Randolph Dermatology & Mohs Micrographic Surgery

Patient Info- Please Provide Photo ID & Insurance & Prescription Cards **Referred by:**_____

First Name:_____ Social Security Number:_____

Last Name:_____ Date of Birth:_____

Sex: Male / Female Gender:_____ Sexual Orientation:_____

Marital Status: Single / Married / Divorced Preferred Language:_____

Separated / Widowed / Other:_____ Ethnicity:_____

Race:_____

Patient's Primary Address

Mailing Address:_____

Home Address:_____

Patient's Contact Information

Home Phone: _____

Cell Phone:_____

Work Phone:_____

E-Mail:_____

Patient's Parent or Spouse:_____

Address:_____

Telephone Number:_____

Patient's Emergency Contact

Emergency Contact's Name:_____

Patient's Relationship to Emergency Contact:_____

Phone Number:_____

Patient's Employment Information

Employee Status: Full time / Part time / Retired / Disabled / Student / Self-Employed / Unemployed

Occupation:_____

Employer:_____

Street Address:_____

City, State, Zip Code:_____

INSURANCE INFORMATION—Please provide copies of all cards

Primary Carrier:_____ Telephone #:_____
Address:_____ ID #:_____
Group #:_____ Effective Date:_____ Subscriber's Name:_____
Subscriber's DOB:_____ Sex: M/F Relationship to patient:_____

Secondary Carrier:_____ Telephone #:_____
Address:_____ ID #:_____
Group #:_____ Effective Date:_____ Subscriber's Name:_____
Subscriber's DOB:_____ Sex: M/F Relationship to patient:_____

Tertiary Carrier:_____ Telephone #:_____
Address:_____ ID #:_____
Group #:_____ Effective Date:_____ Subscriber's Name:_____
Subscriber's DOB:_____ Sex: M/F Relationship to patient:_____

GUARANTOR INFORMATION (Guarantor is the person financially responsible for this patient's bill)

Please complete if guarantor is other than self

Guarantor:_____ Patient's Relationship to Guarantor:_____
Street Address:_____ Social Security Number:_____
City, State, Zip Code:_____ Date of Birth:_____
Home Phone:_____ Cell Phone:_____
Guarantor's Employer:_____ Work Phone:_____
Street Address:_____
City, State, Zip Code:_____

Please complete this section if the patient is covered by Medicare

In order to comply with Medicare regulations, please answer the following questions:

Are you or your spouse employed? ☐ Yes ☐ No
Do you or your spouse have other insurance? ☐ Yes ☐ No
Are you disabled or have end stage renal disease? ☐ Yes ☐ No
Is illness/injury the result of an auto accident? ☐ Yes ☐ No
Is there employer supplemental coverage secondary to Medicare? ☐ Yes ☐ No

Are you a veteran? ☐ Yes ☐ No
Has treatment been authorized by the V.A? ☐ Yes ☐ No
Are you covered under the Black Lung Program? ☐ Yes ☐ No
Is there Medigap coverage secondary to Medicare? ☐ Yes ☐ No
Is there insurance coverage primary to Medicare? ☐ Yes ☐ No

Assignment of Benefits/Authorization

I understand I am responsible for knowing the benefits my insurance plan provides. In doing so, it is also my responsibility to verify proof of insurance by ensuring the office staff has the most current/valid insurance cards on file. I am responsible for presenting a referral on the date of service if my insurance requires it. I am also responsible for acquiring authorization for procedures. I acknowledge that I am financially responsible for all services received in connection with the medical treatment rendered at Randolph Dermatology and Mohs Micrographic Surgery. I understand that my insurance may not pay if we are considered an out of network provider. I further understand that all co-payments are due at the time of service, and I am also responsible to pay other amounts due. These amounts may include annual deductibles, co-insurance, benefit exclusions, cosmetic services, charges denied by my insurance company as not covered or not medically necessary, and/or any fees incurred should my account require collection action.

Signature: _____ Print Name:_____ Date:_____

_____ _____
Guarantor/Legal Guardian Signature Guarantor/Legal Guardian Print Name

NOTIFICATION POLICY

It is our policy not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. When returning calls and an answering machine picks up, we do not leave a message *unless it is regarding your appointment.*
Information also will not be left with an unauthorized person who may answer the phone. Your authorization is required otherwise.

I authorize the staff of Randolph Dermatology and Mohs Micrographic Surgery to leave medical information pertaining to my care by the following methods and to the following people, and will assume the responsibility to notify Randolph Dermatology whenever this information changes.

Please provide information on authorized methods by which we may leave messages (i.e. phone numbers.)

Home Phone/Answering Machine_____ Fax-Home_____

Work Phone/Voice Mail_____ Fax-Work_____

Cell Phone/Voice Mail_____ Pager_____

Please list names of authorized people we may discuss your care, financial situation, or leave messages with (i.e. significant other, spouse, parent, grandparent, etc.)

Name_____Phone_____Relationship_____

Name_____Phone_____Relationship_____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy provides information about how we may use and disclose Protected Health Information (PHI). The notice contains a patient's rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change our notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or healthcare operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information (PHI) about you for treatment, payment, and healthcare operations. You have the right to revoke this consent, in writing, signed by you. However such revocation shall not affect any disclosures we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

THE PATIENT UNDERSTANDS THAT:

- Protected Health Information (PHI) may be disclosed for treatment, payment, or healthcare operations
- The practice has a Notice of Privacy Practices that the patient has the opportunity to review
- The practice reserves the right to change the Notice of Privacy Practices
- The patient may revoke the consent in writing at any time and all future disclosures will then cease
- The practice may condition receipt of treatment upon the execution of this consent

This Consent was signed by:_____

Print Name (Patient or Representative)

_____

Signature Date

Relationship to patient if other than patient:_____

Witness: (Practice Representative)_____

Signature:_____

APPOINTMENT CANCELLATION & NO SHOW POLICY

Thank you for trusting your medical care to Randolph Dermatology and Mohs Micrographic Surgery. When you schedule an appointment with Randolph Dermatology, we set aside enough time to provide you with the highest quality of care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible and no later than 24 hours prior to your scheduled appointment. This advanced notice gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation & No Show Policy below:

- Any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a no show and charged a $35.00 fee.

- Any established patient with a cosmetic appointment or other procedure who fails to show or cancels/reschedules an appointment without providing a 24 hour notification will be considered a no show be charged a $200.00 fee.

- The fee is charged to the patient, not the insurance company.

- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

There may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. Please contact our office manager if you encounter such circumstances. You may contact us on Mondays and Wednesdays from 9:30AM-5:30PM or Tuesdays, Thursdays, and Fridays from 8:00AM-4:00PM. After regular business hours you may leave a message with our answering service. Thank you for trusting your care with Randolph Dermatology and Mohs Micrographic Surgery.

_____
Patient Name (Printed)

_____
Patient Signature Date