Patient Registration Form

First Name _____ M.I. _____ Last Name_____

Parent or Legal Guardian _____

Address _____

City _____ State _____ Zip Code _____

Home Phone _____ Cell phone _____

Social Security Number _____ Date of Birth _____

Male/Female (circle one) Marital Status: S M D W (Circle one)

Email _____ Employer and Phone Number _____

Do we have your permission to contact you at work? _____

Primary Care Physician Name and Number _____

Did your doctor refer you? Yes/No How did you hear about us? _____

Pharmacy of Choice _____

Name Phone Number Location

Insurance Information – Please complete even if we have a copy of your card

Primary Insurance _____

Policy Holder's Name _____

Policy Holder's D.O.B. _____

ID# _____

Group Number _____

Secondary Insurance _____

Policy Holder's Name _____

Policy Holder's D.O.B. _____

ID# _____

Group Number _____

Patient Relationship to Policy Holder
o self o spouse o daughter o son

Permission to talk to others, please list name_____and relationship_____.

Do you have a living will? _____

Do you have a Power of Attorney for healthcare decisions? _____

If yes, please list name and phone number:_____

In case of Emergency, please list contact information:

Name of person and phone number to be notified _____

Relationship _____

Permission granted by Legal guardian or parent to see minors:_____

Parent Father or Mother name:_____ Signature:_____

Patient Signature: _____ Date: _____

LA PEAU DERMATOLOGY
MEDICAL HISTORY

Patient_____ Date_____

Reason for today's visit_____

_____

Past Medical History: (please circle all that apply)

Anxiety	Diabetes	Lung Cancer
Arthritis	End Stage Renal Disease	Lymphoma
Asthma	GERD	Prostate Cancer
Atrial fibrillation	Hearing Loss	Radiation Treatment
Bone Marrow Transplantation	Heart Failure	Seizures
BPH	Hepatitis	Stroke
Breast Cancer	High Blood pressure	Pacemaker
Colon Cancer	HIV/AIDS	
COPD	High Cholesterol	NONE
Coronary Artery Disease	Thyroid Problems (Hyper or Hypo)	
Depression	Leukemia	

Other _____

Past Surgical History: (please list all)-- NONE

_____

_____

_____

Skin Disease History: (please circle all that apply)--- NONE

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

Other _____

Melanoma Family History- Mother Father Sister Brother Daughter Son Other

Do you wear Sunscreen? Yes No Do you tan in a tanning salon? Yes No
If yes, what SPF? _____

Medications: (Please enter all current medications)

_____

_____

_____

_____

_____

Do you currently use any prophylactic antibiotics? Y☐ N☐ Please list_____

Do you currently use IV drugs? Y☐ N☐ If yes, Please list_____

Have you ever been exposed to HIV/AIDS? Y☐ N☐ If yes, Have you ever had a blood transfusion? Y☐ N☐

Any reaction to dental anesthesia (Novocaine)? Y☐ N☐ Do you have allergy to Latex? Y☐ N☐

Do you smoke?	Y	N	Do you bleed easily?	Y	N
(WOMEN) Are you pregnant?	Y	N	Do you have artificial joints,pins or screws?	Y	N
(WOMEN) Date of last Menstrual period?_____			Do you require antibiotics prior to surgery?	Y	N

Allergies: (Please enter all allergies)

_____

_____

_____

Social History: (Please circle all that apply)

Cigarette Smoking/Tobacco Use:
Never
Quit: Former Smoker/User
Smokes/Uses Tobacco Less Than Daily
Smokes/Uses Tobacco Daily

Alcohol:
None
Less than 1 drink a day
1-2 drinks per day
3 or more drinks per day

How many times in the past year have you had 5 or more drinks in a day for men, or 4 or more drinks in a day for women or any adult older than 65?

(please circle) **0 1 2 3 4 5**

Pharmacy Name:_____Location & Phone Number:_____

Primary Care Provider:_____

Date of last visit with Primary Care Provider: _____

Referring Physician:_____

Phone & Fax Number:_____

Signature of Patient or Legal Guardian:_____ Date:_____

Nurse:_____ **Reviewed by:**_____**(initial)** **Date:**_____

La Peau Dermatology, LLC

Financial Policy

We would like to thank you for choosing **La Peau Dermatology** for all your dermatologic needs. **La Peau Dermatology** is committed to providing you with the best possible medical care. The following outlines your financial responsibilities related to payment for professional services.

For Our Patients with Medical Insurance Benefits:

We participate in most major health plans. We have contracts with many HMO's, PPO's Insurance companies and government agencies including Medicare and Medicaid. Our business office will submit claims for any services rendered to a patient who is a member of one of these plans and will assist you in any way reasonable we can to get your claims paid. It is the patient's responsibility to provide all necessary information before leaving the office. If you have a secondary insurance we will automatically file a claim with them as soon as the primary carrier has paid.

Please bring your insurance card(s) and a picture identification with you at the time of your appointment. If you are a member of a plan we do not participate in, you will be a self-pay patient and a minimum of $50.00 must be paid at the time of service.

Co-Payments:

Your insurance company required us to collect co-payments at the time of service. Waiver of co-payments constitutes fraud under state and federal law. For your convenience, we accept cash, checks or the following credit cards: Visa, Mastercard.

Additionally, you may have coinsurance and/or deductibles, or other financial responsibility required by your insurance carrier. Any outstanding balance on your account, after adjusting for all of your insurance responsibilities, will be billed to you.

Waiver of Patient Responsibility:

It is the policy of the practice to treat all patients in an equitable fashion related to patient balances. The practice will not waive, fail to collect or discount co-payments, co-insurance, deductibles or other patient responsibility in accordance with state and federal law, as well as participating agreements with payers. Full or partial financial responsibility may only be waived in accordance with the practice's Charity/Free Care Policy.

Non-Covered and Out of Network Services:

Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be your responsibility.

Coverage Changes:

If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

La Peau Dermatology, LLC

For Our Patients with No Medical insurance:

If you do not have group or individual medical insurance, we do offer a self- pay rate. A minimum of $50.00 will be required on office visits and $100.00 on surgical procedures.

Payment Plan:

Please let us know if you are having difficulty paying your account. We are more than willing to make arrangements that will fit your budget.

Appointment No-Shows:

Please notify the office as soon as possible if you are unable to keep your scheduled appointment. A patient who no shows three times may be dismissed from the practice.

Delinquent Balance Appointment:

If you have a balance more than 120 days old, you will be required to pay an additional amount towards the outstanding balance and a payment plan must be set up.

Non Payment:

All patient responsible balances that remain delinquent after 90 days, with no response to our requests for payment, may be referred to a collection agency.

Collection Agency Fees:

All patients balances that require placement with an outside collection agency will be assessed an additional fee on the account.

The fee will be as follows:
$40.00 to $100.00= $25.00 collection fee
$101.00 to $250.00= $50.00 collection fee
$251.00 plus+ $75.00 collection fee

Cosmetic Services:

Services for cosmetic procedures or any service deem non-medically necessary by the provider, are required to be paid in full at the time of service.

Thank you for your understanding of our financial policy and if you have any questions or concerns, please ask for assistance.

Patient Name: _____

Patient and/or Responsible Party Signature: _____

Date: _____

HIPAA Policy Signature Page

We are required by law to provide you with a notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment, for healthcare operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information as we describe them in our HIPAA policy.

Your signature below signifies that you have received or been offered a copy of our privacy policies also known HIPAA.

_____

Patient Signature

_____

Patient Name Date

May we leave confidential messages on an answering machine? Yes or No (If yes, please list the phone number and sign below).

_____

Patient or Legal Guardian Signature Date

It is the practice of this office not to release your medical information to anyone without your written authorization. If you would like our office to discuss your confidential medical information with someone other than you such as, your primary care physician, spouse or family member, please list the person(s) and their relationship to you.

_____

Printed Name of Authorized Person Relationship

_____

Printed Name of Authorized Person Relationship

_____

Printed Name of Authorized Person Relationship