Adult & Pediatric Dermatology, PC

REGISTRATION FORM

(Please Print)

Today's date:

PATIENT INFORMATION

Patient's last name: **First:** **Middle:** **Date of Birth** **Sex**: □M □F **Marital Status** □M □D □S □W

Street Address:

City/State: **Zip Code:** **Country**: □ U.S. □Other_____

Home Phone: **Work Phone**: **Cell Phone:**

Email: **Contact Preference**: □Home □Work □Cell

Language:

□English □Spanish □French □Japanese □Chinese □Russian □Portuguese

□Other _____

Race:

□Black or African American □White □Asian □Japanese □Korean □Chinese □Dominican

□Other_____

_

Ethnicity:

□Dominican □Hispanic or Latino/Spanish □Not Hispanic or Latino □Mexican □Puerto Rican □South American

□Other_____

Primary Care Physician Name & Address:

How did you hear about us? (please check one box): ❑ Dr. ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ New England Cosmetic Surgery ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card to the receptionist.)

Guarantor	Guarantor's Date of Birth: / /	Guarantor's Address (if different from yours):	Home phone number: ( )

Is this person a patient here? ❑ Yes ❑ No

Is this patient covered by insurance? ❑ Yes ❑ No

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

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 non-covered services, or any balances you are contractually obligated to pay as determined by your insurance plan. I also authorize Adult & Pediatric Dermatology, PC, or the insurance company, to release any information required to process my claims.

Patient/Guardian signature *Date*

The person who takes you into the exam room will review this information with you.

Adult & Pediatric Dermatology, PC

Financial Policy

Acknowledgment and Consent

I have received, understand and agree to the financial policy.

Signature of Patient, Parent/Guardian	Print Name of Patient
Description of Parent/Guardian Authority	Date

Notice of Privacy Practices

Acknowledgement and Consent

By signing below, I acknowledge that I have been provided a copy of this Notice of Privacy Practices and have therefore been advised of how health information about me may be used and disclosed by the medical group listed at the beginning of this notice, and how I may obtain access to and control of this information. I also acknowledge and understand that I may request copies of separate notices explaining special privacy protections that apply to HIV-related information, alcohol and substance abuse treatment information, mental health information, and genetic information from my Health Care Provider. Finally, by signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of the medical group, its staff, and its business associates.

Signature of Patient, Parent/Guardian	Print Name of Patient
Description of Parent/Guardian Authority	Date

Adult & Pediatric Dermatology, PC

PERMISSION FOR VERBAL COMMUNICATION

If you would like to grant someone other than yourself, permission to discuss your Healthcare information with a member of APDerm® please complete this form.

_____ _____
(Print name of patient or place patient label here) (Birth date)

_____ _____
(Street address) (City, state, zip code)

_____
(Phone number)

I permit Adult & Pediatric Dermatology, PC, their physicians, nurses, and other personnel ("Healthc are Providers") to discuss health information, in person or by telephone, with the following family members or friends involved in my medical care: (List family members/friends and state the person's relationship to the patient). This authorization is limited to discussions regarding the following medical condition(s):

_____
(If no limitations are listed, discussions will be permitted regarding any medical condition for which the patient has received care.)

Name	**Phone Number**	**Relationship**
1.	_____	_____
2.	_____	_____

Release of information under this document is limited to verbal discussions with my healthcare providers. This document does not permit release of any written health information to the individuals named above. This authorization is limited to the following timeframe from ____(date) to_____(date). If no dates are indicated, this form will remain in effect for an unlimited amount of time.

If, at any time, I do not want verbal discussions to be permitted between my healthcare providers and any of the individuals named above, I must notify my healthcare provider by contacting the privacy officer @ Adult & Pediatric Dermatology, PC, (978) 849-7504.

Patient's Signature:_____ Date:_____

If this release is signed by a representative on behalf of the patient, complete the following:

Representative's Name: _____

Relationship to Patient: _____

INSTRUCTIONS: Please print, sign and sent to:

Adult & Pediatric Dermatology, PC
Attention: Privacy Officer
526 Main Street
Acton, MA 01720

Phone: (978) 849-7504
Fax: (978) 371-0522

OR
Hand to receptionist

5/2012, 12/1/14, 05/07/15

Adult & Pediatric Dermatology, PC

Name: **Date of Birth:**

MEDICATIONS

Please list the name of the medication, the dosage (i.e. 5mg, 10mg etc), and the frequency you take it.

ALLERGIES

Please list all allergies.

PHARMACY INFORMATION

Any prescription we provide to you today will be sent electronically to your pharmacy of choice. Please list the pharmacy below. If there is more than one pharmacy in your town, please be sure we have the correct street name.

PHARMACY NAME:

PHARMACY TELEPHONE: (if you know it)

TOWN OF THE PHARMACY and STREET NAME:

Do you use a mail away pharmacy? ☐**NO** ☐**YES** **If Yes, what is the name of it?**

Adult & Pediatric Dermatology, PC

APDerm® Medical Questionnaire

Today's Date _____

Patient Name: _____ **D.O.B.** _____
(please print legibly)

□ New Patient □ Return Patient

Primary Care Physician
Name/Address: _____
Primary Care Physician Phone#: _____
Chief Concern: _____ Location: _____
Duration of Symptoms: (enter #) ____ (check one) □ Hours □ Days □ Weeks □ Months □ Years

Severity: (check one) □ Same □ Worse □ Better
What things have you tried to help the problem? **(i.e. topicals, antibiotics, creams, over the counter product, prescriptions)** _____
_____
_____

Current Non-Dermatological Problems: (check all that apply)
□ Anxiety □ CHF □ Depression □ Diabetes □ Dizziness □ Hepatitis □ HIV
□ Irregular Heart Rhythm □ Liver Disease □ Lymphoma □ Other _____

Surgical History: (check all that apply)
□ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Keloids Removed □ Melanoma
□ Benign Moles Removed □ Other Skin Cancer Treatment □ Aortic Valve Replacement □ Cancer Treatment □ Mitral Valve Replacement □ Pacemaker
□ Other _____

Family History: (check all that apply)
□ Acne □ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Eczema
□ Hair Loss □ Melanoma □ Psoriasis □ Rosacea

Social History: (check all that apply)
Occupation: _____ **Smoker**? □ Current □ Previous □ Never Packs Per Day? ____
Alcohol use: □ Yes □ No **Sunscreen Use**: □ Yes □ No □ Sometimes SPF? _____

Cosmetic Skin Care: Do you have any cosmetic skin care questions today?

Adult & Pediatric Dermatology, PC

FINANCIAL POLICY

Dear Patient, Parent or Guardian,

Thank you for choosing Adult & Pediatric Dermatology, PC (APDerm®) as your health care provider. We ask all patients to read and sign our financial policy. If you have any questions or concerns about our payment policies, please contact our billing department at (978)371-7010, press 3, press 2.

As with any physician's office, any charges you incur at APDerm®, which are not covered by your insurance carrier, will be your sole responsibility. We understand the high cost of health insurance and we want to help you receive the benefits to which you are entitled. Your insurance policy is a contract between you and the insurance company. Our office cannot guarantee coverage for any service provided by our office because insurance companies will not guarantee benefits until they receive the claim for services. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

Managed care plans (HMO's and some PPO's) require referral authorization for each visit or service from your Primary Care Physician. You are required to ensure that your referral is in place prior to your visit. If a referral is not in place upon check-in, you will be asked to sign a waiver stating that you are aware that your insurance may not cover the visit and you may be billed for the complete cost of the visit.

If you present an insurance card to us that is your secondary insurance and we do not accept it, you will be responsible for all outstanding balances that your primary insurance does not cover. This could include co-payments, deductibles and co-insurances. Lab tests and/or pathology specimens sent to outside laboratories will be billed separately from APDerm's charges. The laboratory/pathology company will bill your insurance carrier for their charges.

Payment for co-payments, outstanding balances, cosmetic procedures and products is expected at the time of service. Claims rejected by the insurance carrier are the financial responsibility of the patient or the parent/guardian of the patient. If the account becomes past due there will be an additional $10 processing fee for going to collections. Please note that there is a $25 fee for returned checks. We understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Please call well in advance to cancel or reschedule appointments. We reserve the right to charge for missed appointments in the range of $50 to $100 per visit when not cancelled 24 hours in advance.

Patients that have questions regarding our financial policy should contact our billing manager at (978) 849-7505. Please be advised that patients who refuse to sign that they have received and accepted our financial policy will not be seen.

We appreciate your trust in us and we appreciate the opportunity to serve you.

Adult & Pediatric Dermatology, PC

In a continuing effort to give you the best possible care and to efficiently manage our medical practice, we have implemented a new service that gives you several convenient ways to make payment.

Pay at the Time of Service

a. **Copay**
b. **Self-Pay**

We accept all forms of payment including cash, check, credit card (Visa, MasterCard, Discover and American Express) or debit card.

We appreciate your cooperation as we strive to make our patient billing process more efficient.