Medical Dermatology Specialists, Inc.

PATIENT REGISTRATION FORM

5730 Glenridge Drive, Suite T-100, Atlanta, GA 30328

Patient Information:

Patient Name: _____ Social Security Number: _____-_____-_____

Date of Birth: _____/_____/_____ **Sex:** M / F (**Circle one)** Married/Single/Divorced/Widow

Spouse Name: _____

Address: _____

Race: _____ Religion: _____ Primary Language: _____

Home Phone: (____) _____-_____ Work Phone: (____) _____-_____ Cell Phone: (____) _____-_____

Primary Phone: _____**E-mail Address**: _____

Would you be interested in having communications sent to you via your e-mail address? (Examples: appointment Reminders, administrative updates and health bulletins) Yes **?** No?

Other Information:

Primary Care Physician: _____

Who referred you? _____

Preferred Pharmacy:

Pharmacy Name: _____ Address: _____

Pharmacy Phone: (____) _____ Pharmacy Fax: (____) _____

Person responsible for bill or parent (Complete only if different from patient)

Guarantor Name: _____ Social Security Number: _____ - _____ - _____

Relationship to Patient: (please check): ( ) self, ( ) spouse, or ( ) parent Date of Birth: _____/_____/_____

Address: _____ Phone Number: _____

Emergency Contact:

Name: _____ Address: _____

Home Phone: (__) _____ - _____ Work Phone: (___) _____-_____ Relationship: _____

INSURANCE INFORMATION

Insurance Company: _____ Policy Holder: _____

Address: _____ Group Number: _____

Policy Holder ID#:_____ Policy Holder's DOB: ____/_____/_____

I authorize the release of any medical information necessary to process this bill to my insurance company, and request payment of benefits to Medical Dermatologist Specialists. I acknowledge that I am financially responsible for payment whether or not covered by insurance. **(If under 18, parent or legal guardian must sign).**

Signature: _____ Date: _____

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PATIENT MEDICAL HISTORY

Patient Name _____ Account # _____ Date _____

Reason for today's visit _____

Who is your primary care physician? _____

Who referred you to us? _____

MEDICAL HISTORY

Please check those medical conditions that apply to you (this information is kept confidential).

____Heart Disease
____Heart Murmur/Artificial heart valve
____Stroke
____ Gastrointestinal Problems
____Hypertension
____Poor Healing
____Diabetes
____Endocrine or Hormone Stroke Problems
____Skin Cancer
____Seizure Disorders
____Cancer
____Herpes Infections
____Arthritis
____Breathing Difficulties
____HIV Positive
____Sexually Transmitted Diseases
____Tuberculosis
____Shingles
____Hepatitis/Liver disease/Jaundice
____Blood Clotting Disorders
____Asthma / Hayfever
____Kidney Disease
____Other (Please explain below)
____Ulcers
____Seasonal Allergies

Please explain any conditions checked above _____

Please list ALL medications you are currently taking (including aspirin, laxatives, birth control pills, vitamins, etc.)

_____

ALLERGIES (list all known allergies to latex, metals, medications, jewelry, etc.)_____

Do you have a family history of skin cancer? If so what type? _____ ____Yes ____No

Have you ever had skin cancer? If so, what type? _____ ____Yes ____No

Do you have any changing or suspicious moles? _____ ____Yes ____No

(Moles with unusual colors or bleeding)? _____ ____Yes ____No

Are you pregnant or nursing? _____ ____Yes ____No

If no to pregnant are you trying to get pregnant? _____ ____Yes ____No

When was your last flu shot? Date? _____

Do you use tobacco? Yes ___No___ (Such as smokeless tobacco products, cigars, or cigarettes) If yes, how much?

_____

Do you drink alcohol? ____Yes ____No

Are you taking a blood thinner, like Coumadin or aspirin? ____Yes ____No

If so, which? _____

Do you have a heart problem or artificial joint that requires you to take antibiotics before a surgical or dental procedure?

____Yes ____No

Do you have a pacemaker? ____Yes ____No

Thank you for your time in completing your medical history. This helps your doctor to keep current with your health. It is our goal to provide you the best care possible.

Patient / Guarantor Signature *_____ Date _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGMENT OF RECEIPT

I,_____, hereby acknowledge that MDS has given me the opportunity to read a detailed notice of their Privacy Practices.

Patient / Guarantor Signature*_____ Date_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian. If not signed, please provide a reason why the acknowledgment was not obtained.

Witness_____ Date_____

CONSENT TO RELEASE INFORMATION

In the event I cannot be reached, I,_____ give permission for a representative from MDS, to speak with family member (s) or companion (s) listed below regarding care or tests results.

Name_____Phone _____

Relationship_____

Name_____Phone_____

Relationship_____

Is it OK to leave results or information on your voicemail? _____YES _____NO

Patient / Guarantor Signature*_____ Date_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

CONSENT TO CORRESPOND ELECTRONICALLY OR VIA TEXTING

While MDS takes reasonable precautions to protect your confidential information, emails and texts are not a completely secure method of communication.

I acknowledge that if I use electronic mail or texting to initiate contact with a MDS physician or provider regarding my medical care, that MDS physician and /or his/her representative has my permission to correspond via that email address or text.

I give permission for a MDS physician or clinical staff member to email me at _____

_____ or text my cell# at: _____regarding my medical care.

Patient / Guarantor Signature*_____ Date_____

*If patient is a minor (under the age of 18), form must be signed by a parent or legal guardian.

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FINANCIAL POLICY AGREEMENT

_____ _____ _____

PATIENT NAME (PLEASE PRINT) CHART/ACCOUNT NUMBER

Medical Dermatology Specialists is committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangement s as simple as possible. In order to accomplish this in a cost effective manner, we have adopted the following financial policies and ask that you adhere to the following guidelines:

1: You are ultimately responsible for paym ent of charges for services you receive from ou r office. Any check payment dishonored by your bank may res ult in a $45.00 returned check charge being added to your account. _____ (initials)

2: It is your responsibility to provide us with your current address, telephone number, an insurance information at each visit.

3: It is your responsibility to contact your i nsurance carrier to confirm that our physicians participate in your plan. If you see our doctor and they are not currently on your plan, you will be responsible for payment in full.

4: All co-payments and deductibles are du e at time of service. A $25.00 service fee will be charged for failure to pay the co-payment or deductible at time of service. We also reserve the right to refuse t o allow any follow up visits if an outstanding balance exists. ___ _____ (initials)

5: If you miss your appointment, you will be charged a NO-SHOW fee of $50.00 for each a ppointment missed. The NO-SHOW fee of $125.00 will be char ged for a missed procedure/surgical/cosmetic service visit. All cancellations must be at least 1 business day prior to the time of the visit to not be charg ed a NO-SHOW fee. Even rescheduling less than 24 hours prior to your appointment will result in the charge of the NO-SHOW fee. _____ (initials)

6: If your plan requires a referral it is your responsibility to obtain this prior to being seen by the doctor. If we are required to obtain the referral for you, please notify our office 72 hours prior to the visit s o that we have ample time to acquire this information from your insurance company.

FINANCIAL POLICY AGREEMENT

7: Laboratory/Pathology services may be provided by a contracted outside reference lab. Lab/Path charges not covered by your medical insurance will be billed to you by an independent lab/path billing service. I accept responsibility for valid lab/path charges not covered by my medical insurance plan.

8: All medical record requests must be in writing and received in our office 1 week prior to the date needed. Records over 10 pages will only be mailed, not faxed and all medical record requests will have a fee associated based on the number of pages. The usual range of fees for this service is $10-$50, however, very large files may actually require a fee greater than $50.

9: Your insurance company will send you an Explanation of Benefits (EOB) that will explain how the insurance company paid your bill. The EOB will also explain any amount for which you may be responsible. Some insurance plans require you to pay different out of pocket amounts based on where the service is performed. By law, you are responsible for these amounts, as well as for any non-covered services outlined in your health plan. MDS will submit primary, secondary and tertiary claims of our contracted payers on your behalf, but you the patient are responsible for any co-payments, co-insurance and all deductibles. If you did not pay these fees at the time of service they are due in full upon receiving a statement with amount owed from our office or billing service. _____ (initials)

10: Refunds will be processed within 4-5 weeks after any overpayment is discovered on the patient's account or at the time the refund is requested. Patients who have insurance but have made a partial payment or payment in full will not be refunded until payment is received in full from their insurance company. _____ (initials)

11: Our office specializes in Medical Dermatology which means a vast majority of our patients require certain administrative services from us for you that are not covered by your insurance company and that you will be responsible for. Due to that reason our office is collecting an optional Administrative Services Fee (ASF) of $50.00 annually. If elected, the ASF will be effective for a 12 month period from the date you signed. The ASF is only intended to cover the costs of certain administrative services we may provide that are not covered by your insurance. You are not required to pay the ASF; however, if you choose not to pay the optional fee, you will be charged for all non-covered administrative services, as needed. A list of administrative services with associated fees is listed below. _____ (initials)

ADMINISTRATIVE SERVICES FEE (ASF)

Services you are responsible for paying as needed and/or have requested. Includes but not limited to:

1: Completion of all patient requested forms, letters and/or documents requiring the physician's signature; which also include administrative forms requested by third parties, (excludes your insurance company and/or another physician) will be provided to you at $50 per form.

Examples of the forms you the patient may request us to complete and provide:

a. School
b. FMLA (Family Medical Leave Act)
c. Disability
d. Employer
e. Patient Assistance forms

2: Computer-generated reports (claims, statements, payment history, etc.) patient requests, will be charged up to $15 per report provided. These reports are sometimes needed for flex benefit plans and/or yearly tax needs.

3: Appeals or Pro-longed Prior Authorization process are not required of a medical office. Once a medication is decided upon by your doctor, your insurance company may decide that you require a prior authorization prior to covering that medication. Becoming familiar with the prior authorization process may enable you to get your medicine approved faster. But beware, not all medicines will be approved. Even if we and you do everything right, the insurance company may still refuse to cover your medicine. In the end, the insurance company is the one making the decision. To resolve this issue your physician may just change your prescription to another drug that does not require a prior approval. Since your doctor is not aware what your specific insurance company has on their formulary, this step will be done when possible and is an easy but sometimes timely solution. Other times a prior authorization will be completed which entails sending over paperwork requesting a specific medication to your insurance company. The waiting process begins and the medical office will wait for further instructions from your insurance company, usually a request regarding medical records, as well as a reason why the prescribing physician would like to use that specific medication. Once all that is done a review and decision will occur, this process may take 2-3 weeks, in some circumstances, it can actually take months. Depending on the PA decision and your specific request or demand for that particular medication and/or appeals process may begin. The appeals process is a very lengthy and a time consuming process in which administrative services and physician services are not covered by your insurance, the time and effort required to fight an appeals process can be months.

ADMINISTRATIVE SERVICES FEE (ASF)

This process is also not required of a medical office as standard of care. If ASF was not elected an appeal fee of $150.00 per appeal will be charged, regardless of the outcome of the appeal.

4: The ASF does NOT include medical records copying and forwarding of medical records, that is a separate fee.

PLEASE ACCEPT ONE OF THE FOLLOWING OPTIONS:

1) I ACCEPT THE FINANCIAL POLICY THE INCLUDES PAYMENT OF THE ASF. IF ELECTED, THE ASF WILL BE EFFECTIVE FOR A 12 MONTH PERIOD FROM THE DATE SIGNED.

2) I ACCEPT THE FINANCIAL POLICY, BUT CHOOSE NOT TO PAY THE ASF. I UNDERSTAND THAT I WILL NOT BE GIVEN THE CHANCE TO PAY THE ASF FEE AT A LATER DATE DURING THIS 12 MONTH PERIOD FROM THE DATE SIGNED.

I PATIENT/GUARANTOR CHOOSE OPTION _____

_____

PATIENT/GUARANTOR SIGNATURE DATE

Remember if you choose NOT to pay the ASF fees today, you will be charged the administrative services when you request them. They will have to be paid prior to receiving the service.