Dermatology & Mohs Surgery Institute
Patient Registration Form

Date

Patient Information: Please print clearly

Last:_____ **First**:_____ **MI**:_____ □ **Male** □ **Female**

Preferred Name:_____ **Prefix**:_____ **Suffix**:_____ **DOB**:___ / ___ / _____

SS #: _____ - ___ - _____ **Marital Status**: □ Single □ Married □ Divorced □ Widowed □ Legally Separated

Race: □ Caucasian □ African American □ Asian □ Other: _____

Language: □ English □ Other: _____ **Ethnicity**: □ Hispanic or Latino □ Not Hispanic or Latino

Billing or Mailing Address: _____

City: _____ **State**: _____ **Zip**: _____

Primary Phone: (_____) _____ - _____ □ Home □ Cell

Secondary Phone: (_____) _____ - _____ □ Home □ Cell

Email: _____

Emergency Contact: _____ **Relationship**: _____ **Phone**: (_____) _____ - _____

Employment status: □ Employed □ Not Employed □ Retired □ Student □ Disabled

Employer: _____ **Occupation**: _____

How did you hear about us? _____

Guarantor Information: Complete only if the patient is a minor or has an appointed Power of Attorney.

Legal Name: _____ DOB: ____ / ____ / _____ □ Male □ Female

SS #: _____ - ____ - _____ Relationship: _____ Phone: (_____) _____ - _____

Billing Address: _____

City: _____ State: _____ Zip: _____

Employer: _____ Occupation: _____

Sharing of Medical Information

I give the physician and office staff of DMSI permission to discuss my medical condition with the following individuals, if none please select none:

(You must add your spouse or your emergency contact if you wish for us to be able to talk with them.)
(Ask our Receptionist for additional space for Sharing of Medical Information.)

Name: _____ Relationship: _____ Phone: _____

Name: _____ Relationship: _____ Phone: _____

□ None

Communication

I would like Voicemails to be left on the phone number I provided: □ Yes □ No

If Yes I specifically authorize Voicemails to be left for: □ Appointments □ Results □ Medication Issues

Primary Insurance

Name of Insurance: _____

Name of Policy Owner: _____ Policy Owner's DOB: __/__/_____

Policy Owner's Employer: _____ Relationship to Patient: : □ Self □ Spouse □ Parent

Secondary Insurance

Name of Insurance: _____

Name of Policy Owner: _____ Policy Owner's DOB: __/__/_____

Policy Owner's Employer: _____ Relationship to Patient: : □ Self □ Spouse □ Parent

Dermatology & Mohs Surgery Institute
Medical History

Patient Name: _____ **DOB:** ____ / ____ / _____

Medical History: Please check all that apply

- □ Anxiety
- □ Arthritis
- □ Asthma
- □ Atrial Fibrillation (Irregular heartbeat)
- □ Benign Prostatic Hypertrophy (BPH)
- □ Bone Marrow Transplantation
- □ Breast Cancer
- □ Colon Cancer
- □ Chronic Obstructive Pulmonary Disease (COPD)
- □ Coronary Artery Disease
- □ Depression
- □ Diabetes
- □ End Stage Renal Disease
- □ Gastro Esophageal Reflux Disease (GERD)
- □ Hearing Loss
- □ Hepatitis
- □ Hypertension
- □ HIV/AIDS
- □ High Cholesterol (Hyper Cholesterolemia)
- □ Hyperthyroidism
- □ Hypothyroidism
- □ Leukemia
- □ Lung Cancer
- □ Lymphoma
- □ Prostate Cancer
- □ Radiation Treatment
- □ Seizures
- □ Stroke
- □ Other: _____
- □ **None**

Surgical History: Please check all that apply

- □ Appendix Removed (Appendectomy)
- □ Bladder Removed (Cystectomy)
- □ Breast Biopsy (Right, Left, Bilateral)
- □ Breast Lumpectomy (Right, Left, Both)
- □ Breast Mastectomy (Right, Left, Both)
- □ Breast Reduction
- □ Breast Implants
- □ Colectomy: (Colon Cancer Resection)
- □ Colectomy: Diverticulitis
- □ Colectomy: IBD – Inflammatory Bowel Disease
- □ Colon: Colostomy
- □ Coronary Artery Bypass
- □ Joint Replacement, Knee (Right, Left, Both)
- □ Kidney: Kidney Biopsy
- □ Kidney: Kidney Stone Removal
- □ Kidney: Kidney Transplant
- □ Kidney: Nephrectomy
- □ Liver: Hepatectomy
- □ Gallbladder Removed (Cholecystectomy)
- □ Heart: Biological Valve Replacement
- □ Heart: Coronary Artery Bypass Surgery
- □ Heart: Heart Transplant
- □ Heart: Mechanical Valve Replacement
- □ Heart: PTCA
- □ Hysterectomy: Fibroids
- □ Hysterectomy: Uterine Cancer
- □ Joint Replacement, Hip (Right, Left, Both)
- □ Liver: Liver Removal (Hepatectomy)
- □ Liver: Liver Transplant
- □ Liver: Shunt
- □ Ovaries: Ovary Removal (Oophorectomy)
- □ Ovaries: Endometriosis
- □ Ovaries: Ovarian Cancer
- □ Ovaries: Ovarian Cyst
- □ Ovaries: Tubal Ligation
- □ Pancreas: Pancreas Removal (Pancreatectomy)
- □ Prostate: Prostate Removal (Prostatectomy)
- □ Prostate: Prostate Biopsy
- □ Prostate: Prostate Cancer
- □ Prostate: TURP
- □ Rectum: APR
- □ Rectum: Low Anterior Resection
- □ Skin: BCC
- □ Skin: Melanoma
- □ Skin: Skin Biopsy
- □ Skin: SCC
- □ Spleen: Spleen Removal (Splenectomy)
- □ Testicles: Testicle Removal (Orchiectomy)
- □ Uterus: Uterus Removal (Hysterectomy)
- □ Uterus: Fibroids
- □ Uterus: Uterine Cancer
- □ Uterus: Cervical Cancer
- □ Other: _____
- □ **None**

Skin Disease History: Please check all that apply

- □ Acne
- □ Actinic Keratosis
- □ Basal Cell Carcinoma
- □ Blistering Sunburns
- □ Dry Skin
- □ Eczema
- □ Flaking or Itchy Scalp
- □ Hay Fever/ Allergies
- □ Melanoma
- □ Poison Ivy
- □ Precancerous Moles
- □ Psoriasis
- □ Squamous Cell Carcinoma
- □ Other: _____
- □ **None**

<u>Both</u> sides of this page must be completed. Bring this form with you into the exam room.
Do <u>not</u> return this form to the front desk.

Patient Name: _____ DOB: ____ / ____ / _____

Medications: Please list Medication Name

_____

_____

_____

_____ □ **None**

Allergies: Please list all allergies

_____

_____

_____ □ **No Known Allergies**

Social History: Please check one

Tobacco Use: □ Never □ Quit □ Less than daily □ Daily

Alcohol Use: : □ Never □ Yes: How much and how often_____

Family History

Do you have a family history of Melanoma? □ Yes □ No

If yes, which relative(s)? _____

Any other family history: _____

Review of Systems

Are you Pregnant? □ Yes, Due Date_____ □ No □ Not Applicable

Are you planning to become pregnant? □ Yes □ No □ Not Applicable

Do you have problems with: □ Bleeding □ Healing □ Scarring

Artificial Heart Valve within the past 2 years? □ Yes, When_____ □ No

Artificial Joints within the past 2 years? □ Yes, When_____ □ No

Pacemaker? □ Yes □ No

Blood Thinners or Aspirin? □ Yes □ No

Referring Physician: Please give as much information as possible

_____ First Name

_____ Last Name

□ Doctor □ Nurse Practitioner
□ Physician Assistant □ Other: _____

_____ Phone Number

_____ Fax Number

_____ Location

Primary Care Physician: Please give as much information as possible

_____ First Name

_____ Last Name

□ Doctor □ Nurse Practitioner
□ Physician Assistant □ Other: _____

_____ Phone Number

_____ Fax Number

_____ Location

Pharmacy: Please give as much information as possible

_____ Name

_____ Location

_____ Phone Number

Both sides of this page must be completed. Bring this form with you into the exam room.
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DERMATOLOGY
& MOHS SURGERY INSTITUTE

To better serve you, our patient, we would like to invite you to access the Patient Portal.

If you haven't received a call regarding your biopsy results, follow up with our office via patient portal.

If you have any questions after a biopsy or surgery, please message your doctor on the patient portal. They will respond promptly.

We also urge patients to:

- Review and verify your contact information
- Input past medical history/medications/allergies/social history/family history/preferred pharmacy • View finalized visit notes and patient handouts
- And communicate with the staff.
- Follow up with your doctor after your procedure.

To log in, you will receive an email (that you provided us with) with your username and a link to set a password. The email link will expire in 72 hours. If the link has expired, they can use the 'forgot password' link on the login page. If you did not provide us with an email please inform the front desk and they can manually generate a username and password for you.

You can access the portal 2 ways:

a. Go to **www.dermatologymohsinstitute.com** and click on button for the patient portal
   OR
b. Go directly to **dermandmohs.ema.md** (do NOT put www. first!!)
   NOTE: The portal works best in the Mozilla Firefox browser but can still be viewed in other browsers. You can download the Firefox browser for free at www.mozilla.org.

If you have any questions and/or concerns, please contact the office 309-451-3376.

DERMATOLOGY
& MOHS SURGERY INSTITUTE

Patient Financial Policy

Thank you for choosing us for your healthcare needs. As your healthcare provider, we are committed to providing you with the best possible care. Please read our financial policy and, if you have any questions, please ask one of our associates for assistance or call our billing office at (844) 733-1400.

You will be asked to show the front office staff your current insurance card at each visit. Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurance company to which you are entitled.

PATIENTS WITH INSURANCE POLICIES

For Insurance companies that we participate with:

We are pleased to bill your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at time of service. In addition, you will be responsible for any amount the insurance plan deems not covered, up to the entire amount.

If we do not hear from your insurance company:

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues.

*For insurance companies that we **DO NOT** participate with:*

If your insurance has an out-of-network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. PhyNet reserves the right to collect any unmet deductible or coinsurance at the time of service. It is ultimately the patient's responsibility to verify if we are in your network and what the out-of-pocket costs in using an out-of-network provider will be.

SELF PAY PATIENTS

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required prior to the service. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express. A returned check fee of $35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card.

COPAYMENTS

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are not prepared to pay your co-pay, your appointment will be rescheduled.

COINSURANCE

Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example,you may have an 80/20 plan, meaning the insurance will consider and pay on 80% of the charges and the remaining 20% is your responsibility. It is very important to review your coverage to determine your level of coinsurance.

NO SHOW FEES

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a $50 fee for an office visit and a $150 fee for a missed surgical/cosmetic appointment.

PAST DUE ACCOUNTS

In the event a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fees associated with collecting the outstanding balance.

DISABILITY AND OTHER SPECIAL FORMS

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time-consuming and generally falls outside of the contractual relationship between you and your insurance company. We will be happy to complete these forms at the following rates:

- FMLA - $25
- Disability/Physician Attestation - $25
- Miscellaneous Forms - $25
- Medical Records - $35

Payment of the form filing fee is due at the time of request and a medical release form must be signed.

We will gladly discuss your proposed treatment and will do our best to answer any questions relative to your insurance. You must realize that: A) your insurance is a contract between you, your employer, and the insurance company. B) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As your medical provider, our relationship and concern is with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, **all charges are your responsibility from the date services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature:_____ Date:_____

Patient Name:_____

DERMATOLOGY
& MOHS SURGERY INSTITUTE

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Dermatology & MOHS Surgery Institute to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). Dermatology & MOHS Surgery Institute Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology & MOHS Surgery Institute reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology & MOHS Surgery Institute management.

With my consent, Dermatology & MOHS Surgery Institute may call my home or other designated location and leave a message on voice mail or in-person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology & MOHS Surgery Institute may communicate with me via SMS/Text or iMessage in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology & MOHS Surgery Institute may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

CHECK ONE

- With my consent, I hereby give Dermatology & MOHS Surgery Institute permission to discuss/ share my PHI pertaining to my treatment and/or diagnosis with _____
  [Relationship to patient: _____] Contact Phone # _____
  Please initial: _____

- I choose not to give consent to Dermatology & MOHS Surgery Institute to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Dermatology & MOHS Surgery Institute.

By signing this form, I am consenting to Dermatology & MOHS Surgery Institute use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Dermatology & MOHS Surgery Institute Notice of Privacy Polices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology & MOHS Surgery Institute may decline to provide treatment to me.

Results notification will be primarily through the patient portal for benign or normal pathology/lab results. Benign or normal reports will be uploaded to your portal once reviewed by your provider and you will receive an email informing you when your report(s) have been uploaded. We will call you at your provided phone number(s) for any abnormal results or those that require further explanation. If you wish to opt out of portal notifications, you must do so in writing.

_____ _____

Signature of Patient or Legal Guardian | Name of Legal Guardian (if applicable)

_____ ____/____/_____ ____/_____/_____

Patient's Name | Patient DOB | Date Signed