Dorset Street DERMATOLOGY
where health meets beauty

Patient Registration Form

Today's Date: _____

Name (Last, First, MI): _____

Preferred name or nickname: _____

Date of Birth: ____/____/_____ Social Security #: _____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Email: _____

Preferred method of contact: ☐ Home ☐ Work ☐Cell phone ☐E-mail

May we e-mail personal medical information to you? ☐ YES ☐ NO

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Other

Race*_____ Ethnicity*_____ Language*_____
**Required for US Government Reporting*

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Primary Phone: ( ) _____ Alternate Phone: ( ) _____

RESPONSIBLE PARTY (if different from patient) – ***MUST BE COMPLETED IF PATIENT IS A MINOR***.

Name: _____ Relationship: _____

Date of Birth: ____/____/_____ Home Phone ( ) _____ Work Phone ( ) _____

Have you contacted your insurance company to verify coverage for your office visit(s)? ☐ Yes ☐ No

Under your insurance plan, is a referral required to see a specialist? ☐ Yes ☐ No

Did another Health Care Provider recommend that you see us today? ☐ Yes ☐ No

If YES, Please list: _____

If NO, how did you hear about us? _____

Are you interested in discussing our skin care products or rejuvenation program? ☐Yes ☐No

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Medical History Form

Name: _____ **Date of Birth:** _____ **Today's Date:** _____

Are you allergic to any medications? ☐Yes ☐No If yes, please list below:

_____

Have you ever had dental anesthesia (Novocaine)? ☐Yes ☐No Did you have a bad reaction? ☐Yes ☐No

List all medications, vitamins, and supplements you are currently taking: _____

_____

_____

_____

Do you have or have you ever had the following diseases or conditions (please leave blank if unknown):

Lungs:		**Other Systemic:**	
Bronchitis	☐Yes ☐No	Diabetes	☐Yes ☐No
Emphysema	☐Yes ☐No	Thyroid	☐Yes ☐No
Asthma	☐Yes ☐No	Kidney	☐Yes ☐No
Chronic Cough	☐Yes ☐No	Bladder	☐Yes ☐No
Morning Cough	☐Yes ☐No	Gastrointestinal	☐Yes ☐No
Wheezing	☐Yes ☐No	Stomach upset when taking antibiotics	☐Yes ☐No
Cardiovascular:		Yeast infection when taking antibiotics	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Arthritis/Joint deformity/Joint pain	☐Yes ☐No
Chest Pain	☐Yes ☐No	Limited motion	☐Yes ☐No
Heart Attack	☐Yes ☐No	Artificial Joint	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Convulsions, seizures, epilepsy	☐Yes ☐No
Irregular Heartbeat	☐Yes ☐No	Fainting	☐Yes ☐No
Phlebitis	☐Yes ☐No		
Pacemaker	☐Yes ☐No		

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ☐Yes ☐No If YES, type: _____

Has anyone in your family had skin cancer? ☐Yes ☐No If YES, type: _____

Do you have a history of any specific skin diseases? ☐Yes ☐No If YES, type: _____

Do you have problems with healing? ☐Yes ☐No

Do you develop keloids (scars) after surgery? ☐Yes ☐No

Do you bleed easily? ☐Yes ☐No

Do you develop skin rashes in reaction to: ☐Medications ☐Food ☐Environment ☐Bandages ☐Neosporin ☐Other _____

Other History:

Do you use tobacco? ☐Yes ☐No If YES, what and how often? _____

Have you been diagnosed with or have you been exposed to HIV (AIDS)? ☐Yes ☐No

Have you been diagnosed with or do you currently have a resistant staph (MRSA) infection? ☐Yes ☐No

Have you been diagnosed with or have you been exposed to Hepatitis C? ☐Yes ☐No

(Women) Are you pregnant or breastfeeding? ☐Yes ☐No Due Date: _____

Name and location of your pharmacy: _____

Patient Signature:_____Date: _____

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Office and Financial Policies

Thank you for choosing Dorset Street Dermatology for your dermatology care. We are committed to providing you with the highest quality medical care, in an efficient, timely and cost-effective manner. Please take a moment to review our financial policy so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Insurance: Please present your insurance card when you check in and we will gladly bill your insurance company for charges incurred at our clinic. If you do not have your card, we will not be able to bill your insurance and payment for all treatment will be required at the time of service. Please remember, your health insurance is a contract between you and your insurance company. It is your responsibility to understand your coverage and benefits, including deductibles, co-insurance, referrals and pre-authorization requirements. If your insurance plan requires a referral or pre-authorization, it is your responsibility to ensure we have one on-file at the time of your visit. If your insurance deems a service to not be a covered service, you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 90 days will become your responsibility as a non-covered service. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date services are rendered.

Co-Payments, Non-Covered Services, and Cosmetic Procedures: Payment is required at the time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express.

Credit Card on File: All medical patients are required to keep a credit card on file and signed authorization to charge the card for patient balances. If the credit card is denied for any reason, we reserve the right to charge an additional $25 administrative fee if we are not able to run a new credit card within 7 days. You will be contacted via phone asking for the new credit card information.

Returned Checks: A $35.00 charge will be added for any non-sufficient funds notices from the bank.

No Shows and Late Cancellations: We require advance notice of one business day if you must cancel your appointment. We reserve the right to charge $50.00 for any appointment that is not cancelled more than one business day in advance.

Collection Fee: Accounts over 90 days old will incur a 1.5% penalty per month and be forwarded to a collection agency.

Minors: A parent or guardian must accompany a minor for their first visit or provide the office with a written consent for treatment before the appointment time. A parent or guardian is responsible for providing current insurance information for the minor, placing a credit card on file for the minor's account, and providing payment in full for any co-pays, non-covered services and cosmetic procedures.

I have read the above policies and accept the terms as outlined above. I give Dorset Street Dermatology permission to release information to my insurance carrier.

Patient or Responsible Party Signature: _____ **Date:** _____

Receipt of Notice of Privacy Practices: My signature below indicates that I have received and/or reviewed a copy of my provider's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature: _____ **Date:** _____

MEDICARE PATIENTS ONLY: The office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement:

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 Medical 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 or benefits apply.

Signature as it appears on Medicare Card: _____ **Date**: _____

If you have a supplemental policy and it is a policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file: I authorize Medicare supplemental benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on Supplemental Insurance Card: _____ **Date**: _____

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Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. These factors are driving offices to either squeeze more patients into shorter periods of time or to stop accepting insurance. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies on average take approximately 2 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims or in person.

I always pay my bills on time. Why do I have to do this?
The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be an in-network provider with most insurance companies. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy or I have other payment questions?
Please contact our billing department directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits.

Will I still receive a paper bill by mail?
Yes. You will receive one bill which will show what will be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, just hold onto the statement for your records and your card will be charged.

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Credit Card on File Agreement

Dorset Street Dermatology has implemented a new credit card policy. Much like many other businesses such as a hotel or car rental agency, attorneys, etc. we now have a similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill.

Co-pays are still due at the time of service.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a statement which you will have 30 days to pay. After 30 days, if the bill remains unpaid, we will bill your credit card.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please do not hesitate to ask.

By signing below, I authorize Dorset Street Dermatology to keep my signature and my credit card information securely on-file in my account. I authorize Dorset Street Dermatology to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Dorset Street Dermatology a new, valid credit card which I will allow them to charge over the telephone. Even though Dorset Street Dermatology is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Visa □ **MasterCard** □ **Discover** □ **American Express** □

Patient's Name (Print): _____ DOB: ___/___/_____

Name on Card (Print): _____

Last Four Digits of Credit Card Number: _____ Exp. Date: ___/____

Please fill out information below for any other person(s) you authorize this credit card for:

Patient Full Name (Print): _____ DOB: ___/___/_____

Patient Full Name (Print): _____ DOB: ___/___/_____

Patient Full Name (Print): _____ DOB: ___/___/_____

Credit Card Holder's Signature: _____ Date: _____

□ Please check this box if you prefer not to receive a statement and would like us to bill your credit card immediately for any balances due after the processing of your insurance.