

REGISTRATION FORM

(Please Print Clearly)

Today's date:		Reason for visit:		
How did you hear about us?: <input type="checkbox"/> Friend <input type="checkbox"/> Insurance <input type="checkbox"/> Internet <input type="checkbox"/> Doctor: <input type="checkbox"/> Other:				
Primary Care Physician		Specialist Physician:		
PATIENT INFORMATION				
Patient's last name:		MI:	First:	DOB:
Preferred Name:		Email:		
Street address:		Social Security no.:		Preferred Contact No.:
P.O. box (if preferred):		City:		State & Zip Code:
Mobile No.:		Work No.:		Home No.:
Occupation:		Employer:		Employer phone no.:
GUARANTOR OR RESPONSIBLE PARTY				
(Patient is Responsible Party if OVER 18 years of Age) (Please give your insurance card to the receptionist.)				
Responsible Party's Name:		DOB:	Address (if different):	Preferred Contact No.:
Is this person a patient here?		<input type="checkbox"/> Yes <input type="checkbox"/> No	Relationship to Patient:	
INSURANCE INFORMATION				
<u>Primary Insurance</u>				
Subscriber's name:		Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
<u>Secondary Insurance</u>				
Subscriber's name:		Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
<u>Tertiary Insurance</u>				
Subscriber's name:		Birth date:	Group no.:	Policy no.:
Patient's relationship to subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other				
IN CASE OF EMERGENCY				
Name of friend or relative:		Relationship to patient:	Home phone no.:	Work phone no.:
Health Insurance Portability and Accountability Act (HIPAA) <i>I have been offered a copy of ATLANTA DERMATOLOGY & AESTHETICS, PC'S Notice of Privacy Practice.</i>				
Signature of Patient/Guardian: _____		Date: _____		
AUTHORIZATION INFORMATION				
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 Atlanta Dermatology & Aesthetics, PC or insurance company to release any information required to process my claims.				
Signature of Patient/Guardian: _____		Date: _____		

Past Medical History (please CHECK all that apply):

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial Fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood Pressure	Stroke
COPD	HIV/AIDS	N/A
Coronary Artery Disease	High Cholesterol	
	Thyroid Problems	

OTHER: _____

Past Surgical History (please CHECK all that apply):

Appendix Removed	Mechanical Valve Replacement	Ovaries Removed: Ovarian Cancer
Bladder Removed	Biological Valve Replacement	Prostate Removed: Prostate Cancer
Mastectomy (Right, Left, Bilateral)	Heart Transplant	Prostate Biopsy
Lumpectomy (Right, Left, Bilateral)	Joint Replacement, Knee (Right, Left, Bilateral)	TURP (prostate removal)
Breast Biopsy (Right, Left, Bilateral)	Joint Replacement, Hip (Right, Left, Bilateral)	Spleen Removed
Breast Reduction	Joint Replacement, within last 2years	Testicles Removed (Right, Left, Bilateral)
Breast Implants	Kidney Biopsy (Nephrectomy)	Hysterectomy: Fibroids
Colectomy: Colon Cancer Resection	Kidney Removed (Right, Left)	Hysterectomy: Uterine Cancer
Colectomy: Diverticulitis	Kidney Stone Removal	N/A
Colectomy: IBD	Kidney Transplant	
Gallbladder Removed	Ovaries Removed:	
Coronary Artery Bypass	Endometriosis	
	Ovaries Removed: Cyst	

OTHER: _____

Skin Disease History (please CHECK all that apply)

Acne	Eczema	Psoriasis
Actinic Keratoses	Flaking or Itchy Scalp	Squamous Cell Skin Cancer
Asthma	Hay Fever/ Allergies	N/A
Basal Cell Skin Cancer	Melanoma	
Blistering Sunburns	Poison Ivy	
Dry Skin	Precancerous Moles	

OTHER: _____

Alerts (please CHECK all that apply):

Allergy to Adhesive	MRSA
Allergy to Lidocaine	Pacemaker
Allergy to Topical Antibiotics	Require antibiotics prior to surgical procedure
Artificial Heart Valve	Rapid heartbeat with epinephrine
Artificial Joint Replacement	Are you pregnant or currently trying to get pregnant?
Blood Thinners	N/A
Defibrillator	

Patient Sun Protection

Do you wear sunscreen? Yes No If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Family Medical History (immediate relatives ONLY):

Do you have a Family History of Melanoma? Yes No

If so, which relative?

Medications

(List current medication. if none, put N/A):

Allergies:

(incl. food, & seasonal. If none, put N/A)

Social History (please circle all that apply):

Cigarette Smoking:

Never Smoked

Currently Smokes

Has smoked in the past (socially)

Former Smoker

Alcohol Use:

NONE

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

Race: _____

Ethnic Group: _____

Pharmacy Information (Very Important)

Prescription(s) will be sent to your pharmacy electronically.

Pharmacy Name:

Pharmacy Phone No.:

Pharmacy Address:

Zip Code:

FINANCIAL POLICY

Welcome and thank you for choosing our practice. Our goal is to provide excellent care and superior patient service. Our policies printed below, will help us to better serve you.

Payment

- Our office accepts cash, personal checks, CareCredit, Visa, MasterCard, American Express, and Discover.
- If your insurance cannot be verified at the time of your visit, you may reschedule or be a Self-Pay patient.
- Co-payments are due at the time of service.
- **Co-insurance (deductible) Plans:** If your insurance plan does not require copayment and your deductible or out-of-pocket has not been met, you may receive a bill for your office visit. A deposit may be required prior to scheduling surgical procedures.
- Partial payment may be required when scheduling cosmetic procedures
- **Self-Pay:** New patients - \$175 Established patients - \$100. Procedure costs are quoted by the provider.
- **Refunds:** Our office does not issue refunds for services rendered or products (incl. in-office prescriptions) purchased. You can return the product to the office, and the amount may/will be credited to your account.

Insurance

- The patient is responsible for **ALL** in-network inquiries.
- To protect against fraud you MUST present your insurance card at each visit, and we REQUIRE a government-issued ID on file.
- We will file claims to your insurance carrier and accept payment directly from them. It is the patient's responsibility to keep us informed with up to date insurance coverage and contact information. **Patients are fully responsible for all costs denied by their insurance.**
- **It is your responsibility to know your insurance benefits. We can never guarantee insurance coverage for any service provided.**
- If your plan requires a referral or prior authorization to see the provider, it is your responsibility to obtain this prior to your visit.
- **MEDICARE PATIENTS:** If you are currently covered under Medicare, please present ALL insurance cards at the time of your visit. Medicare offers a Medicare Advantage plan in lieu of traditional Medicare. If you have chosen an Advantage plan and do not present the correct card, you will be responsible for any denied charges.

Labs

- Lab tests ordered through our office are billed separately by the lab to your insurance. Patients are responsible for any lab charges.
- If your insurance requires that tests be sent to a specific lab, **it is your responsibility to tell the Nurse**, not the front desk, at the time the test is ordered.

Collections

- Balances are due within 30 days of statement date.
- **Past due balances:** Outstanding balances are sent to a collections agency and your account with our practice may be closed.
- **BILLING COMPANY: West Coast Derm Billing (WCDB), 1-888-541-9232. Please call for any questions.**

Patients Under 18 Years Old

- The patient registration form must be signed and guaranteed by the legal guardian accompanying the minor at the first appointment. The "Responsible Party" is legally responsible for payment.

Phone Consultations

- For any extensive medical phone conversations or consultations with the providers, a billable code will be filed to your insurance which may or may not be covered by your insurance plan.

Fees

- **Confirmation calls** (made within 2 days of appointment) are considered a courtesy. We are not responsible for voicemails that are full and phone numbers that are disconnected. Patients are responsible for maintaining their appointment dates. To protect the practice, we must charge a "no show" fee for missed appointments. The fee is \$50 for any **missed appointments and appointments cancelled or rescheduled** without a 24 hour notice.
- **Returned check fee:** You will be responsible for the full amount of any check returned from the bank for non-payment, in addition to a \$35 check return fee.
- **Forms:** A fee of \$35 is assessed for printed medical records, medical letters for work, school, legal proceedings, health insurance, and paperwork for life insurance and disability applications.

By signing this form, I am stating that I have read the information above and understand my financial responsibility for my account.

Patient/Guardian signature

Date