SUSAN T. ELLIOTT, M.D.
Foxhall Dermatology
4910 Massachusetts Ave. N.W., Suite #308
Washington, D.C. 20016-4382

PATIENT REGISTRATION

Patient Name______________________________ Date __________

Address____

City______________ State____ Zip________ E-mail______________________

Phone(H)________________ (W)________________ (C)________________

Date of Birth__________ Age ___Sex ___Marital Status ___ Ethnicity_______ SS#____-___-____

Person Responsible for Payment____

Address (If Different)____

City ______________ State ______ Zip__________ (Phone)________________

Pharmacy Name____________________ Location______________________
Phone__________________ Fax____________________

Language spoken__________________ Referring Physician____________________

How did you hear about **FOXHALL DERMATOLOGY**? Friend___ Internet___ Doctor___Ad___

PRIMARY INSURANCE	**SECONDARY INSURANCE**
Name__________________	Name__________________
Address__________________	Address__________________
City____________State ___Zip________	City__________State___ Zip ________
Subscriber's Name________________	Subscriber's Name ________________
Subscriber's DOB________________	Subscriber's DOB ________________
ID #______________ Group # ______	ID #______________ Group__________

FINANCIAL AGREEMENT

I understand that Dr. Elliott participates with several insurance companies and hereby assign any or all insurance benefits due and payable from my participating company to her. I authorize the insurance company to pay benefits directly to the physician. Further, I authorize the treating physician to release to my insurance company any medical records or documents required to process a claim. If benefits are denied because my coverage has lapsed or authorizations have not been supplied, I acknowledge that I will be responsible, in full, for services rendered to me, my spouse and my children. Furthermore, I acknowledge that if a deductible or co-payment is included in my plan, I will be responsible for that amount. In the case that this account should become delinquent and is placed in the hands of an attorney for collection, **I agree to pay attorney fees of 33 1/3 % of the principal, plus all court costs and interest at the rate of 1.5% per month (18% per annum), beginning 30 days after the monies were due or expenses incurred.** I further agree to pay returned check charges of **$25** per check. I acknowledge that payment is expected when services are rendered if I belong to an insurance carrier with which Dr. Elliott does not participate. I understand and personally guarantee to be financially responsible to Dr. Elliott for any and all charges not covered by the assignment of the insurance payment.

Signature ______________________________________ Date __________

Susan T. Elliott, M.D.
Foxhall Dermatology

A NOTICE TO OUR PATIENTS REGARDING OUR OFFICE POLICY

In an attempt to keep our patients informed and to insure proper reimbursement for services rendered, we ask that you carefully read the following instructions. By working closely together, we can provide you with better care and avoid confusion in the future.

Insurance Coverage: We currently participate with a number of health plans. This does change periodically; therefore, you may wish to inquire as to our participation with your particular plan. Please be aware that, as medical providers, our relationship is with you and not your insurance company. Problems relating to your coverage should be handled between you and your carrier

Payment Policy: It is your responsibility to be informed as to your insurance coverage. We cannot adjust charges or diagnosis codes after services are rendered. If your insurance carrier denies payment, we require payment within 60 days. We will bill you for charges allowed, but not paid, by your insurance plan. Copays are required at the time of your visit. If you do not have insurance coverage, charges must be paid in full at the time services are rendered. Unacknowledged invoices over 90 days old will be forwarded to Charles Anderson, Esq. for further collection. Charges associated with these actions will be the responsibility of the patient.

Lab Work: To allow our phone lines to be available for incoming callers, please allow our office 10 days to contact you with laboratory results. If you do not hear from our office within 10 business days, we encourage you to call.

Cancellations: We ask for a 24 hour notice for cancellations. We may charge a fee for appointments not kept and notification not given. This is not reimbursable by your insurance.

Prescription Refills: We require at least 48 business hours for prescription refills. Please contact your pharmacy first and they will contact our office for completion of this request. There may be a "prescription refill fee" for refills filled on demand or short notice. We encourage advanced planning for refills.

Forms and Letters: Because of the volume of paperwork associated with managed care, our office may charge a fee for form completion and custom letters. We must have a one-week notice for these requests.

To Recap:

1. Please allow us to call you with laboratory results.
2. 24 hour notice for appointment cancellations to avoid a "no show" fee.
3. Unpaid balances are processed for collection after 60 days without response on the account.
4. Prescription refills require at least 48 hours advance notice. Contact your pharmacy first.
5. Prescription refill fee may be imposed for short notice on demand refill requests.
6. There **WILL** be fees incurred for all form completions, letters. etc.

__________________ PATIENT NAME　　__________________ PATIENT SIGNATURE　　__________ DATE

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have received, read and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact his organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requests restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name ______________________________

Relationship to Patient ______________________________

Signature ______________________________

Date ______________________________

OFFICE USE ONLY

I attempted to obtain the patients signature in acknowledgment of this *Notice of Privacy Practices Acknowledgment*, but was unable to do so as documented below:

Date	Initials	Reason

MEDICAL HISTORY

Do you have any of the following?

Condition		Condition	
Bleeding Problems	Y N	Kidney Disease	Y N
Difficulty Healing Wounds	Y N	High Blood Pressure	Y N
Keloids	Y N	Liver Disease/Hepatitis	Y N
Abnormal Scarring	Y N	Arthritis	Y N
Diabetes	Y N	Back or Neck Problems	Y N
Artificial Heart Valve	Y N	Fever Blisters	Y N
Pacemaker	Y N	Skin Cancer	Y N
Artificial Joints	Y N	Heart Disease	Y N
Lung Disease	Y N	Melanoma	Y N

If yes to any of the above, please explain: ____________________

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Are you pregnant? ____________________

Why are you being seen today? ____________________

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Prior Hospitalization/Surgery: ____________________

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Current Medications: ____________________

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Allergies: ____________________