Dorset Street DERMATOLOGY
where health meets beauty

Patient Registration Form

Today's Date: _____

Name (Last, First, MI): _____

Preferred name or nickname: _____

Date of Birth: ____/____/_____ Social Security #: _____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Email: _____

Preferred method of contact: ☐ Home ☐ Work ☐Cell phone ☐E-mail

May we e-mail personal medical information to you? ☐ YES ☐ NO

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Other

Race*_____ Ethnicity*_____ Language*_____
**Required for US Government Reporting*

Employer: _____ Occupation: _____

Emergency Contact: _____ Relationship: _____

Primary Phone: ( ) _____ Alternate Phone: ( ) _____

RESPONSIBLE PARTY (if different from patient) – ***MUST BE COMPLETED IF PATIENT IS A MINOR***.

Name: _____ Relationship: _____

Date of Birth: ____/____/_____ Home Phone ( ) _____ Work Phone ( ) _____

Have you contacted your insurance company to verify coverage for your office visit(s)? ☐ Yes ☐ No

Under your insurance plan, is a referral required to see a specialist? ☐ Yes ☐ No

Did another Health Care Provider recommend that you see us today? ☐ Yes ☐ No

If YES, Please list: _____

If NO, how did you hear about us? _____

Are you interested in discussing our skin care products or rejuvenation program? ☐Yes ☐No

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Office and Financial Policies

Thank you for choosing Dorset Street Dermatology for your dermatology care. We are committed to providing you with the highest quality medical care, in an efficient, timely and cost-effective manner. Please take a moment to review our financial policy so that you understand your responsibility regarding the charges for the services rendered to you by this office.

Insurance: Please present your insurance card when you check in and we will gladly bill your insurance company for charges incurred at our clinic. If you do not have your card, we will not be able to bill your insurance and payment for all treatment will be required at the time of service. Please remember, your health insurance is a contract between you and your insurance company. It is your responsibility to understand your coverage and benefits, including deductibles, co-insurance, referrals and pre-authorization requirements. If your insurance plan requires a referral or pre-authorization, it is your responsibility to ensure we have one on-file at the time of your visit. If your insurance deems a service to not be a covered service, you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance carrier within 90 days will become your responsibility as a non-covered service. While the filing of insurance claims is a courtesy that we extend to patients, all charges are your responsibility from the date services are rendered.

Co-Payments, Non-Covered Services, and Cosmetic Procedures: Payment is required at the time of service. We accept cash, checks, Visa, MasterCard, Discover and American Express.

Credit Card on File: All patients are required to keep a credit card on file and signed authorization to charge the card for patient balances. Please present the credit card to put on file when you check in. If the credit card is denied for any reason, we reserve the right to charge an additional $25 administrative fee if we are not able to run a new credit card within 7 days. You will be contacted via phone asking for the new credit card information.

Returned Checks: A $35.00 charge will be added for any non-sufficient funds notices from the bank.

No Shows and Late Cancellations: We require advance notice of 48 hours if you must cancel/reschedule your appointment. If appropriate notice is not given you will be charged at least a $50 fee directly to the credit card on file. The fee varies based on the type of procedure:

- Appointment with an Aesthetician - $50 fee
- Botox/Dysport/Xeomin - $50 fee
- Sclerotherapy - $200 fee
- Injectable Procedure - $250 fee for late cancellations, $500 fee if no notification is given (no-show)
- Sculptra - $325 per vial deposit required at time of scheduling. Deposit is nonrefundable if cancelled with less than 3 business days' notice.
- Fraxis CO2 Laser Procedure - $500

Collection Fee: Accounts over 90 days old will incur a 1.5% penalty per month and be forwarded to a collection agency.

Minors: A parent or guardian must accompany a minor for their first visit or provide the office with a written consent for treatment before the appointment time. A parent or guardian is responsible for providing current insurance information for the minor, placing a credit card on file for the minor's account, and providing payment in full for any co-pays, non-covered services and cosmetic procedures.

I have read the above policies and accept the terms as outlined above. I give Dorset Street Dermatology permission to release information to my insurance carrier.

Patient or Responsible Party Signature: _____ **Date**: _____

Receipt of Notice of Privacy Practices: My signature below indicates that I have received and/or reviewed a copy of my provider's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature: _____ **Date**: _____

MEDICARE PATIENTS ONLY: The office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer 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 Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medical 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 or benefits apply. I also authorize Medicare supplemental benefits, if applicable, 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 Medicare Card: _____ **Date**: _____

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Medical History Form

Name: _____**Date of Birth:** _____ **Today's Date:**_____

Are you allergic to any medications? ☐Yes ☐No If yes, please list below:

_____

Have you ever had dental anesthesia (Novocaine)? ☐Yes ☐No Did you have a bad reaction? ☐Yes ☐No

List all medications, vitamins, and supplements you are currently taking: _____

_____

_____

_____

Do you have or have you ever had the following diseases or conditions (please leave blank if unknown):

Lungs:		**Other Systemic:**	
Bronchitis	☐Yes ☐No	Diabetes	☐Yes ☐No
Emphysema	☐Yes ☐No	Thyroid	☐Yes ☐No
Asthma	☐Yes ☐No	Kidney	☐Yes ☐No
Chronic Cough	☐Yes ☐No	Bladder	☐Yes ☐No
Morning Cough	☐Yes ☐No	Gastrointestinal	☐Yes ☐No
Wheezing	☐Yes ☐No	Stomach upset when taking antibiotics	☐Yes ☐No
Cardiovascular:		Yeast infection when taking antibiotics	☐Yes ☐No
High Blood Pressure	☐Yes ☐No	Arthritis/Joint deformity/Joint pain	☐Yes ☐No
Chest Pain	☐Yes ☐No	Limited motion	☐Yes ☐No
Heart Attack	☐Yes ☐No	Artificial Joint	☐Yes ☐No
Heart Murmur	☐Yes ☐No	Convulsions, seizures, epilepsy	☐Yes ☐No
Irregular Heartbeat	☐Yes ☐No	Fainting	☐Yes ☐No
Phlebitis	☐Yes ☐No	Cancer	☐Yes ☐No
Pacemaker	☐Yes ☐No	If yes, what type:_____	

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:

Have you ever had skin cancer? ☐Yes ☐No If YES, type: _____

Has anyone in your family had skin cancer? ☐Yes ☐No If YES, type: _____

Do you have a history of any specific skin diseases? ☐Yes ☐No If YES, type: _____

Do you have problems with healing? ☐Yes ☐No

Do you develop keloids (scars) after surgery? ☐Yes ☐No

Do you bleed easily? ☐Yes ☐No

Do you develop skin rashes in reaction to: ☐Medications ☐Food ☐Environment ☐Bandages

☐ Neosporin ☐Other _____

Other History:

Do you use tobacco? ☐Yes ☐No If YES, what and how often? _____

Have you been diagnosed with or have you been exposed to HIV (AIDS)? ☐Yes ☐No

Have you been diagnosed with or do you currently have a resistant staph (MRSA) infection? ☐Yes ☐No

Have you been diagnosed with or have you been exposed to Hepatitis C? ☐Yes ☐No

(Women) Are you pregnant or breastfeeding? ☐Yes ☐No Due Date: _____

Name and location of your pharmacy: _____

Patient Signature:_____Date: _____

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Credit Card on File Agreement

Much like many other businesses such as a hotel or car rental agency, attorneys, etc., Dorset Street Dermatology has a similar policy where we ask for a credit card which may be used later to pay any balance that may be due on your bill.

Co-pays are still due at the time of service.

At check in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any. At that time, you will be sent a notice that summarizes the amounts that were transferred to you by your insurance company, which will be billed to your credit within 30 days. These transferred amounts are outlined in the Explanation of Benefits (EOB) that is mailed to you by your insurance company.

Your ability to dispute a charge or question your insurance company's determination of payment will remain unchanged.

If you have any questions about our policy, please read the FAQ on the back and do not hesitate to ask.

By signing below, I authorize Dorset Street Dermatology to keep my signature and my credit card information securely on-file in my account. I authorize Dorset Street Dermatology to charge my credit card for any outstanding balances when due.

If the credit card that I give today changes, expires, or is denied for any reason, I agree to immediately give Dorset Street Dermatology a new, valid credit card which I will allow them to charge over the telephone. Even though Dorset Street Dermatology is not processing the new card in person, I agree that the new card may be used with the same authorization as the original card I presented.

Visa □ **MasterCard** □ **Discover** □ **American Express** □	
Patient's Name (Print): _____	DOB: ___/___/_____
Name on Card (Print): _____	
Last Four Digits of Credit Card Number: _____	Exp. Date: ___/____
Please fill out information below for any other person(s) you authorize this credit card for:	
Patient Full Name (Print): _____	DOB: ___/___/_____
Patient Full Name (Print): _____	DOB: ___/___/_____
Patient Full Name (Print): _____	DOB: ___/___/_____

Credit Card Holder's Signature: _____ Date: _____

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Frequently Asked Questions Regarding the Credit Card on File Agreement

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy and it is a growing trend in the healthcare industry. Insurance reimbursements are declining and there has been a large increase in patient deductibles. These factors are driving offices to either squeeze more patients into shorter periods of time or to stop accepting insurance. We have decided to focus on becoming more efficient in our billing and collections processes instead.

How much and when will money be taken from my account?
The insurance companies on average take approximately 2 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, you will be sent a statement showing your portion. You will have 30 days to send an alternative form of payment if you prefer. If no alternative payment is received, your patient financial responsibility will be processed.

How do you safeguard the credit information you keep on file?
We use the same methods to guard your credit card information as we do for your medical information. The card information is securely protected by the credit card processing component of our PCI and HIPAA compliant practice management system. This system stores the card information for future transactions using the same sort of technology that any online retailer would. We can't see the card number – only the last four numbers, giving us no way to use the card outside of the billing system. There is no way to export the card information out of our system. The only way to use it is to process a payment in our practice management system.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. It also drives our administrative costs down because our staff sends out fewer statements and spends less time taking credit card information over the phone or entering it from the billing slips sent in the mail, which are less secure methods than us storing the information. The extra time the staff has can now be spent on directly helping the patients, either over the phone, with insurance claims or in person.

I always pay my bills on time. Why do I have to do this?
The entire billing process is time consuming and wasteful, and the few patients that we do have to send to a collection agency end up costing a lot of money. Reducing unnecessary costs are essential to allowing us to continue to be an in-network provider with most insurance companies. Nothing is changing about how much you end up paying.

What if there is a payment discrepancy or I have other payment questions?
Please contact our billing department directly to settle payment discrepancies or for other payment questions. This policy in no way compromises your ability to dispute a charge or questions your insurance company's explanation of benefits.

Will I still receive a paper bill by mail?
Yes. You will receive one bill which will show what will be charged to your card in 30 days. If you prefer to pay by an alternative method, you may do so during that period. If you do not wish to make any payment method changes, just hold onto the statement for your records and your card will be charged.

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PATIENT COMMUNICATION FORM

A. Family and Friends. It is the office policy of **Dorset Street Dermatology, LLC** not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please check (√) the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. (If you wish to add names later on, please confirm this in writing, or call our staff.)

Spouse: _____ _____ yes _____ no

Parent: _____ _____ yes _____ no

Other: _____ _____ yes _____ no

_____ _____ yes _____ no

_____ _____ yes _____ no

B. Alternative Communications. You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

I hereby request the following means of contact only:_____

_____

_____

PRINTED NAME_____

Patient/Parent/Guardian Signature:_____

Date: _____

LASER FOCUS MEDSPA
at DORSET STREET DERMATOLOGY

COSMETIC DERMATOLOGY QUESTIONNAIRE

Name: Date:	What is the primary reason for your visit today?

What concerns or services would you like to discuss? Please check all that apply:

❑ Laser Hair Removal	❑ Botox/Dysport/Xeomin/Jeuveau	❑ Mole Removal
❑ Laser Skin Resurfacing	❑ Frown Lines between Brows	❑ Leg Vein Injections
❑ Laser Vaginal Rejuvenation	❑ Crow's feet (eyes)	❑ Facial veins
❑ Forever Young IPL	❑ Wrinkle Fillers for Lines	❑ Chemical Peels
❑ Skin Tightening (Face or Body)	❑ Facial Fillers for Volume	❑ Scars (Acne or Surgical)
	❑ Thin Lips	❑ Neck/Chest Skin
❑ Body Sculpting with Exilis	❑ Rejuvenation of Hands	❑ Longer, Thicker Eyelashes
❑ Fat Reduction with Exilis	❑ Rejuvenation of Earlobes	❑ Skin Care Advice
❑ Rejuvenation of Hands	❑ Dark circles/ puffiness eyes	❑ Meet with our Aesthetician
	❑ Blotchy/Discolored Skin	❑ Other _____

What are your areas of concern? _____

Current medications if any: _____

Please answer the following question on a scale of 1 to 5 by circling the appropriate number:
When looking at my face in the mirror, I believe I look younger, the same age, or older than my true age.

Younger Than		*True Age*		*Older Than*
1	**2**	**3**	**4**	**5**

How did you hear about us? _____

Approval to contact you: ❑ ***Yes*** ❑ ***No***	**Best way to reach you:** ❑ ***Email (please list below)*** ❑ ***Telephone:***
❑ **Approval to send you skin care tips, information on studies, products & services, and special offers.**	***Email address:***

How can we help you? Suggestions for how we can improve:

_____

_____

Thank you from the Laser Focus/DSD team!

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HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information.

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for an office visit may require that your relevant protected health information be disclosed to the health plan to obtain approval for the office visit.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities of the physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical staff, licensing, and conducting or arranging for other business activities. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment.

We may use or disclose your protected health information in the following situations without your authorization. These situations include but are not limited to:

- **Public health issues as required by law: communicable diseases, health oversight, abuse or neglect, Food and Drug Administration requirements.**
- **Legal proceedings or situations involving law enforcement, coroners, funeral directors, organ donation, criminal activity, military activity, national security, workers' compensation, inmates.**
- **Required Uses and Disclosures: Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.**

Other Permitted and Required Uses and Disclosures Will Be Made Only With Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our Main Phone Number.

Signature on the payments policy page is only acknowledgement that you have received/reviewed this Notice of our Privacy Practices.