WINE COUNTRY DERMATOLOGY

Registration Form

Please give your Insurance Card and Photo ID to the Receptionist

Today's Date:						
PATIENT INFORMATION						
Last Name: _____	First Name: _____	Middle Initial: _____	Mr.	Miss Ms.	Marital Status Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	Former Name:	Birth Date:	Age:	Sex: ❑M ❑F	
Preferred Language:		Ethnic Group/Race:				
Social Security Number(Optional):	Home Phone:	Cell Phone (Preferred):	IF WE NEED TO CONTACT YOU: ❑ Ok to leave detailed voicemail ❑ Leave call back number only			
Street Address/ PO Box:		City:	State:	ZIP Code:		
Occupation:		Employer:				
Email Address (Required):			Consent to communicate via email □ Yes □ No			
Preferred Pharmacy:	Pharmacy Address:					
Person(s) We are authorized to release medical results to (if any):						
Primary Care Physician:			Phone Number:			
Referring Physician:			Phone Number:			
IN CASE OF EMERGENCY						
Name of Friend or Relative:	Relationship to Patient:		Cell Phone:	Home Phone:		
INSURANCE INFORMATION						
Person Responsible for Bill:	Birth Date:	Address (if different):	Home Number:			
Is this person a patient here? ❑ Yes ❑ No						
Occupation:	Employer:	Employer Address:	Employer Phone Number:			
Is this patient covered by insurance? ❑ Yes ❑ No						
Primary Insurance:						
Subscriber Name:	Subscriber SSN:	Birth Date:	Group #	Policy #	Co-Payment $:	
Patient's Relationship to Subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other		

AUTHORIZATION, CONSENT OF PROFESSIONAL SERVICES AND RELEASE OF INFORMATION - HIPPA CONSENT

ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT:
NECESSARY FORMS WILL BE COMPLETED TO EXPEDITE INSURANCE CARRIER PAYMENTS. THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. ALL SERVICES PROVIDED TO YOU AS A PATIENT OF WINE COUNTRY DERMATOLOGY ARE PAYABLE AT TIME OF SERVICE AND ARE THE SOLE RESPONSIBILITY OF YOU "THE PATIENT" AND/OR GUARANTOR OF "YOUR CHILDREN". I HEREBY AUTHORIZE WINE COUNTRY DERMATOLOGY TO INSURANCE COMPANIES OR THEIR REPRESENTATIVES INFORMATION CONCERNING MY (MY DEPENDENT'S) ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO WINE COUNTRY DERMATOLOGY ALL PAYMENTS FOR MEDICAL SERVICES RENDERED BY MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. I HEREBY AUTHORIZE AND RELEASE THE DOCTOR AND WHOMEVER HE/SHE MAY DESIGNATE AS HIS/HER ASSISTANT TO ADMINISTER TREATMENT, PHYSICAL EXAM, LABORATORY PROCEDURES, MEDICAL CARE OR ANY CLINICAL SERVICE THAT HE/SHE DEEMS NECESSARY IN MY CASE, AND I FURTHER AUTHORIZE HIM/HER TO DISCLOSE ALL OR PART OF MY RECORD TO ANY PERSON OR CORPORATION WHICH IS OR MAY BE LIABLE UNDER CONTRACT TO THE CLINIC OR TO THE PATIENT OR TO A FAMILY MEMBER OR EMPLOYER OF THE PATIENT FOR ALL OR PART OF THE CLINIC CHARGE, INCLUDING BUT NOT LIMITED TO HOSPITAL OR MEDICAL SERVICES COMPANY, AND INSURANCE COMPANY.

I UNDERSTAND THAT WINE COUNTRY DERMATOLOGY MAY NEED TO USE AND DISCLOSE INFORMATION ABOUT MY HEALTH OR MEDICAL PROBLEMS FOR THE PURPOSE OF ARRANGING, CONDUCTING, OR REFERRING MY TREATMENT; FOR OBTAINING PAYMENT FOR SERVICES, AND FOR THE PURPOSE OF OPERATING THE PRACTICE. I CONSENT TO THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

I UNDERSTAND THAT MY CONSENT IS NOT NEEDED IF THE LAW REQUIRES WINE COUNTRY DERMATOLOGY TO REPORT SOME ASPECT OF MY PROTECTED HEALTH INFORMATION TO A GOVERNMENT AGENCY (FOR EXAMPLE, SUSPECTED ABUSE, COMMUNICABLE DISEASE AND POTENTIAL BODILY HARM TO MYSELF OR OTHERS).

I UNDERSTAND THAT I HAVE THE RIGHT TO REVIEW WINE COUNTRY DERMATOLOGY PRIVACY NOTICE TO REQUEST RESTRICTIONS BE PUT ON THE USE OF MY INFORMATION, AND TO REVOKE MY CONSENT AT A LATER DATE.

I UNDERSTAND THAT IF I WITHHOLD CONSENT FOR THE USE OF MY INFORMATION FOR THE PURPOSE OF TREATMENT, PAYMENT OR OPERATIONS, WINE COUNTRY DERMATOLOGY MAY REFUSE TO UNDERTAKE MY CARE.

I, THE UNDERSIGNED, HEREBY CONSENT TO THE FOLLOWING TREATMENT: ADMINISTRATION AND PERFORMANCE OF ALL TREATMENTS ADMINISTRATION OF ANY NEEDED ANESTHETICS, PERFORMANCE OF SUCH PROCEDURES AS MAY BE DEEMED NECESSARY OR ADVISABLE IN THE TREATMENT OF THIS PATIENT, USE OF PRESCRIBED MEDICATION, PERFORMANCE OF DIAGNOSTIC PROCEDURES/TESTS, CULTURES, BIOPSIES AND SURGERY, PERFORMANCE OF OTHER MEDICALLY ACCEPTED LABORATORY TESTS THAT MAY BE CONSIDERED MEDICALLY NECESSARY OR ADVISABLE BASED ON THE JUDGMENT OF THE ATTENDING PHYSICIAN OR THEIR ASSIGNED DESIGNEES. I FULLY UNDERSTAND THAT THIS IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS OR TREATMENT. I INTEND THIS CONSENT TO BE CONTINUING IN NATURE EVEN AFTER A SPECIFIC DIAGNOSIS HAS BEEN MADE AND TREATMENT RECOMMENDED. THE CONSENT WILL REMAIN IN FULL FORCE UNTIL REVOKED IN WRITING.

MEDICARE PATIENTS: I AUTHORIZE TO RELEASE MEDICAL INFORMATION ABOUT ME TO THE SOCIAL SECURITY ADMINISTRATION OR ITS INTERMEDIARIES FOR MY MEDICARE CLAIMS. I ASSIGN THE BENEFITS PAYABLE FOR SERVICES TO WINE COUNTRY DERMATOLOGY.

HIPPA ACKNOWLEDGEMENT:
I HAVE RECEIVED AND HAVE READ WINE COUNTRY DERMATOLOGY'S NOTICE OF PRIVACY PRACTICES

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

IN MY ABSENCE OR FOR THE BENEFIT OF GAINING MEDICAL ADVICE ON MY BEHALF, I AUTHORIZE THE FOLLOWING PERSON TO GAIN PATIENT HEALTH INFORMATION FOR OR WITH ME:

_____ _____
LISTED AUTHORIZED REPRESENTATIVE OR N/A DATE

I CERTIFY THAT I HAVE READ AND FULLY UNDERSTAND THE ABOVE STATEMENTS AND CONSENT FULLY AND VOLUNTARILY TO ITS CONTENT. ALL INFORMATION PROVIDED ABOVE IS TRUE AND CORRECT TO MY KNOWLEDGE.

_____ _____
PATIENT OR GUARDIAN SIGNATURE DATE

MEDICAL HISTORY AND INTAKE FORM

PLEASE CIRCLE ALL THAT APPLY

PAST MEDICAL HISTORY

Anxiety
Arthritis
Artificial Joints
Asthma
Atrial Fibrillation
Bone Marrow Transplantation
BPH
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Other _____

Primary Care Physician
_____

PAST SURGICAL HISTORY

Melanoma Surgery, Date _____
Squamous Cell Carcinoma Surgery
Basal Cell Cancer Surgery
Appendix Removed
Bladder Removed
Breast Biopsy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left, Bilateral)
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Colostomy
Gallbladder Removed
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
Percutaneous transluminal coronary angioplasty
Joint Replacement, Hip (Right, Left, Bilateral)
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement within last 2 years
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Kidney Removed (Right, Left)
Liver: Hepatectomy
Liver: Liver Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Ovarian Cancer
Ovaries Removed: Cyst
Tubal Ligation
Pancreas: Pancreatectomy
Prostate Biopsy
Prostate Removed: Prostate Cancer
Transurethral Resection of the Prostate
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Fibroids
Hysterectomy: Uterine Cancer
Hysterectomy: Cervical Cancer
Other _____

SKIN DISEASE HISTORY

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

_____

Do you wear Sunscreen? ☐ Yes ☐ No

If yes, what SPF? (sun protection factor)

_____

Do you tan in a tanning salon? ☐ Yes ☐ No

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

If yes, which relative(s)?

_____

_____

PLEASE ENTER ALL CURRENT MEDICATIONS AND ALLERGIES

MEDICATIONS

ALLERGIES

PLEASE CIRCLE ALL THAT APPLY

SOCIAL HISTORY

TOBACCO
- Never smoked
- Former smoker
- Smokes less than daily
- Smokes daily

SEXUAL HISTORY
- Not sexually active
- Sexually active with one partner
- Sexually active with more than one partner
- Same sex partner

ILLICIT DRUG USE
- Drug use
- IV drug use

ALCOHOL
- None
- Less than 1 drink a day
- 1-2 drinks a day
- 3 or more drinks a day

SAFETY
- I feel safe at home
- I do not feel safe at home
- Other _____

FAMILY HISTORY

Only First-Degree Blood Relatives: Parents, Full Siblings, Children:

Eczema
Psoriasis
Seasonal Allergies
Asthma
Hay Fever
Problems with Bleeding
Problems with Blood Clots
Scarring, Keloids
Colon Cancer
Kidney Cancer
Other_____

Have you had the Pneumococcal Vaccine?
☐ Yes ☐ No

REVIEW OF SYSTEMS

Headaches
Blurry Vision
Abdominal Pain
Joint Aches
Depression
Fatigue
Fever or Chills
Chest Pain
Shortness of Breath
Muscle Weakness
Tingling or Numbness
Night Sweats
Unintentional Weight Loss
Swollen/painful lymph nodes
Loss of Appetite
Bone Pain
Problems with Bleeding
Problems with Healing
Scarring, Keloids
Hay Fever
Immunosuppression
Changing Mole
Rash
Anxiety
Bloody Stool
Bloody Urine
Cough
Sore Throat
Thyroid Problems
Wheezing

ALERTS

Allergy to Lidocaine
Allergy to Adhesive
Allergy to Topical Antibiotic
Pregnancy or Planning a Pregnancy
Pacemaker or Defibrillator
Artificial Joints within Past 2 Years
Artificial Heart Valve
Premedication Prior to Procedures
Blood Thinners
Rapid Heartbeat with Epinephrine
Yeast Infections with Antibiotics
GI Upset with Antibiotics
Over Sea Travel or Contact

COVID-19 Risk:
Fever ≥ 100.4 °F

Resided or traveled to country with wide-spread COVID-19 transmission in the last 21 days

Contact with an COVID-19 patient without proper equipment in the last 21 days

Headaches, weakness, muscle pain, vomiting, diarrhea, abdominal pain.

OUR OFFICE POLICIES

Thank you for choosing **Wine Country Dermatology** for your skin care needs. It is our goal to provide you with a positive experience. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike. Due to the growing complexity between the insurance company, the physician, and you the patient, we have established a set of guidelines regarding financial responsibility and office policies.

With some plans, you may be required to see a Primary Care Physician (PCP) to see a dermatologist or another specialist. If your plan requires authorization by a PCP. If you have an **HMO or plan that requires a referral**, it is your responsibility to obtain a valid referral. **You may have to reschedule the appointment if the referral is not in place at the time of the visit.** Please update us with your address, phone numbers, email address and health insurance. Please have your insurance card with you at the time of the visit. **You should arrive 10 minutes prior to your visit to allow yourself time to check-in.**

Referral / Insurance Procedures
Initials: _____

Please keep in mind that appointments are **time-slots reserved specifically for you**. We require a **24-hour** advance notice if you are unable to keep your scheduled appointment.We charge **$65.00** for appointments not kept. Our no show fee is also assessed **for late arrivals of more than 7 minutes after your scheduled appointment and will be rescheduled**. **Patients with repeat cancellations or missed appointments may be discharged from our practice. Abusive/inappropriate behavior towards staff and/or other patients will result in dismissal of your care from our practice.** As a courtesy, we offer an appointment reminder text which will allow you to cancel or reschedule at that time. However, it is ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.

Missed Appointments, Late Cancellations, & Non-Compliance
Initials: _____

Your insurance company may deem certain procedures as not medically necessary, or cosmetic. The following are some examples: removal of benign lesions: **skin tags, angiomas, sun spots or liver spots, milia, sebaceous hyperplasia, or seborrheic keratoses**, etc.If you and your doctor decide to continue with a procedure that falls into this category, we require payment in full at the time of service.

Not Medically Necessary or Cosmetic Procedures
Initials: _____

Many times, it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, there is a separate fee for processing and interpretation of the biopsy and/or lab work. This means that you will receive a separate bill from another laboratory for these tests. We will attempt to use a lab which files directly with your insurance carrier. Although the lab will file with your insurance, you are responsible for any bills you may receive from the laboratory or pathology services used. If you receive a bill from the lab, please contact the lab directly to resolve any billing concerns.

Laboratory and Pathology Fees
Initials:_____

Please contact your pharmacy for a refill or leave a message for our medical assistants and they will return your call by the end of the following business day.

Prescriptions Policies
Initials:_____

There is a **$35** fee for all returned checks. We will file your insurance for you if we are in your network. It is your responsibility to verify if a provider/physician is in your insurance network prior to your visit. If we have a contract with your plan, we will file a claim with your insurance company. If your insurance plan is not in network or not contracted with our practice, the total cost of your visit will be your responsibility.

Payment Policies
Initials:_____

It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may wish to contact the number on the back of your card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or diagnosis codes which they will not cover. Our **office never guarantees** that your insurance will pay for all services. We will make every attempt to file your claim as straightforward and simple as possible. However, if for any reason your claim is denied, **you are responsible** for the amount due on your account.

Denied Insurance Payment Policies
Initials:_____

All claims are subject to a deductible if a procedure is performed (biopsy, cryosurgery, excisions, etc.). A deductible is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a coinsurance, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. It is your responsibility to understand your plan and any associated deductible or coinsurance. You will be billed for this amount should your insurance company notify us that additional payment is due from you.

Co-payments, Deductibles and Coinsurance Policies
Initials:_____

We will send you three statements regarding your balance. The second statement is considered past due. If you receive a third statement noted **"Final" your account balance will be turned over to a collection agency if not paid within 60 days.**

Collection Efforts Policies
Initials:_____

OFFICE POLICIES CONFIRMATION

I, _____ have received a copy of the office policies for Wine Country Dermatology and understand the policies in regards to:

- Missed Appointments, Late Cancellations, & Non-Compliance
- Not Medically Necessary or Cosmetic Procedures
- Laboratory and Pathology Fees
- Biopsy Call Backs
- Prescriptions
- Methods of Payment
- Insurance
- Co-payments, Deductibles and Coinsurance
- Collection Efforts

_____ _____

PATIENT OR GUARDIAN NAME DATE