Account #_____
Returned Checks $35
Front desk initials_____

Mid - Atlantic Dermatology & Laser Center P.C

New Patient Registration Forms

Name (First,MI,Last)_____Date of Birth____/____/____Age:____Sex: M F

Mailing Address (street)_____Apt#_____

City_____State____Zip_____Home(___)_____Mobile(___)_____

SS#_____Marital Status: ○ Single ○ Married ○ Divorced ○ Widowed ○ Separated

Email address_____Would like to receive emails from Mid-Atlantic Dermatology

Employer _____Phone Number (___)_____

Name of referring physician (Primary Care Physician) _____Phone Number_____

Parent, Spouse, or Responsible Party

Name (First,MI,Last)_____Date of Birth_____/_____/_____Age:_____Sex: M F

Mailing Address (street)_____Apt#_____

City_____State_____Zip_____

Alternate Address (optional)_____

Home Phone (___)_____Mobile Phone(___)_____SS#_____

In case of emergency

Name :(First, MI,Last)_____Phone (___)_____Relationship to Patient_____

Pharmacy Information

Pharmacy Name:_____Phone Number (__)_____Fax(__)_____

Insurance Information

Primary insurance information (all fields must be completed)

Insurance Name: _____

ID/Policy Number:_____ **Group Number:**_____

Subscriber/Policy Holder Information:

Name (First,MI,Last)_____ **D.O.B**____/____/____

SS#_____ **Relationship to Patient**_____

Secondary insurance information (all fields must be completed)

Insurance Name: _____

ID/Policy Number:_____ **Group Number:**_____

Subscriber/Policy Holder Information:

Name (First,MI,Last)_____ **D.O.B**____/____/____

SS#_____ **Relationship to Patient**_____

Third insurance information (all fields must be completed)

Insurance Name: _____

ID/Policy Number:_____ **Group Number:**_____

Subscriber/Policy Holder Information:

Name (First,MI,Last)_____ **D.O.B**____/____/____

SS#_____ **Relationship to Patient**_____

Release of information and assignment of benefits and Insurance authorization consent

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, Insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Responsible Party Signature_____ Date:____/____/____

Name_____ Date_____Date of Birth_____

Do you have or have you ever had any of the Following?

Yes	No	
☐	☐	Skin Cancer/Melanoma
☐	☐	Acne
☐	☐	Cold sores
☐	☐	Keloids/Bad scars
☐	☐	Eczema/ Skin rashes
☐	☐	Difficulty with wound healing
☐	☐	Difficulty with skin infections
☐	☐	Psoriasis
☐	☐	Asthma/hay fever/Hives/Sinus Problems
☐	☐	Rheumatic Fever
☐	☐	Heart Disease
☐	☐	High blood pressure
☐	☐	Heart Murmur/Mitral Valve Prolapse
☐	☐	Artificial joint, heart valve, or Prosthesis
☐	☐	Heart burn/Ulcers/Gastritis/Reflux
☐	☐	Kidney Disease
☐	☐	Glaucoma
☐	☐	Diabetes
☐	☐	Tuberculosis
☐	☐	Blood-Bourne Infections
☐	☐	Autoimmune disease (lupus, rheumatoid Arthritis)
☐	☐	Blood transfusions Dates:_____
☐	☐	Hepatitis-B or C (please circle)
☐	☐	HIV
☐	☐	Surgery/hospitalizations Operation _____Date_____hospital_____

Are you allergic to any medications?
(Please List) If none, Check here

Are you currently taking of using any medication or vitamin/mineral supplements?
(Please list) if none, check here

Other Questions	**Yes**	**No**
Are you currently taking Accutane or have you used Accutane in the past?	☐	☐
Do You smoke?	☐	☐
Do you drink?	☐	☐
Do you bleed easily for a long time after A cut or extraction?	☐	☐

Have any blood relatives ever had any of the Following?

Yes	No	
☐	☐	Skin cancer
☐	☐	Melanoma
☐	☐	Abnormal moles
☐	☐	Asthma/ Hay fever
☐	☐	Eczema/Skin rashes
☐	☐	Diabetes
☐	☐	Psoriasis
☐	☐	Other skin disease_____

Females only

Are you pregnant?	☐	☐
Are you nursing?	☐	☐
Do you take birth control Pills?	☐	☐

Name of birth control ?_____

Signature:_____**Date:**_____

Mid-Atlantic Dermatology & Laser Center, P.C.

Financial Responsibilities - Cosmetic

Payment Options:

We accept Visa, MasterCard, American Express, Discover, Cash and Personal Checks as forms of payment. We also recommend Care Credit Patient Financing, a special program for cosmetic procedure patients. With Care Credit you can finance your cosmetic procedures and surgery without upfront costs, annual fees, or pre-payment penalties.

I understand that this **cosmetic treatment** will not be covered by my medical insurance. I agree to take full responsibility for payment of the charges incurred

The results of certain procedures may not last as long as expected or meet the degree of your expected improvement. It is **important that you understand that all services are non-refundable.**

Any complications requiring additional medical care and/or treatment or revisionary procedures would be your responsibility also.

- **Labs:** Our office utilizes some outside facilities for blood work, biopsies, cultures, etc. Insurance and/or billing are handled separately by these facilities. You will receive a separate explanation of benefits from your insurance carrier. You may also receive a separate bill from the lab, depending on the benefits of your plan.

_____ _____

Signature of Patient or Responsible Party **Date**

Mid-Atlantic Dermatology & Laser Center, P.C. - Financial Policy

We appreciate the opportunity to serve you, and want to thank you for choosing our clinic for your Dermatologic services. We are committed to your treatment success and strive for providing you excellence in service. Prior to receiving any services, we do require you to read and sign the following statement regarding our Financial Policy:

Forms of Payment: We accept Cash, Check, Visa, MasterCard, American Express, Discover and Care Credit

Co-Payments & Deductible Due at Time of Service: Co-pays that are required by your insurance company are due at the time of service. If you have no insurance and are self-pay, or if having an elective non-covered service, your balance in full is required at time of service. If you or any of your family members have an outstanding balance, we may ask for payment of this balance at this time.

INSURANCE: The patient is responsible to make available to the Practice complete insurance information, for accurate filing of claims. Insurance information includes **referrals (HMO)** from your **primary care doctor (PCP)** for primary care doctor and secondary insurance coverage if require. The patient agrees that if the insurance company denies benefits for any reason* that he/she is responsible for the full amount of the bill immediately. **For services not covered by the patient's benefit plan, payment is due at the time of service.**

Rates for Non-Contracted Insurance Carriers: If we have a contract with your insurance carrier, then the maximum financial responsibility of you and your insurance carrier combined is determined by our contract with thern as une **"allowable fee"** for the specific services rendered. However, if we do not have a contract with your insurance carrier, then total financial responsibility is determined by your **Out Of Network** fee schedule for services rendered.

TRICARE PRIME INSURANCE: I understand my insurance requires a prior authorization and/or referral. By initialing below I acknowledge that I have been informed I will need to reschedule my appointment or sign a waiver agreement accepting full financial responsibility if a referral/authorization has not been obtained for my Office Visit/ procedure.

_____**(Patients/ Responsibility Parties Initial)**

Minor Patients: A parent or legal guardian must accompany minors at the time of initial visit, and this person becomes the responsible party. Unaccompanied minors at subsequent visits are still expected to make co-payments and to update any changes to patient or insurance information. If parents are separated or divorced, accurate parent and insurance information is required at the time of service, and only with written consent can any parent become the responsible party. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances.

Returned Check Fees: If your check is returned by the bank due to insufficient funds in your account, there will be a **$35** fee assessed to your account.

Account Balances/ Collection Fees: Our general policy is that balances due be paid within **30 days**. Any balances that goes unpaid for more than 60 days **an additional charge of 1% per month will be added to any accounts that are delinquent**. Please contact us immediately if special financial circumstances arise, as we may be able to make arrangement or a payment plan. Outstanding balances not paid within **90** days will be turned over to a **collection agency & you will be responsible for a maximum of 30% of the debt, and all collection costs, and expenses, including reasonable attorney's fees.**

My signature below indicates that I have read, understand and agree to the terms of this Financial Policy: Thank you for taking the time to read and understanding our Financial Policy. (Revised 2/25/2016)

_____ _____ _____

PRINT **Signature of Patient or Responsible Party** **DATE**

Mid-Atlantic Dermatology & Laser Center, P.C.

PARENTAL PERMISSION FOR TREATMENT OF MINORS

By law, a parent or legal guardian must be present during the exam and treatment of a minor under the age of 18.

If you wish that your child be evaluated and treated by the doctor or medical provider in your Absence, please complete the following.

I_____ give permission for
(Parent/Legal Guardian)

_____ To be evaluated and treated by the
(Minor's Name)
Doctor or medical provider without a parent or legal guardian present.

I have read and agree with the above statements.

_____ _____
Parent/ Legal Guardian Signature Date

_____ _____
Witness Date

Mid-Atlantic Dermatology & Laser Center, P.C.

Consent for Medical Treatment of a Minor

Patient Name _____ **Patient Date of Birth** _____

All minors seeking medical treatment must be accompanied by a **parent/legal guardian** during the first office visit for a new problem. After the initial appointment, a minor may be seen for treatment only with written authorization from the **parent/guardian** under the conditions specified in this consent. If the **parent/legal guardian** cannot attend the appointment, the following instructions that you select will be adhered to in the treatment of the minor patient:

Please circle Yes or No on each of the following items:

Yes/No *I require that all treatment must occur in the presence of the parent/legal guardian. I do not want the minor patient in my care to be seen at all in my absence.*

Yes/No *I authorize Mid-Atlantic Dermatology & Laser Center, P.C. to treat a new diagnosis under the condition that Mid-Atlantic Dermatology & Laser Center, P.C obtains verbal consent from the parent/legal guardian before the new diagnosis is treated.* If a new diagnosis is rendered during a return visit during which the **parent/legal guardian** is not present, *Mid-Atlantic Dermatology & Laser Center, P.C* may treat the new diagnosis with verbal consent from the parent/legal guardian. If the parent/legal guardian cannot be reached at the time of the visit, the new diagnosis will not be treated and a follow-up appointment will be scheduled.

Yes/No *I authorize Mid-Atlantic Dermatology & Laser Center, P.C to write new prescriptions for the minor, and treatment of lesions requiring minor surgical procedures, biopsy, or injections. As deemed necessary for treatment.* Some medications require that blood work and/or a pregnancy test (such as Accutane for the treatment of acne) be given before **prescribing/refilling**. In these circumstances, the **parent/legal guardian/appointed adult must be present.**

Yes/No *I appoint the following adult* _____, *whose relationship to the child is* _____, *to consent to medical care which is deemed necessary by Mid-Atlantic Dermatology & Laser Center, P.C as authorized herein.* A **parent/legal guardian** may appoint another adult to accompany the minor patient to the appointment. If the parent/legal guardian is not available, the Virginia Family Code allows only certain adults to consent for medical treatment to minors if parental consent cannot be obtained. These are: a grandparent, an adult brother, sister, aunt or uncle, and any adult who has actual care, control, and possession of the minor and has written authorization to consent from the parent/legal guardian.

I, _____, am the **parent/legal guardian** of the minor child _____. I have the legal right to consent for medical treatment for this patient. I hereby authorize *Mid-Atlantic Dermatology & Laser Center, P.C* to provide medical treatment as indicated above. I understand that this consent will be valid for 12 months from the date signed unless revoked by me in writing.

_____

Print

_____ _____ _____

Parent/Guardian Name **Parent/Guardian Signature** **Date**

Mid- Atlantic Dermatology & Laser center P.C

Patient consent for use & disclosure of protected health information

With my consent, Mid-Atlantic Dermatology Center may use and disclose protected health information (PHI) about me to carry out treatment, payment & health operations (TPO). Please refer to Mid-Atlantic Dermatology Center's notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Mid- Atlantic Dermatology Center reserves to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Kim Gross, Privacy offer at 828 Healthy Way, Suite 300, Virginia Beach, VA 23462.

With my consent Mid-Atlantic Dermatology may mail to my home to other designated location and leave messages on voice mails or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With my consent Mid-Atlantic Dermatology may mail to my home to other designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statements as long as they are marked Personal and confidential.

With my consent, Mid-Atlantic Dermatology Center may e-mail to my home or other, designated location any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statement. I have the right to request that Mid-Atlantic Dermatology Center restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if It does, its bound by this agreement.

By signing this form, I am consenting Mid-Atlantic Dermatology Center's use and disclosure of my PHI and to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosure in reliance upon my prior consent. If I do not sign this consent, Mid-Atlantic Dermatology Center may decline treatment to me.

_____

Patients Printed Name

_____

Signature of patient or legal guardian

_____

Date