REGISTRATION FORM

(Please Print)

PATIENT INFORMATION				
Patient's Last name:	**First:**	**Middle:**	**Date of Birth:**	**Sex:** □ M □ F **Marital Status:** □ M □ D □ S □ W
Street Address:				
City/State:	**Zip Code:**		**Country**: □ U.S. □ Other__________	
Home Phone:	**Work Phone**		**Cell Phone:**	
Email:			**Contact Preference**: □ Home □ Work □ Cell	
Race: □ American Indian or Alaska Native □ Native Hawaiian or Pacific Islander □ Black or African American □ Other ___________	□ Hispanic □ Asian □ White □ Decline	**Ethnicity:** □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown □ Decline	**Language:** □ English □ Spanish □ French □ Russian □ Portuguese □ Chinese □ Other ______________	
		Interpreter requested for visits? □ YES □ NO		
Primary Care Physician Name:				
Primary Care Physician Address:				
How did you hear about us? (please check one box):		□ My Primary Care Physician	□ Dr.	
□ Family □ Friend □ Close to home/work		□ Insurance Plan □ Hospital	□ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative:	Relationship to patient:	Cell/Home phone no.: ( )	Work phone no.: ( )

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist)			
Primary Insurance Name		Secondary Insurance Name:	
Policy#:	Group #	Policy#:	Group #
Subscriber's Name:		Subscriber's Name:	
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other	Subscriber's Date of Birth:	Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other	Subscriber's Date of Birth:
Subscriber's Address (if different than patient):		Subscriber's Address (if different than patient)	

The above information is true to the best of my knowledge. I have received, understand and agree to the financial policy. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any non-covered services, or any balances I am contractually obligated to pay as determined by my insurance plan. I also authorize Adult & Pediatric Dermatology, PC, or the insurance company, to release any information required to process my claims.	
Patient/Guardian signature	***Date:***
Relationship to patient if signature is not patient:	

Consent to Treatment

Initial: ____ I authorize and request care by Adult & Pediatric Dermatology, PC's physician, physician assistant, and/or nurse practitioner (Provider) and their care team. My Provider will recommend the necessary care to treat my condition. This care may include medical, surgical, or diagnostic treatment such as laboratory tests. Recommended care will not be performed until the treatment or service is explained to me and I consent. I understand I may choose another provider at any time to deliver care or to render a second opinion. I understand my care team may include medical students and other clinical trainees. I am aware that I have the option to decline a trainee's involvement in my care at any time by notifying the practice staff or Provider.

Notice of Privacy Practices

Initial:_____ I acknowledge the receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how my protected health information may be used and disclosed by Adult & Pediatric Dermatology, PC. I understand that Adult & Pediatric Dermatology, PC may change its privacy practices at any time. I also understand that the current version of the Notice of Privacy Practices is available on Adult & Pediatric Dermatology, PC website, at each office, or upon my request.

Financial Policy

If you have questions about our financial policy or to pay your bill, please contact our billing department at (978) 371-7010, press 3, press 2. We accept cash, check, Visa, MasterCard, American Express, and Discover.

Insurance: We participate in most insurance plans. At each visit we verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. It is your responsibility to know your benefits. Please contact your insurance company directly with any questions you may have regarding your coverage.

Co-Payments and Deductibles: Co-payment and co-insurance are determined by your insurance. All co-payments must be paid at the time of service. A deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

Referrals: If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to obtain one. If the referral is not sent to us prior to your appointment, you will be responsible for the cost of services rendered.

Non-Covered Services: Some services you receive may not be covered by your insurance. If you and your provider agree that non-covered services are needed or if you request a non-covered service, you will be responsible for full payment of the non-covered service. Aesthetic services are always payable at the time of the visit.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or guardian to their first appointment. To provide treatment to a minor without the presence of a parent or guardian during subsequent visits, a signed consent form must be on file. All copays or monies due are expected to be paid at the time of each service.

Non-Payment and Returned Checks: We understand that temporary financial problems may affect timely payment of your balance. Please communicate your situation with the billing department so that we can assist you in the management of your account. If your account is 90 days past due, your account will be referred to a collection agency. This agency may report your delinquency to a credit bureau. You also may be dismissed from our practice for non-payment. There will be a $25 charge for checks returned for insufficient funds.

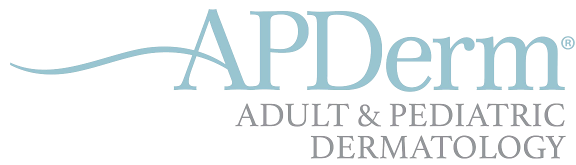
Missed Appointments: Please give us 24 hours advance notice if you must cancel your appointment. We reserve the right to charge $50.00 - $100.00 for missed appointments or for those not cancelled within 24 hours.

By signing below, I acknowledge I have read, understand and agree with the above policies and statements, and that all my questions have been answered in a language that I understand.

Print Patient's Name: ____ Date:______________________

Patient/Guardian Signature: ____

Relationship to Patient (if signature is not patient): _________________________



PERMISSION FOR VERBAL COMMUNICATION

Adult & Pediatric Dermatology, PC recognizes that patients may prefer family members or friends to be involved in their care. For example, a patient may want their spouse or adult child to assist with billing questions, to be informed about appointments on their behalf or to be updated of their health status. This form serves as a record of your wishes. Please complete this form if you would like to allow our healthcare team members to discuss your health information with a specific individual. This document does not permit release of any written health information to the individuals named.

____ (Print name of patient or place patient label here)

______________________________ (Date of birth)

Please list the individual(s) that you allow us to speak with about your care:

Family or Friend's Name	Phone Number	Relationship

I acknowledge and understand that:

- *I am allowing* Adult & Pediatric Dermatology, PC *to share information with the above-named individual(s) only by verbal discussions and that my permission does not give the above-named individual(s) access to my hard-copy or electronic medical record.*
- *The information I allow* Adult & Pediatric Dermatology, PC *to share is not limited unless specified:* _______________ ____.
- *My permission will remain in effect for an unlimited amount of time unless another date is listed or I cancel my permission:* __________________.
- *I can change my permission at any time by contacting the dermatology office where I receive care, but that my cancellation will not have an effect on information shared prior to my cancellation.*
- *Information shared with the above-named individual(s) may be further shared by them and not protected under confidentiality and privacy laws.*
- *My permission is voluntary, and* Adult & Pediatric Dermatology, PC *may not condition my treatment, payment or eligibility for services on my signature.*
- *If at any time I do not want my healthcare team members to discuss my healthcare information with the above-named individual(s), I must provide written notice to the dermatology office where I receive care or contact the privacy officer at (978) 849-7582 or 526 Main Street, Suite 302, Acton, Massachusetts 01720*.

By signing below, I acknowledge I have read, understand and agree with the information on this form and that all my questions have been answered in a language that I understand.

Patient/Guardian Signature:______________________________Date:____

Representative's Name: ________________________________Relationship to Patient : ___________________________

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ADULT & PEDIATRIC DERMATOLOGY

Name: **Date of Birth:**

MEDICATIONS
Please list the name of the medication, the dosage (e.g., 5mg, 10mg), and the frequency you take it.

ALLERGIES
Please list all allergies.

PHARMACY INFORMATION
Any prescription we provide to you today will be sent electronically to your pharmacy of choice. Please list the pharmacy below. If there is more than one pharmacy in your town, please be sure we have the correct street name.
PHARMACY NAME:
PHARMACY TELEPHONE: (if you know it)
TOWN OF THE PHARMACY and STREET NAME:

Do you use a mail away pharmacy? ☐NO ☐YES If Yes, what is the name of it?

Adult & Pediatric Dermatology, PC Medical Questionnaire

(Please print legibly)

Today's Date: ___________________________

Patient Name: ____ **Date of Birth**: ________________________

□ New Patient □ Return Patient

Chief Concern: ____

Location: ____

Duration of Symptoms: (enter #) ______ (check one) ☐ Hours ☐ Days ☐ Weeks ☐ Months ☐ Years

Severity: (check one) ☐ Same ☐ Worse ☐ Better

What have you tried to help the problem? (e.g., topicals, antibiotics, creams, over the counter product, prescriptions)
____
____
____

Current Non-Dermatological Problems: (check all that apply)

□ Anxiety □ CHF □ Depression □ Diabetes □ Dizziness □ Hepatitis □ HIV

□ Irregular Heart Rhythm □ Liver Disease □ Lymphoma □ Other__________________________

Surgical History: (check all that apply)

□ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Keloids Removed □ Melanoma

□ Benign Moles Removed □ Other Skin Cancer Treatment □ Aortic Valve Replacement □ Cancer Treatment

□ Mitral Valve Replacement □ Pacemaker □ Other_____________________________________

Family History: (check all that apply)

□ Acne □ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Eczema □ Hair Loss

□ Melanoma □ Psoriasis

Social History: (check all that apply)

Occupation_____________________________ Smoker? □ Current □ Previous □ Never Packs Per Day_____

Alcohol use: □ Yes □ No Sunscreen use: □ Yes □ No □ Sometimes SPF?_________