetic treatment will be sent for dermatopathology for tissue evaluation and diagnosis**. All charges related to the skin samples sent for dermatopathology incur a separate fee from the procedure or treatment. The fee may or may not be covered by your insurance. Any costs related to this service are patient responsibility.

Signature of Patient/Responsible Party_____

Printed Name _____ Date_____

## ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

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 to acknowledge that you have been provided with a copy of our Notice of Privacy Practices.

Signature of Patient/Responsible Party_____

Printed Name _____ Date _____

_____ _____ _____

Signature of Staff Member Title Date

# INSURANCE AUTHORIZATION

**For 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 of Patient/Responsible Party Date

**If you have 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.

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

_____ _____

Signature as it appears on Medicare Card Date

**If you have 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

# PATIENT MEDICAL HISTORY FORM

This form is a part of your permanent medical record. Thank you for taking the time to complete it as thoroughly and accurately as possible.

**Patient's Name** (*Last*)_____ (*First*)_____ DOB___/___/___

Nickname _____ **Weight** _____ lbs **Height** _____

**Date of Visit** _____ **Reason for Visit** _____

## COSMETIC CONSULTATION

Please indicate if you would like to discuss treatment options for the following:

☐ wrinkles ☐ sun damage/sunspots ☐ hair removal

☐ spider veins/broken blood vessels ☐ uneven skin texture/tone

## MEDICATIONS

Please list all current medications, including topical creams, vitamins, OTC's, and herbal supplements:

1._____ 6._____

2._____ 7._____

3._____ 8._____

4._____ 9._____

5._____ 10._____

## MEDICAL HISTORY

Please list all current medical conditions:

1._____ 6._____

2._____ 7. _____

3._____ 8._____

4._____ 9._____

5._____ 10._____

Have you ever had skin cancer or atypical moles? **YES** **NO**
If yes, what type _____

Do you require antibiotics prior to surgery or dental work? **YES** **NO**

Are you nursing? **YES** **NO**
Are you pregnant? **YES** **NO**
If yes, due date _____
Are you trying to get pregnant? **YES** **NO**

**ALLERGIES**
Please list any known drug allergies:

1._____ 4._____

2._____ 5._____

3._____ 6._____

Are you allergic to latex? **YES** **NO**

Are you allergic to any local anesthetics? **YES** **NO**

**FAMILY HISTORY**
Please list any medical conditions (including but not limited to skin conditions, such as non-melanoma and melanoma skin cancers, psoriasis, eczema) of the following family members:

Father _____

Mother _____

Siblings _____

Children _____

Paternal Grandfather _____

Paternal Grandmother _____

Maternal Grandfather _____

Maternal Grandmother _____

**SOCIAL HISTORY**
Please be honest. This can affect medication selection and dosing.

1) What is your occupation? _____

2) Do you smoke? **YES** **QUIT** **NO**
If yes, how often and how much? _____

3) Do you drink alcohol? **YES** **NO**
If yes, how often and how much? _____

4) Do you use recreational drugs? **YES** **NO**
If yes, how often and how much? _____

5) Do you use sunscreen? **YES** **SOMETIMES** **NO**

6) How much sun exposure do you normally have? **LIMITED** **MODERATE** **EVERYDAY**

7) Do you have a history of extensive sun exposure or sunburns? **YES** **NO**

8) Do you have a history of tanning bed use? **YES** **NO**

## REVIEW OF SYMPTOMS

Please check any of the following that you have experienced in the past 6 months:

| | | | |
|---|---|---|---|
| **GENERAL**<br>❑ loss of appetite<br>❑ fever / chills<br>❑ fatigue | **DERMATOLOGY**<br>❑ rash<br>❑ dry/sensitive skin<br>❑ suspicious lesions | **BLOOD/LYMPH**<br>❑ swollen glands | |

**I hereby certify the above information to be true and correct to the best of my knowledge.**

Signature of Patient/Responsible Party _____ Date_____