# 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*) _____

Preferred Name ________________________ 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.*

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

If yes, whom ________________________________________________ Relationship _________________

Emergency Contact ____________________ Relationship _______________ Phone _______________

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

Preferred Pharmacy _____________________________ Location _______________________________

How did you hear about us? ______________________________________________________________

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**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.*

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**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

You are responsible for any and all charges that your insurance company does not cover. All out-of-pocket costs, including **deductibles, co-pays, co-insurances, and non-covered/cosmetic fees, will be collected at the time of service.** Any non-covered or other out-of-pocket expenses determined (after claims process) will be billed. All outstanding balance amounts will be requested and collected at the time of check-in for continued/return care visits. If unable to make payment for anticipated out-of-pocket expense at the time of service, we will request a credit card to be kept on file to cover all balances. 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 commercial insurance 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. Coordination of benefit for multiple insurance carriers will be done by special request/management consideration.

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 (PCP) prior to each visit with us. If a referral is not obtained, 1) you have the option to reschedule your appointment until a referral is received or 2) you may proceed with evaluation/ treatment and total cost will be collected at time of the visit. Retro-active referrals or authorization will not be obtained.

**Payment Options**

For your convenience, this office accepts Cash, Checks, Discover, Master Card, and Visa. We also have an on-line payment option (www.dermloudoun.com).
There is a **$25.00 charge for returned checks**. Cash and credit card will be only accepted payment methods for any returned check scenarios.

If you fail to meet you 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. Patient with demonstrated slow pay or bad debt history will be asked for Payment in Full (or a credit card on file) to cover future treatment costs.

**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.

**Cosmetic/Laser Return Policy**
No refunds are made for products, treatment packages or pre-paid treatments once they are purchased. If for some reason you are not able to use an un-rendered, pre-paid service, you may do a onetime exchange of the unused portion toward other services. Unopened products may be exchanged for alternative products within 7 days of purchase.

**Cosmetic/Laser Treatment Expiration**
All treatment packages and pre-paid treatments must be used within 12 months of date of purchase or they will expire without refund or exchange.

** 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.*
** <u>Do not sign</u> 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__________________

## <u>CONSENT TO TREATMENT</u>

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___/___/___

Preferred Name: ________________________ **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**

Have you had your

Flu Vaccine? **YES** **NO**

If yes, when ______________________________

Pneumococcal Vaccine? **YES** **NO**

If yes, when______________________________

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?____________________ How many times a day?__________

3) Do you drink alcohol? **YES** **NO**

If yes, how often?____________________How many drinks a day?__________

How often do you have more than 6 drinks on one occasions?_________________

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