Dermatology Center of Lake Orion
Patient Registration Form
(PLEASE Print Clearly)

Patient Information:

Last Name ________________ First Name ________________ Middle Initial__________ Sr. Jr. II III _____

Date of Birth ____-____-______ Age _____ Gender: M / F

Mailing Address __________________________________ Apt ____ Lot ____ PO Box# _______

City _____________________________ State ___________________ Zip Code ____________

Phone Number: ________________ Home ___________________ Cell ________________ Other

Email Address ____

Marital Status: **(Circle One)** Single Married Divorced Widowed
Race/Ethnicity: **(Circle One)** Asian – White/Caucasian – Black/African American – Hispanic – Other ___________

Emergency Contact ________________________ Relationship _______________ Phone # _________________

Reason for today's visit:

____

____

Duration: ____

Parent or Guardian: _____ Same as Above or

Last Name ________________ First Name ________________ Middle Initial__________

Date of Birth ____-____-______ Age _____ Gender: M / F

Mailing Address __________________________________ Apt ____ Lot ____ PO Box# _______

City _____________________________ State ___________________ Zip Code ____________

Phone Number: ________________ Home ___________________ Cell ________________ Other

Pharmacy Name ____

Pharmacy Address: ____

Pharmacy Phone #: ____

Family Doctor ____________________ **City** __________________ **Phone #** _______________________

Primary Insurance (must be filled out completely if applicable):

Insurance Name: ________________________________ Co-Pay: $____________

Policy Holder/Subscriber Name: _________________________ Relationship to Patient: _________________

Policy Holder's Date of Birth ____-____-_____

ID# __________________________ Group # ______________________________

Subscriber Address (if different)

___

Secondary Insurance (must be filled out completely if applicable)

Insurance Name: ________________________________ Co-Pay: $____________

Policy Holder/Subscriber Name: _________________________ Relationship to Patient: _________________

Policy Holder's Date of Birth ____-____-_____

ID# __________________________ Group/Plan # ______________________

Subscriber Address (if different)

___

I, the undersigned, a patient of Dermatology Center of Lake Orion, do hereby authorize physicians and staff of Dermatology Center of Lake Orion to administer treatment as is necessary. I understand as a courtesy Dermatology Center of Lake Orion will prepare insurance forms and bill my insurance company directly. I hereby request assignment of payment of all insurance benefits to Dermatology Center of Lake Orion. I am ultimately responsible for all services rendered, unless otherwise provided by law.

Patient/Parent or Guardian Signature: X_________________________ Date: ______________

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation-AFIB
Cancer: ___________
COPD
Depression
Diabetes
Hepatitis A, B and/or C
Heart Disease
Other: ____

HIV/AIDS
Hypertension
Hyperthyroidism
Hypothyroidism
Leukemia
Lymphoma
Pacemaker
Seizures
Stroke

Past Surgical History: (procedure and year)

____

____

____

Please list and Skin Cancer Procedures you have had:

____

____

____

Skin History:

Do you have a family history of Melanoma? Yes No
If yes, which relative (s) ________________________________

Any family history of Skin Cancer (s)? Yes No
If yes, which relative(s) _________________________________

Do you wear Daily Sunscreen? Yes No How often: Daily Rarely Never
SPF? _____ Does it contain Zinc Oxide? Yes No

Tanning Salon Use (past or present)? Yes No If yes, how often? ___________

Patient/Parent Signature: _________________________________ Date: ___________

History and Intake Form Continued …..

Dermatology Medical History: (please list below)

____

____

____

____

Have you ever received Botox, Dysport or Fillers (Restylane/Juvéderm) Yes No
If yes, which products? _________________________________

Medications: (please list all current medications and dosage)

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Medication Allergies: (please list)

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Social History:

Cigarette Smoking	Alcohol Usage
Never Smoked	None
Quit: Former Smoker	Less than 1 drink per day/week
Quit Date: _________	1-3 drinks per day/week
Smoke daily _______ pack(s)/day	4 or more drinks/ day

Do you have an Advanced Directive? ________________________________

Patient/Parent Signature: ___________________________________ Date: ___________

Financial Policy/Agreement

Insured Patients: Dermatology Center of Lake Orion is a contracted provider with many insurance companies. Patients are strongly urged to contact their insurance carrier directly with any questions regarding coverage, eligibility and benefits. It is the patient's responsibility to know their insurance benefits; however, if there is a need for assistance in determining coverage of a proposed course of treatment our office is more than happy to help research a patient's insurance coverage and give an estimated out of pocket cost. Co-pays and deductibles are a contractual obligation between the patient and their insurance company as well as Dermatology Center of Lake Orion and the insurance company. Co-pays and/or balances are due at the time of service or within 30 days of receipt of a statement from Dermatology Center of Lake Orion. We understand that extenuating circumstances do arise and our office is more than willing to set up a payment plan that fits your financial situation. Please discuss any financial situation with our billing department as soon as possible.

Uninsured Patients: Patients without insurance will be given a quote prior to their appointment. Payment will be due at time of service. In the event a patient's recommended course of treatment is different than the treatment quoted, the patient will be advised and a new quote will be provided prior to rendering care. Please remember that any biopsies taken at the time of the appointment will be sent to an outside laboratory for preparation and evaluation. This service will incur additional charges by the laboratory and are the responsibility of the patient.

Cosmetic Procedures/Non-Covered Services: It is not Dermatology Center of Lake Orion's policy to set up payment plans for cosmetic or non-covered services. Therefore, payment for these services is due at the time of service.

Out of Network/Non-Contracted Insurance Carrier: In the event that a patient has an insurance with which we are not contracted the patient will be seen as an uninsured patient and will be quoted for services prior to the office visit. Payment will be collected at the time of service. This includes any and all laboratory fees.

Cancellation & No-Show Policy: Please contact our office with at least 24 hours advance notice of appointment cancellation. All No-Show's will be charged a $40.00 fee for all medical appointment and a $100.00 fee for all cosmetic appointments.

Collection Policy/Fees: If you are experiencing financial difficulties, please contact our Office Manager. We will gladly work with you to make payment arrangements. If previous payment arrangements have not been set up with our office, a $ 10.00 past due fee will be added to accounts over 30 days past due. Account balances over 90 days past due may be referred to our collection agency. In the event that your account is turned over to our collection agency, you agree to all fees of the collection agency which may be based on a percentage of your debt owed. All costs, expenses and attorneys' fees will incur in such collection efforts.

My signature below indicates that I understand and accept the above statements.

____ ____________________________

Patient/Parent Signature **Date**

Notice of Patient Privacy Acknowledgement and Consent

We are required by law to protect the privacy of your medical information and to provide you with written notice describing: HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION.

We may use or disclose your medical information both created and received by this practice for purposes of providing or arranging for your health care. This may include information about your health history, heath status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescription, and similar types of health-related information. This may also include information regarding payment for or reimbursement of the care that we provide to you, and any related administrative activities supporting your treatment.

We may be required or permitted by certain laws, regulations, or circumstances to use and disclose your medical information for certain purposes without your authorization. Under other circumstances we may need your written authorization (that you may later revoke) in order to use or disclose your medical information.

As our patient, you have important rights relating to inspecting and copying your medical information that we maintain, amending or correcting that information, obtaining an accounting of our disclosures of your medical information, requesting that we communicate with you confidentially, requesting that we restrict certain uses and disclosures of your health information, and the right to file a complaint if you feel your rights have been violated.

We have available a detailed NOTICE OF PRIVACY PRACTICES which fully explains your rights and our obligations under the law. We may revise this notice from time to time. You have the right to receive a copy of our most current notice in effect. If you have not yet received a copy of our current NOTICE OF PRIVACY PRACTICES OR YOUR MEDICAL INFORMATION, please ask the front desk and we will provide you with a copy.

If you have any questions about the NOTICE OF PRIVACY PRACTICES on your medical information, please contact our office at (248)814.7546

________ Patient/Parent Initials

Release of Confidentiality

I understand that by signing below I am allowing any trained employee of Dermatology Center of Lake Orion to reveal information in this patient chart to:

____

Name **Relationship** **Phone Number**

____

Name **Relationship** **Phone Number**

I will not hold Dermatology Center of Lake Orion responsible for releasing information pertaining to test results, medications, consultations or any other related items to the above-named people. By signing this I also understand that I will not be notified before any information is released and that I do give permission for Dermatology Center of Lake Orion to speak to the people named above about my medical condition or medical records

If the above spaces are left blank, I acknowledge that the staff of Dermatology Center of Lake Orion will <u>NOT</u> release any personal medical information to anyone but the patient OR if the patient is a minor, to parents/guardian.

Patient/Parent/Guardian signature **Date**

<u>Authorization to Leave Messages</u>

It may be necessary that the staff of Dermatology Center of Lake Orion leave you messages regarding scheduled appointments, as well as other information pertaining to your care (i.e.: pathology and lab results). At no time will a staff member of our office discuss your medical condition without your consent. Please indicate below by checking the corresponding preference(s). You have the right to revoke this consent in writing at any time.

_____ I allow Dermatology Center of Lake Orion to leave voice messages reminding me of upcoming appointments at the following number: ________________________

_____ I allow Dermatology Center of Lake Orion to leave detailed voice messages regarding personal information relating to my care (i.e.: pathology or lab results) at the following number: __________________________________

_____ I decline to have Dermatology Center of Lake Orion leave any voice messages.

____________ Patient/Parent/Guardian Initials