Patient Registration Form

Patient (Legal) Last Name	Patient (Legal) First Name	Full Middle Name	Preferred Name

Patient's Address (Number, Street, Apt #)	City	State	Zip Code

Billing Address (if same as above, leave blank)

Patient's Address (Number, Street, Apt #)	City	State	Zip Code

Preferred Phone		Home	Cell	Work	Other:
1st Alternate Phone		Home	Cell	Work	Other:
2nd Alternate Phone		Home	Cell	Work	Other:
Email Address					

Marital Status **(circle one)**	Date of Birth	Gender
Single Married Divorced Widow		Female Male

Social Security Number	Preferred Language	Referring or Primary Care Physician

Ethnicity **(circle one)**	Hispanic or Latino / Non-Hispanic or Latino / Unknown
Race **(circle one)**	American Indian or Alaska Native / Asian / Black or African American Native Hawaiian or Other Pacific Islander / Caucasian / Other / Decline to State or Unknown
How did you hear about us?	

Emergency Contact

Emergency Contact's Name	Relationship to Patient	Phone

Health Insurance Information

Health Plan Information	**Primary** Health Plan	**Secondary** Health Plan	**Tertiary** Health Plan
Insurance Name			
Health Plan Address			
ID number			
Subscriber Name / DOB			
Relationship to Subscriber			
Group Number			

Patient Signature _____ Print Name _____

Guardian Signature (if patient is under 18) _____ Print Name _____ Relationship _____

Deerfield Dermatology

Patient Full Name: _____ Date of Birth: _____

Consent for Treatment

I hereby authorize and consent to the performance of examinations, diagnostic procedures, and treatments, which my attending provider and I agree, are necessary. This consent shall remain in effect until I choose to revoke it in writing.

(Minors Only) I agree to immediately notify Deerfield Dermatology, in writing, of any of the following legal status changes between my minor and myself - loss of Parental Rights - Change in Guardianship - Divorce with loss of visitation rights.

_____ _____

Patient Signature Print Name

_____ _____ _____

Guardian Signature (if patient is under 18) Print Name Relationship

Acknowledgement Receipt of Notice of Privacy Practices (NOPP)

The undersigned acknowledges he/she has received a copy of the Notice of Privacy Practices. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information (PHI). You may obtain a copy by contacting our office at (847) 480-0004.

_____ _____

Patient or Legal Representative Signature Date

Staff Use Only:_____NOPP Offered, Pt Declined to Sign_____Emergency Situation NOPP Not Offered

Assignment of Benefits

By signing this document (below), I understand if claims are denied due to eligibility status, invalid medical group, or invalid Primary Care Physician (PCP), I will assume full responsibility for all charges incurred by me and all dependents. Additionally, I will be held financially responsible for any non-covered benefits or deductibles for services, which have been provided to me. I agree to pay such amounts within 30 days of my insurance carrier processing the claim. I hereby assign my insurance carrier to make payments directly to Deerfield Dermatology. I understand that co-payments and outstanding balances are due at the time of service. We always recommend that you check with your health plan prior to receiving any medical services to assess your benefits and eligibility coverage.

It is my responsibility to understand my insurance benefits and plan coverage.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Other Financial Policies

Release of Information for Reimbursement

To the extent necessary to obtain reimbursement, the physician's office may disclose any portion of the patient's record, including his/her medical records, to any party the patient has identified as liable for any portion of the physician's charges, including but not limited to , insurance companies, health care service plans, workers' compensation carriers, social security administration and peer review organizations. You agree, in order for us to service your account or to collect any amounts you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. We may include using pre-recorded/artificial voice messages and/or use of an automatic dialing device, as applicable.

Charges for the Completion of Forms and Copying Medical

There is a charge for the completion of forms and copying of medical records.

Payment Method

For your convenience, we accept Care Credit, American Express, VISA, MasterCard, Discover Card, cash and personal checks. Please make your check payable to Deerfield Dermatology. In the event that a payment is returned due to Non-Sufficient Funds, I understand that I will be assessed a $40.00 charge.

By signing this document, I understand the Assignment of Benefits and Other Financial Policies listed above.

_____ _____

Patient or Legal Representative Signature Date

Medical Information Release Form- HIPAA

Patient Name: _____Date of Birth: _____

Release of Information

□ I authorize the release of information including the diagnostic, records of examination rendered to me, and claims information. This information can be released to:

□ Spouse: _____
(Include name and phone number)

□ Child (ren): _____
(Include name and phone number)

□ Other: _____
(Include name and phone number)

□ This information is not to be released to anyone.

Messages

Please call: □ Home Phone □ Cell phone □ Work number

If unable to reach me:

□ you may leave a detailed message

□ please leave a message asking me to return your call

□ Other: _____

_____ _____
Patient or legal representative signature Date

_____ _____
Print name Relationship (if signed by other than patient)

This release of information will remain in effect until terminated by me in writing.

Financial Policy

Patient Name: _____Date of Birth: _____MRN: _____

Cosmetic Patients:
All cosmetic and laser services are due at the time of service. If in addition, any medical decision making is provided for anything outside of cosmetic services, we will bill your insurance carrier for those charges.

Cancellation Policy:
Please be advised that we require at least a 24-hour notice to cancel or reschedule a medical appointment. A $50.00 will be accessed to your account with a cancellation or reschedule of less than 24 hours' notice or for failure to cancel an appointment.

Card on File

To help ensure that we can assist our patients with making timely payments and continuity of care with our practice, we offer our patients the option to place a "card on file" or a $150.00 deposit on their account to timely take care of balances after their insurance processes their balance. This information is kept confidential and is stored in a PCI compliant database for our patients' security.

Check only one option:

Option 1: Credit card on file: I will receive two statements from Deerfield Dermatology. If no payment is received, then the credit card information provided below will be processed for my balance on my account 15 days following my 2nd statement. An email receipt will be sent to me.

Last 4 digits of Credit Card: _____	Expiration date: _____/_____	CVV Code: _____

I hereby acknowledge receipt of the services, authorize Deerfield Dermatology Associates, LTD, to bill the credit card I have provided above to keep on file for such services., and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.

□ **Option 2:** $150.00 Deposit: I will leave a $150.00 cash or credit card deposit per visit. I will be billed for any remaining balance or refunded if I overpaid on my account.

□ **Option 3:** Self-Pay: I am self-pay or a cosmetic patient and will pay the full balance at the time of service.

I have read, understand and agree to this policy.

_____ _____ _____
Patient Signature Print Name Date

_____ _____ _____
Guardian Signature (if under 18) Print Name Relationship

This release of information will remain in effect until terminated by me in writing.

Welcome to Deerfield Dermatology Associates, Ltd.

Date:

PERSONAL MEDICAL HISTORY

Patient Name: _____
Last Name First Name Middle Initial

Birthdate: _____ / _____ / _____ Age**:** _____

Please check YES or NO for conditions you have or have had in the past.

Y N	FAMILY HISTORY	Y N	PERSONAL HISTORY	Y N		Y N		Y N	
☐☐	Basal Cell Carcinoma Relation: _____Date: _____	☐☐	Basal Cell Carcinoma Date: _____	☐☐	Jewelry/Nickel Allergy	☐☐	Gout	☐☐	Kidney Disease
				☐☐	Latex Allergy	☐☐	Cataracts	☐☐	Liver Disease
☐☐	Squamous Cell Carcinoma Relation: _____Date: ____	☐☐	Squamous Cell Carcinoma Date: _____	☐☐	Iodine Allergy	☐☐	Glaucoma	☐☐	Lung Disease
				☐☐	Seasonal Allergies	☐☐	Colitis-diarrhea	☐☐	Mitral Valve Prolapse
☐☐	Melanoma Type: _____ Relation: _____Date:_____	☐☐	Melanoma Date: _____ Type: _____	☐☐	Photosensitivity	☐☐	Diabetes	☐☐	Multiple Sclerosis
				☐☐	Allergic to local anesthetic	☐☐	Epilepsy	☐☐	Pacemaker
☐☐	Eczema Relation: _____	☐☐	History of skin disease Type: _____	☐☐	Cold sores/ Herpes	☐☐	AIDS/ HIV Positive	☐☐	Prostate Problems/ Cancer
				☐☐	Anemia	☐☐	Heart disease	☐☐	Rheumatic Fever
☐☐	Asthma Relation: _____	☐☐	Actinic Keratosis	☐☐	Arthritis	☐☐	Heart surgery	☐☐	Stroke
		☐☐	Precancerous Mole	☐☐	Bleeding disorder	☐☐	Hepatitis	☐☐	Tuberculosis
☐☐	Seasonal allergies Relation: _____	☐☐	Asthma	☐☐	Blood transfusion	☐☐	High Blood Pressure	☐☐	Venereal Disease
		☐☐	Eczema	☐☐	Cancer Type: _____	☐☐	High Cholesterol	☐☐	Tobacco use qty: ___ Quit___
☐☐	Psoriasis Relation: _____	☐☐	Hives/ Urticaria	☐☐	Joint replacement: _____	☐☐	Hyperthyroidism	☐☐	Alcohol use per week: _____
		☐☐	Food Allergies: _____	☐☐	Past surgeries: _____	☐☐	Hypothyroidism	☐☐	Other: _____

CURRENT MEDICATIONS: ☐ NONE or list
_____

_____
_____

PLEASE LIST ALL MEDICATION ALLERGIES: ☐ NONE
_____

PHARMACY NAME: _____**LOCATION:** _____**PHONE NO.:**
_____

Physician who referred you _____Name of General Internist *(if different)* _____