Medicare Patient Registration

Name: ______________________________________ ❑ Female ❑ Male
First *Middle* *Last*

Date of Birth: ____________________ Social Security #______________________
Month / Day / Year

Address: ____
Street # *Street Name* *Apt#*

____
City *State* *Zip*

Home Phone: (___)___________________ Cell Phone: (___)___________________

Employer____

Email if you would like to receive our news letters______________________________

Emergency Contact

Name of Spouse or Close Relative or Friend___________________________________
Phone (_____)_________________________

PRIMARY INSURANCE
Policy Name______________________
Insured's Name____________________
DOB__________**Relation**____________

SECONDARY/SUPPLEMENTAL INSURANCE
Policy Name____________________
Insured's Name________________
DOB__________**Relation**_________

Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.

Answer questions below by placing a check in the appropriate column:

YES	NO	
❑	❑	Are you in a Medicare HMO other Senior Medicare Plan? If yes, Identify:___________________________
❑	❑	Have you recently joined a Medicare Advantage Plan? If yes, identify: ___________________________
❑	❑	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
❑	❑	Are you covered by a commercial HMO/PPO which makes Medicare secondary?
❑	❑	Is this illness covered by the VA (Veteran's Administration)?
❑	❑	Is this illness covered by the Federal Black Lung or End Stage Renal Disease Program?
❑	❑	Is this illness due to an automobile accident?
❑	❑	Is this illness due to an injury at work?
❑	❑	Are you receiving Medicaid?

Please turn over your authorization is needed to file claims on your behalf

Payment Policy

***Medicare**:* **We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual $155.00 deductible and paying for the 20% copayment. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**

Medicare Authorization:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information 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.

___________________________________ ____/____/____

Signature as it appears on Medicare card *Date*

Supplement Insurance or Medicare Advantage

If you have a supplemental policy and it is a supplemental policy to which your Medicare carrier automatically "crosses over" or a **Medicare Advantage Plan** we are required to keep a separate signature on file:

I request authorized supplemental benefits and/or **Medicare Advantage Plan** *be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.*

___________________________________ ____/____/____

Signature as it appears on insurance card *Date*

Commercial Insurance Primary to Medicare:

If you have a commercial insurance policy that is primary to Medicare, we are required to have your signature on file authorizing us to file claims for you and to release information to that payor if they require it for proper consideration of a claim.

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

______________________________________ _____/____/____

Signature as it appears on insurance card *Date*

02/17/2010

Office Policies

APPOINTMENTS: Patients are seen by appointment. For urgent and acute situations we often schedule "work-in" appointments. Work in appointments are made to address one acute problem only so that patients with scheduled appointments are not kept waiting. Except in emergencies, patients with scheduled appointments will be seen before "work-in" patients.

We work very hard to keep our appointment schedule. However, because we see emergencies in the office there will inevitably be delays. We apologize in advance.

We will call to confirm most appointments two days in advance. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment. **We charge $25.00 for missed appointments.**

SOCIAL SECURITY NUMBERS: We handle patient's social security numbers and personal information in a confidential manner but we may release personal and medical information to another doctor's office in the event of a referral. We use social security numbers for insurance and billing purposes at Atlantic Dermatology Associates. This required information we ask from each of our patients.

INSURANCE: Insurance is a contract between you and your insurance company. We are actually not involved in that contract, therefore, we cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, labs, or other charges. Currently we file claims for BCBS plans that can be filed through NC, United Health Care, Medcost, Cigna, NCTA, Aetna, Medicare and Tricare. For all other insurance, we will provide you with the required information so you can file your claim with your insurance company. If we are non-participating with your insurance plan, then you will be responsible for payment at the time the services are provided. If you have an insurance that has a co-payment, our office policy is to collect this before services are rendered. Also, if there is any change in your insurance carrier, it is your responsibility to inform us prior to your appointment.

You must have a current insurance card for us to file your insurance. If you do not have your card at the time of your appointment, you will be expected to pay in full if you wish to be seen, or your appointment can be rescheduled.

MINORS: All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area.

PAYMENT: Payment is due from each patient at the time of service. We accept cash, check, VISA, and MasterCard. We do not bill parents or guardians not present in the office at the time of their appointment. Patients with co-pays, deductibles, percentages, etc are expected to pay at the time of their appointment. Simply put, payment of any portion of your bill that you are responsible for "out of pocket" is expected at the time of your appointment. There will be a $35.00 service fee on all returned checks.

PHONE CALLS: You may need to contact the office with questions. Most call may not be returned for up to several hours. Please provide a return phone number that can be reached for several hours, or provide additional phone numbers. In an emergency dial 911 first.

AFTER HOUR PROBLEMS: We are on call 24 hours a day, available only for urgent issues that cannot wait for the office to open the next business day. To contact us, please call the office number.

ACKNOWLEDGEMENT: I have read, understand, and agree to follow the above office policies.

Patient/Guardian signature__________________________ Date_______________

Printed name of patient______________________________

Printed name of guardian and
relationship to patient if applicable____

History and Intake Form

Past Medical History:

Anxiety Y/N
Arthritis Y/N
Asthma Y/N
Atrial fibrillation Y/N
BPH Y/N
Breast Cancer Y/N
Colon Cancer Y/N
COPD Y/N
Coronary Artery Disease Y/N
Depression Y/N
Diabetes Y/N
End Stage Renal Disease Y/N
GERD Y/N
Hearing Loss Y/N
Hepatitis Y/N
Hypertension Y/N
HIV/AIDS Y/N
High cholesterol Y/N
Hyperthyroidism Y/N
Hypothyroidism Y/N
Leukemia Y/N
Lung Cancer Y/N
Lymphoma Y/N
Prostate Cancer Y/N
Radiation Treatment Y/N
Seizures Y/N
Stroke Y/N
Bone Marrow Transplantation Y/N
Other ____

Past Surgical History:

Appendix Removed Y/N
Bladder Removed Y/N
Mastectomy Y/N
(Right, Left, Bilateral)
Lumpectomy Y/N
(Right, Left, Bilateral)
Breast Biopsy Y/N
(Right, Left, Bilateral)
Breast Reduction Y/N
Breast Implants Y/N
Colectomy Y/N
Colon Cancer Y/N
Resection Colectomy: Y/N
Diverticulitis Irritable Bowel Disease Y/N
Gallbladder Remove Y/N
Coronary Artery Bypass Y/N
Angioplasty (PTCA) Y/N
Mechanical Valve Replacement Y/N
Biological Valve Replacement Y/N
Heart Transplant Y/N
Replacement, Knee
(Right, Left, Bilateral) Y/N
Replacement, Hip
(Right, Left, Bilateral) Y/N
Kidney Biopsy Y/N
Kidney Removed (Right, Left) Y/N
Kidney Stone Removal Y/N
Kidney Transplant Y/N
Endometriosis Y/N
Ovarian Cyst Y/N
Ovaries Removed Y/N
Ovarian Cancer Y/N
Prostate Removed TURP Y/N
Prostate Cancer Y/N
Prostate Biopsy Y/N
Skin Biopsy Y/N
Basal Cell Cancer Surgery Y/N
Squamous Cell Cancer Surgery Y/N
Melanoma Surgery Y/N
Spleen Removed Y/N
Testicles Removed Y/N
(Right, Left, Bilateral)
Hysterectomy Y/N
Fibroids Y/N
Uterine Cancer Y/N
Other: _______________

Skin Disease History:

Acne Y/N
Actinic Keratoses Y/N
Asthma Y/N
Basal Cell Skin Cancer Y/N
Blistering Sunburns Y/N
Dry Skin Y/N
Eczema Y/N
Flaking or Itchy Scalp Y/N
Hay Fever Or Allergies Y/N
Melanoma Y/N
Poison Ivy Y/N
Precancerous Moles Y/N
Psoriasis Y/N
Squamous Cell Skin Cancer Y/N
Other: _________________

Name: ____ Today's Date: __________________
DOB: __/___/____ Age: _______ Who is your Family Physician?______________________________
How were you referred to Atlantic Dermatology Associates, PA?______________________________
Referring Physicians & Possibly other physicians will be updated of your care unless you circle: Do Not Update

Do you faint easy with procedures? Y/N
Do you wear Sunscreen? Y/N If yes, what SPF? _________
Do you tan in a tanning salon? Y/N
Do you have a family member with Melanoma? Y/N
If yes, which relative(s)? ____

Medications: (Please enter all current medications)

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Allergies: (Please enter all allergies)

____

____

Social History:

Sexually active with one partner	Y/N	Has smoked in the past	Y/N
More than one partner?	Y/N	Drug Use	Y/N
Currently Smokes	Y/N		

Review of Systems: Are you currently experiencing any of the following?

***If yes to any of these symptoms, please follow up with your primary care provider as we only treat dermatological conditions.*

Pacemaker	Y/N	Yeast infections on *Antibiotics*	Y/N	Cough	Y/N
Defibrillator	Y/N	GI upset with *Antibiotics*	Y/N	Depression	Y/N
Artificial Joints *Within past 2 yrs*	Y/N	Bleeding problems	Y/N	Fever or chills	Y/N
Artificial heart Valve	Y/N	Problems healing	Y/N	Headaches	Y/N
Meds Required *Prior To procedure*	Y/N	Scarring *(Keloid/ Hypertrophic)*	Y/N	Hay Fever	Y/N
Adhesive allergy	Y/N	Immunosuppression	Y/N	Joint aches	Y/N
Allergy to *topical antibiotics*	Y/N	Changing Mole	Y/N	Muscle weakness	Y/N
Blood thinners	Y/N	Rash	Y/N	Neck stiffness	Y/N
Pregnant or planning Pregnancy	Y/N	Abdominal Pain	Y/N	Night sweats	Y/N
Allergy to *Lidocaine*	Y/N	Anxiety	Y/N	Seizures	Y/N
Rapid heartbeat to *epinephrine*	Y/N	Bloody Stool	Y/N	Shortness of breath	Y/N
		Bloody Urine	Y/N	Sore throat	Y/N
		Blurry Vision	Y/N	Thyroid problems	Y/N
		Chest Pain	Y/N	Unintentional Weight loss	Y/N
				Wheezing	Y/N

Are you interested in cosmetic or Esthetic Services? Y/N What bothers you? ______________________

______________________________ __/__/__ ______________________________ __/__/__
Patient Signature (or Guardian) Date Physician/Nurse Date

Pharmacy of choice: ____

NAME:______________________________ DATE:_________________________

COSMETIC SKIN CARE SERVICES

Dear Patient:

New technologies have expanded the range of products and procedures available to enhance the appearance of your skin. To help us provide you with the services you desire and the best treatment possible, we would like you to answer a few questions regarding your skin, hair and nail needs. So please take a few minutes to give us this important information.

Thank You,

The following is a list of the various cosmetic services we provide to our patients. Please indicate the procedures in which you may be interested, or for which you would like more information from the doctor or our nurses.

- "AGE SPOT" REMOVAL
- BOTOX THERAPY-for crows feet and forehead lines
- COSMETIC MAKEOVER/COSMETIC PRODUCTS/SUNSCREENS
- FACIAL PEELS-for lines and spots
- INDIVIDUALIZED TOTAL SKIN CARE REGIMENS
- LASER HAIR REMOVAL
- LASER REMOVAL OF FACIAL VEINS, SUN OR AGE SPOTS
- MICRODERMABRASION-for smoothing facial lines and evening skin color
- ALPHA HYDROXY ACID PRODUCTS-topical therapy anti-aging/wrinkles
- SCLEROTHERAPY-leg "spider" vein removal
- TATTOO REMOVAL
- THERAPY FOR BRUISED SKIN/DARK EYE CIRCLES
- JUVEDERM AND RESTYLANE FILLERS-for nasal folds and lip and mouth lines

ADDITIONAL COMMENTS:

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Revised 8/29/07