GERMAIN DERMATOLOGY

NEW PATIENT REGISTRATION

Last Name, First Name _____Middle Initial_____ Nickname_____

SSN#: _____ Date of Birth: _____ Age: ____ Sex: M / F Marital Status: S M D W

Race: _____ Preferred language: _____ Ethnicity: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Preferred Contact Method: Cell phone_____ Home Phone _____ Work Phone _____

Email Address: _____Can we send you email regarding specials and events? ☐ Yes ☐ No

Preferred Appointment Confirmation Reminder: E-mail___ Phone___

Military: Y / N If yes, are you Retired? ☐ Yes ☐ No

Employer: _____ Occupation: _____

Guardian /Parent Name (if patient is under 18):_____

Guardian/Parent SSN#: _____ Guardian/Parent Date of Birth: _____

Emergency Contact: _____ Phone Number: _____

Do you have a Primary Care Physician? ☐ Yes ☐ No
If so, who? _____ Phone Number: _____

Were you referred by a Physician to our practice? ☐ Yes ☐ No
If so, who? _____ Phone Number: _____

Primary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (required): _____ Policy Holder's DOB (required):_____

Secondary Insurance: _____ Policy Holder's Name: _____

Policy Holder's SSN# (required): _____ Policy Holder's DOB (required): _____

PLEASE PRESENT ALL INSURANCE CARDS TO THE RECEPTIONIST

I hereby authorize the physician to provide information to insurance carriers concerning my medical care and I hereby irrevocably assign to the doctor all payments for all the medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance. A copy of this authorization shall be considered as the original. I also give consent for my photo to be taken and used as part of my plan of treatment and confidential medical record.

Signature of Patient or Parent/Guardian: _____Date: _____

Germain Dermatology Medical History

Patient: _____ Date of Birth: ____/_____/_____ Chart#: _____

Do you have now or have you ever had any of the following past medical history?

	Y	N		Y	N		Y	N
Abnormal Bleeding/Bleeding Disorder	□	□	Heart Murmur	□	□	Seizures/Fainting/Epilepsy	□	□
Alcohol/Drug Dependency	□	□	Hepatitis B or C-	□	□	***Please specify**_____		
Anxiety/History of Anxiety	□	□	***Please Specify**_____			Stomach Issues/Crohn's/ IBS/GERD	□	□
Arthritis/Joint Pain	□	□	High Blood Pressure	□	□			
Asthma	□	□	High Cholesterol	□	□	***Please specify**_____		
Cancer (**what type**) _____	□	□	HIV/AIDS	□	□	ADHD	□	□
Defibrillator	□	□	Kidney Disease	□	□	Thyroid Disorder	□	□
Depression/History of	□	□	Liver Disease	□	□	Tuberculosis/History of TB	□	□
Diabetes	□	□	Lupus/SLE	□	□	Other Medical Condition	□	□
Glaucoma	□	□	Mitral Valve Prolapse	□	□	***Please Specify**_____		
Hay Fever/Allergies	□	□	Multiple Sclerosis	□	□			
Hernia	□	□	Pacemaker	□	□			
Heart Attack/Heart Disease	□	□	Stroke	□	□			

Do you have now or have you ever had any of the following past medical skin history?

	Y	N		Y	N
Acne	□	□	Actinic Keratosis (pre-cancerous lesion (s))	□	□
Eczema	□	□	Biopsy Proven Atypical/ Dysplastic Mole	□	□
Fever Blisters/Cold Sores/Herpes Simplex	□	□	Proven Skin Cancer-Unknown Type	□	□
Keloid(s)/Scars/Healing Problems	□	□	Melanoma	□	□
Skin Allergies/Sensitive Skin	□	□	Basal Cell Carcinoma	□	□
Psoriasis	□	□	Squamous Cell Carcinoma	□	□
Rosacea	□	□			

Do you have a family history of the following?

	Y	N		Y	N		Y	N
Acne	□	□	Endocrine Disease	□	□	Psoriasis	□	□
Abnormal Bleeding/Hemophilia	□	□	Heart Disease	□	□	Skin Disease	□	□
Autoimmune Disorders	□	□	High Blood Pressure	□	□	***Please Specify**_____		
Cancer	□	□	Hemophilia	□	□	Skin Cancer- Melanoma	□	□
Diabetes	□	□	Kidney Disease	□	□	Skin Cancer- Basal Cell	□	□
Eczema	□	□	Liver Disease	□	□	Skin Cancer- Squamous Cell	□	□
						Skin Cancer-Type Unknown	□	□

Please list all previous surgeries and dates:

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Are you allergic to any medications? □ y □ n **If yes, list below:**

1._____2._____3._____

Please list all current medications and dosage (ie: prescriptions, acne medications, OTC medications, and vitamins):

1._____2._____3._____

4._____5._____6._____

Are you allergic to any of the following?

Local Anesthetic (lidocaine) □ y □ n Latex □ y □ n Adhesive Tape □ y □ n

Social History

Do you use illegal drugs? □y □n

Do you drink alcohol? □y □n

Smoking History

□Current every day smoker □Former smoker

□Current some day smoker □Never smoker

If YES:

1. How <u>often</u> do you have a drink containing alcohol?
   - □Monthly or less often □2 to 4 times per month
   - □2 to 3 times per week □4 or more times per week
2. How <u>many</u> drinks do you have on a typical day when you are drinking?
   - □Less than 2 □3 or 4
   - □5 or 6 □7 to 9
   - □10 or more
3. How often do you have 6 or more drinks?
   - □Never □Less than monthly
   - □Weekly □Daily or almost daily

FEMALE PATIENTS ONLY

Are you pregnant? □ y □ n

Are you nursing? □ y □ n

Are you trying to become pregnant? □ y □ n

Type of Contraception (please choose at least one option):

Trying to get pregnant	□	IUD	□
Abstinence (not sexually active)	□	Oral Contraceptive (birth control pills)-	□
Condoms	□	***Please specify pill name**_____	
Hormone Implant	□	Post-Menopausal	□
Hormone Shot (Depo or Other)	□	Tubal Ligation	□
Partner Vasectomy	□	Vaginal Ring (NuvaRing)	□
Hysterectomy	□	**NO CONTRACEPTION**	□
N/A **Male**	□	Other- **Please Specify** _____	□

What is your reason for being seen today?_____

Patient Signature (or authorized representative): _____

Date ___/___/___

Pharmacy Name: _____ Phone: _____

Photo Consent

I give consent for medical photographs to be made of me or my child (or for person whom I am legal guardian). I understand that the photos will become a part of my medical record and will be used for medical record purposes only

Financial Policy

Germain Dermatology is dedicated to you and your well-being. We promise to do our best to provide you with the highest possible care available. As a private practice, we are not subsidized by any government or private programs. We offer our service to you at a competitive price that is comparable to any other Dermatology practice in the area

Payment is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, co-payment amount, or non-covered charges from your insurance company.

YOUR MEDICAL INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE WILL FILE CLAIMS WITH YOUR INSURANCE COMPANY AS A COURTESY TO YOU, BUT YOU ARE RESPONSIBLE FOR ANY CHARGES THAT YOU HAVE INCURRED AS A PATIENT WITH GERMAIN DERMATOLOGY. YOU MUST PRESENT A CURRENT INSURANCE CARD AT EACH VISIT. IF YOU OR YOUR CHILDREN DO NOT PRESENT A CURRENT INSURANCE CARD, YOU WILL BE RESPONSIBLE FOR PAYMENT AT THE TIME OF YOUR VISIT.

If your account becomes delinquent and you have not established or met payment options with our billing office, your account will be turned over to a collection agency and we will ask you to seek your medical care from another medical office. If you have a credit of $25.00 or less once your insurance claim has been processed you will be notified and it will remain on your account unless a refund is requested. Refunds are only given in the form of a check and will be mailed out upon request.

Insurance coverage will normally cover payment for some of the healthcare services we provide. Most insurance plans have co-pays, deductibles, or co-insurances that are paid by the patient.

For the plans that Germain Dermatology participates with, we will honor the amount allowed by your insurance company. We will file your claim with them for reimbursement of the charges associated with the services we provided, and we will write off the amount we have agreed to discount. If your plan has a copay/deductible/co-insurance, we are required by the agreement, to collect it at the time of service. We cannot pre-determine what your insurance carrier will/will not define as necessary care. We believe that should be determined by your physician. If, for whatever reason, the company does not pay for the services, please understand you will be responsible for the unpaid balance. You will receive a detailed statement including your insurance companies' response. Due to the delay in receiving payment for the services, and the cost of communicating with them and you, we would appreciate your timely response to any balance remaining. For your convenience, we accept all major credit cards. We are contracted with an outside collection agency to help collect outstanding, past due balances. If you are sent to collections, or if you have a returned check, you will be charged a $30.00 billing fee.

For patients that are presently without insurance coverage, we want you to know that both your physical and financial interests are considered as we treat your illness, however, we are primarily dedicated to treating that illness as effectively as we can. For us to remain efficient and viable, we ask that you pay for treatment at the time of service. Unfortunately, it is impossible to determine what the cost of the care will be prior to the date of service. We will do our best to inform you of what to expect along the way, but please understand that we do not have control over the cost of many of the elements involved in that care We are contracted with an outside collection agency to help collect outstanding, past due balances. If you are sent to collections, or if you have a returned check, you will be charged a $30.00 billing fee.

We are devoted to your care and well-being. Thank you for your cooperation and understanding of our financial policy.

Germain Dermatology Wants You to Know How We Protect Your Private Health Information

Please review the Notice of Health Information Privacy Practices of Germain Dermatology. If you have any questions or concerns, please do not hesitate to ask one of our staff members.

I acknowledge that I have received a copy of the practice's Notice of Privacy Practices and have been given an opportunity to ask questions.

Consent to Disclose Information to Family Member and/or Personal Representative

You may give Germain Dermatology written authorization to disclose your protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, prescription refills, etc.) on your home answering machine, voice mail at work, cell phone, or another party that you designate.

I understand that I may cancel this authorization at any time in writing. However, if I cancel this authorization, I also understand that the cancellation will not affect any action Germain Dermatology took in reliance on this authorization before receipt of written notice of cancellation.

ASSIGNMENT OF BENEFITS
ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Germain Dermatology Associates. I authorize Germain Dermatology Associates to provide to my insurance company any information necessary to process claims for services rendered to me.

MEDICARE

I authorize medical or other information about me to be released to the Social Security Administrations and Health Care Financing Administration or its intermediaries or carrier needed for this or a related Medicare 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 of benefits apply.

MEDIGAP

If you have a supplemental policy and it is a MEDIGAP policy to which you're Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Germain Dermatology Pathology Financial Policy

Pathology is ordered by our providers to properly diagnose certain skin disorders. In most cases, a sample (surgical biopsy) of the suspicious skin growth or rash is taken so that a microscopic examination of the sample can be performed, and a diagnosis can be made. The work associated with processing each biopsy, preparing slides, microscopically examining the slide, and issuing a report of the resulting diagnosis is known as surgical pathology. To increase the quality of care for our patients, we utilize a licensed lab to process these specimens.

Unless specified, **Germain Dermatology Lab** is the Pathology Lab that we will send your specimen to. If you are Self-Insured, or your insurance plan requires a copay, co-insurance, or deductible, for pathology fees, you will receive a separate statement from them directly. If the initial review of your biopsy indicates that further, more in-depth testing will be required to reach the correct diagnosis, additional charges may be billed to you or your insurance company by a non-affiliated lab.

****If your insurance requires, or you prefer the use of a specific lab, it is your responsibility to provide us with that information prior to being seen. Failure to do so may result in additional out-of-pocket costs to you.**

The providers and staff at Germain Dermatology are devoted to your care and well-being. Thank you for your cooperation and understanding of our pathology financial policy.

I have received Germain Dermatology's Pathology Financial Policy. I understand that charges not covered by my insurance, as well as applicable co-payments and deductibles, are my responsibility. I authorize my insurance benefits be paid directly to Germain Dermatology Lab.

Germain Dermatology
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I have read Germain Dermatology's policies and financial practices. I acknowledge that I may request a copy of the policies provided. By initialing below, I confirm that I understand the information given to me today.

Please Initial:

_____ **I understand and agree to the terms of Germain Dermatology's Photo, Financial & Pathology Policy.**

At my request, I authorize Germain Dermatology to disclose my protected health information to:

*****if name is not listed, we *CANNOT* disclose any of your information to anyone other than yourself*****

1. Family Member/Personal Representative: _____
   Relationship to Patient: _____ Phone Number: _____
2. Family Member/Personal Representative: _____
   Relationship to Patient: _____ Phone Number: _____

PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of Practice's *Notice of Privacy Practices*:
By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NPP), and that I have read (or had the opportunity to read if I so chose) and understand the Notice of Privacy Practices (NPP) and agree to its terms.

_____ _____ _____

Name of Patient **Date of Birth** **Signature of Patient/Parent/Guardian** **Date**

How would you like correspondence between you and our office?

- ☐ Leave detailed message on my home answering machine (phone #:_____)
- ☐ Leave detailed message on my voice mail at work (phone #:_____)
- ☐ Leave detailed message on my cell phone voice mail (phone #:_____)
- ☐ Can we send medical financial information via email? (e-mail:_____)
- ☐ Can we confirm your appointments via email? □ Yes □ No
- ☐ Can we confirm your appointments via text message? □ Yes □ No
- ☐ Would you like receive emails about our specials and events?

Are you covered by any other insurance that makes Medicare secondary? Y / N

If Medicare is your secondary insurance, please circle the type of coverage you have:

1. Working Aged/Spouse Group Plan
2. ESRD
3. No Fault/Auto Primary
4. Worker's Comp
5. Public Health Service/ Other Fed Agency
6. Veteran's Admin
7. Disabled
8. Beneficiary Under age 65
9. Other Liability Ins is Primary
10. Black Lung

Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?
YES _____ NO _____

Signature: _____ **Date:** _____

Join Germain Dermatology in the effort to save paper, you may also access these consents online at our website germaindermatology.com