Dermatology and Skin Cancer Consultants, PLLC
Patient Registration Form 06/17/2016

Patient Name: ❑ Mr. ❑ Mrs. ❑ Miss. ❑ Ms. ❑ Dr.

First: _____ Middle: _____ Last: _____

Address: _____ City: _____ Zip Code: _____

Social Security#: ____-____-____ ❑ Single ❑ Married ❑ Other: _____

Date of Birth ____/____/____ Gender: ❑Male ❑Female Phone #: (____) _____

Work #: (____) _____ Cell #: (____) _____ Email: _____

We will email ***requested* records to your email address per the HIPAA Omnibus Rule, but please be advised that there is a risk of unencrypted emails being an unsecure method of exchange.**

Emergency Contact: Name:_____ Relationship:_____

PH#: (____) _____ Cell# or Work#: (____) _____

Pharmacy: _____ Street: _____ City: _____

****Social Security Numbers are required for lab work and in tracking insurance payments.****

Primary Insured (Responsible Party) Employment: ❑Full Time ❑Part Time ❑Retired ❑Other

Name (if other than patient): _____

Occupation: _____ Company: _____

Work Address: _____ City: _____ State: _____ Zip Code: _____

SSN: ____-____-____ Birthdate ____/____/____ Relationship to patient _____

If you were referred by a Doctor please provide their information below:

First: _____ Middle: _____ Last: _____

City: _____ State: _____ Phone #: (____) _____

Who is your Primary Care Doctor?

First: _____ Middle: _____ Last: _____

City: _____ State: _____ Phone #: (____) _____

****To request medical records from another doctor, please ask the nurse to sign a records release form.****

I have read the Financial Policy provided to me on a separate sheet by Dermatology & Skin Cancer Consultants, LLC and agree to abide by the terms that it sets forth.

Patient (or Guardian) Signature: _____ Date: _____

Dermatology and Skin Cancer Consultants, PLLC
MEDICAL HISTORY FORM 04/28/2016

What is the Reason for your Visit? _____

Please check below in order to receive test results*

I GIVE DERMATOLOGY AND SKIN CANCER CONSULTANTS, PLLC PERMISSION TO .....

	TEST RESULTS	GENERAL MEDICAL ISSUES
LEAVE MESSAGE ON CELL PHONE	❑	❑
LEAVE MESSAGE ON HOME PHONE	❑	❑
LEAVE MESSAGE WITH SPOUSE	❑	❑
SEND ME TEXTS	❑	❑
SEND ME EMAILS	❑	❑

DRUG ALLERGIES

❑ No Known Drug Allergies

ALLERGIES	
1.	**3.**
2.	**4.**

MEDICATIONS

❑ No Medications ❑ Medications Unknown

CURRENT MEDICATIONS	DOSE (mg)	FREQUENCY	PRESCRIBED BY

❑ *Additional Medications* ***(check here and list on back or have receptionist make copy of list)***

REVIEW OF SYSTEMS (Please check all Current Symptoms)

SKIN

BLEEDING MOLE ❑ No ❑ Yes CHANGING MOLE ❑ No ❑ Yes THINNING HAIR ❑ No ❑ Yes
DRY SKIN ❑ No ❑ Yes NAIL CHANGES ❑ No ❑ Yes
SKIN RASH ❑ No ❑ Yes SUN SENSITIVITY ❑ No ❑ Yes
Additional Notes: _____

ALLERGIC/IMMUNOLOGIC

JOINT PAIN ❑ No ❑ Yes DRY EYES/MOUTH ❑ No ❑ Yes
Additional Notes: _____

CONSTITUTIONAL SYMPTOMS

DIZZINESS ❑ No ❑ Yes NAUSEA/VOMITING ❑ No ❑ Yes
FEVER OR CHILLS ❑ No ❑ Yes UNEXPECTED WEIGHT LOSS/GAIN ❑ No ❑ Yes
Additional Notes: _____

Additional Notes: _____ **Patient Weight:** _____

PAST MEDICAL HISTORY (Please List All Medical Conditions Below)

_____

_____

PAST SURGERIES

OPERATION	DATE	NOTES

SKIN CANCER HISTORY

❑ MELANOMA ❑ OTHER SKIN CANCER Comments: _____

FAMILY HISTORY

		Afflicted Family Member	Comments
NO RELEVANT FAMILY HISTORY	❑		
AUTOIMMUNE DISORDERS	❑		
COLON CANCER	❑		
DIABETES	❑		
THYROID DISEASE	❑		
HIGH BLOOD PRESSURE	❑		
LIVER DISEASE	❑		
LUNG DISEASE	❑		
SKIN CANCER	❑		
MELANOMA	❑		

ALCOHOL & DRUG USAGE

❑ I DO NOT DRINK ❑ OCCASIONAL/SOCIAL (1-2 DRINKS) ❑ DAILY (1-2 DRINKS) ❑ DAILY (3+ MORE DRINKS)
❑ I DO NOT USE DRUGS ❑ I DO USE DRUGS; DRUG TYPES: _____

SMOKING STATUS

CURRENT EVERY DAY SMOKER ❑	CURRENT SOME DAY SMOKER ❑	FORMER SMOKER ❑
NEVER SMOKER ❑	HEAVY TOBACCO SMOKER ❑	LIGHT TOBACCO SMOKER ❑

Smoking Dates: Began _____ Stopped _____

PATIENT VERIFICATION OF MEDICAL HISTORY (Please Check One)

- ❑ I COMPLETED MY ABOVE MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.
- ❑ AS A PARENT/GUARDIAN OF THIS PATIENT, I COMPLETED AND VERIFIED THE ABOVE MEDICAL HISTORY AS TRUE AND ACCURATE TO THE BEST OF KNOWLEDGE.
- ❑ MEDICAL HISTORY OBTAINED BY DERMATOLOGY AND SKIN CANCER CONSULTANTS STAFF.

*****All biopsy specimens are sent for analysis to a Dermatopathologist. You will get a separate bill from the Pathology lab.**

Patient/Guardian Signature: _____ Date: _____

DERMATOLOGY & SKIN CANCER CONSULTANTS

Patient Name:_____Phone #:_____Social Security #:_____

Consent for Financial/Office Policies of Dermatology & Skin Cancer Consultants, PLLC:

Please remember that your health insurance is a contract between you and your insurance company. It is YOUR responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, and lab contracts. As a service to you, we will submit a claim to your insurance company for all visit charges, but we do not share in the contract between you and your insurance company. You are responsible for any charges not covered by your insurance plan. Any amount not covered by the insured/patient's insurance is due on the day services are rendered. A photo-copy of your ID and insurance card is needed by our billing department to assist you in filing your claim. It is the patient's responsibility to inform this office if your insurance requires pre-certification or pre-authorization of services prior to scheduling of such services. The patient will be responsible for services denied by insurance due to "No Eligibility", "Non-Covered Service", "Pre-authorization/Certification Not Obtained". Statements are released after your insurance pays, denies, or non-payment by your insurance. _____

In Network Coverage: For insurance companies that we are contracted with, we will determine your copay due at the time of the visit. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. _____

Out of Network Coverage: For these plans, your copay is due at the time of the visit. You are responsible for the charges of the provided services, which may be higher than the similar services for an in-network provider. Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. Feel free to be a Self-Pay patient and submit your bill for reimbursement to your insurance company. _____

Co-payments, deductibles, and fees: Co-payments and co-insurance amounts, deductibles, and all non-covered items and charges are the insured/patient's financial responsibility and are DUE AT THE TIME OF SERVICE. Failure to produce payment may result in your appointment being rescheduled. Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to patients, you, the insured. Dermatology And Skin Cancer Consultants, PLLC has financial policies to enable efficient operational processes. Please see our Credit Card on File Policy. _____

Self-Pay Patients: Self-pay or uninsured patients are responsible for payment at the time of service. The fee schedule is based upon the fee schedule in place by the practice. _____

Non-Covered Services: Cosmetic services cannot be submitted to insurance and payment in full is due at the time of service by credit card or cash only, no checks will be accepted. _____

Returned Check Fee: All returned checks will be charged a $50 processing fee. _____

Credit Card on File Policy: WE ASK THAT YOU KEEP A CREDIT/DEBIT/HSA CARD ON FILE to be used for any unpaid balances. Due to the high number of deductible plans, and higher patient coinsurance benefits, this has become necessary at our organization. Please keep in mind, we will not charge your card if you do not owe anything. Once your credit card information is entered into our EMR, it is encrypted and safely stored by our organization. By signing the agreement, you understand that once the health plan has paid their portion for your care that you will receive an Explanation of Benefits (EOB). The health plan EOB will state any balance remaining to be paid by the patient. Dermatology And Skin Cancer Consultants, PLLC may charge your credit card the balance due when they receive a copy of the EOB. Charges will be made after the claim has been adjudicated by your insurance and you will have received an EOB from your insurance detailing the amount

billed. If the charge exceeds $250 you will receive a courtesy call or email informing you of the charge. Circumstances when your card would be charged include but are not limited to missed co-payments, deductibles and co-insurance, and non-covered services and/or denial of services. _____

If the credit card we have on file for you changes, please notify us immediately by calling our office at (731) 784-4300. It's not uncommon for people to change or cancel their credit cards, including when it expires. If we run your credit card and it's denied for any reason, we reserve the right to charge an additional $50 declined card fee if we are not able to run a new credit card within 7 days. We will contact you or leave you a phone message if this occurs. _____

Medicare Patients: We will bill Medicare for you. We must have your signature on file and we will also bill secondary insurance carriers for you. We do not bill tertiary insurances. All co-payments are due at the time of service. The patient will be responsible for any balance not paid by Medicare and secondary insurance. _____

Outstanding Balances: If your account is not paid within 30 days of receiving the first bill, you will receive a phone call. If the account balance is not paid in 60 days, your account will be turned over to a collection agency and assessed a 42% processing collection fee. Failure to pay bills will result in dismissal from the practice. ____

Re-billing Fee: A re-billing fee of $5.00 will be imposed on accounts that are over thirty (30) days past-due ___

Referrals: Your insurance plan may require a referral to be completed before seeing a specialist. It is your responsibility to obtain the proper referral in order to be seen for your appointment. If you don't have a referral at your appointment time, your appointment may be rescheduled and you could be charged a missed appointment fee of $30._____

Pathology/Laboratory Services: DSCC uses third parties for our laboratory work and pathology services. You/your insurance will receive an additional bill from the lab service provider (Dermlab, LabCorp, etc.). We are unable to adjust these charges as they are provided by a separate entity. _____

Missed Appointments: Please provide at least 24 hours' notice to cancel an appointment. We do this so your appointment slot can be offered to another patient in need of attention. You will be charged a $30 fee if you fail to keep your appointment or cancel with less than 24 hours' notice. SURGERY appointments require at least 48 hours' notice to cancel an appointment. If you fail to keep your surgery appointment, you will be charged a $50 fee. After TWO missed appointments in a row, you will be dismissed from the practice._____

Prescription Policy: Please call for refills during regular office hours and leave the patient's name, DOB, phone number, medication, and the pharmacy requested. Please allow 48 business hours to complete the request. For oral medications, biologics, and some topical medications, the patient needs to be evaluated every 6 months. We cannot refill a prescription if the patient has not been evaluated within 12 months. Our office does not process PRIOR AUTHORIZATIONS; if your medication requires this we will forward your prescription to a mail order pharmacy to facilitate this process. _____

Minor Policy: All minor patients must be seen on the first visit with their Guardian/Representative. _____

I have read and understand the Financial/Credit Card on File/Office Policies of Dermatology And Skin Cancer Consultants, PLLC. I agree to abide by the policies set forth above.

Patient/Guardian signature: _____Date:_____

DERMATOLOGY
& SKIN CANCER
CONSULTANTS

Consent for Treatment of a Minor Child

I, being the parent or guardian of _____, do hereby request and authorize the physicians and staff of Dermatology and Skin Cancer Consultants, PLLC to perform necessary services for my child which are deemed advisable by the provider whether or not I am present at the actual appointment.

Below is a list of individuals who have permission to bring my child in for treatment:

_____
_____
_____
_____
_____
_____
_____
_____

_____ _____
Signature of Parent or Guardian Date

_____ _____
Witness Date

Patient DOB:_____

*This form should be witnessed by a member of the Dermatology And Skin Cancer Consultants Staff. If you are un-able to accompany your child to his/her initial appointment, your signature must be notarized.

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