GEORGE DERMATOLOGY

PATIENT REGISTRATION FORM

PATIENT

This section refers to the PATIENT ONLY

Name: Sex: Date of Birth

Address:

City, State, Zip: Email:

Home Phone: Cell Phone:

Employer: Phone:

Occupation:

Primary Care Physician: Phone:

Referred By: Phone:

***Pharmacy:** **Phone:**

RESPONSIBLE PARTY

Review/complete if person responsible for the bills is a MINOR or NOT the PATIENT

Name: Sex: Date of Birth

Address:

City, State, Zip:

Home Phone: Work Phone:

Relationship to Patient:

INSURED SUBSCRIBER (OR SPOUSE)

Name: Sex: Date of Birth

Address:

City, State, Zip:

Home Phone: Work Phone:

Relationship to Patient:

EMERGENCY CONTACT INFORMATION

Name: Relationship to Patient:

Home Phone: Cell Phone:

PHONE CALLS

Do we have permission to:

Leave messages concerning your appointment, test results, and responses to patient phone calls?

Home Phone ____ YES ____ NO Cell Phone ____ YES ____ NO

Discuss your medical condition with a member of your household? ____ YES ____ NO

If yes, whom? 1._____ Relationship _____

2 _____ Relationship _____

AUTHORIZATION

I hereby give **George Dermatology** my consent to any necessary medical evaluation and treatment. I hereby authorize the release of information and/or photos between any of my treating physicians; to my insurance company to process my claim and authorize payment directly to **George Dermatology**. I understand that I am financially responsible for charges not paid in a timely manner by my insurance. I understand that I am responsible for any and all balances remaining after insurance pays. I understand that I am responsible for all balances at time of visit if I do not have insurance. The above information is correct to the best of my knowledge.

Signed _____ Date _____

PATIENT/GUARDIAN SIGNATURE

GEORGE DERMATOLOGY
MEDICAL HISTORY

Today's Date:_____

Patient:_____ Date of Birth:_____

Reason for today's visit:_____

Are you allergic to any medications? □ YES □ NO If yes, list below **or attach copy**:

1._____ 2._____

3._____ 4._____

Have you ever had dental anesthesia (Novocain)? □ YES □ NO Any bad reaction? □ YES □ NO

Do you take an antibiotic prior to dental cleaning? □ YES □ NO

Do you have any artificial joints/joint replacements? □ YES □ NO

Do you take a blood thinner? □ YES □ NO If YES, which one? _____

Do you have a pacemaker/defibrillator/stimulator/other electrical device in your body? □ YES □ NO

List **or attach a copy** of all medications you are currently taking (including prescription, birth control, over-the-counter, vitamins, supplements and herbals):

1._____ 2._____ 3._____

4._____ 5._____ 6._____

Do you have now, or have you ever had diseases or conditions of: (Please CIRCLE if yes)

Asthma	Diabetes	Arthritis
Shortness of Breath	Amputation	Artificial Joint
High Blood Pressure	Thyroid Disease	Polycystic Ovarian Syndrome
Chest Pain	Abnormal Kidney Function	Seizures
Heart Attack	Dialysis	Immune Suppressed
Irregular Heartbeat	Stomach Absorptive Disorder	Glaucoma
Inflammation of a Vein	Stomach Ulcer	Liver Disease
Blood Clot	Bleeding Disorder	Depression/Anxiety
Artificial Heart Valve	Yeast Infection while taking antibiotics	Dementia

Are you currently experiencing: (Please CIRCLE if yes)

Fever/Chills	Weakness/Vision Changes	Easy Bleeding/Bruising
Cough/Shortness of Breath	Sun Sensitivity	Burning with Urination
Nausea/Vomiting/Diarrhea	Joint Pain	Swollen Glands
Chest Pain	Rash	Bleeding/Painful/Itching/Changing Skin
Headache	Nose Bleeds	Lesions

List any other diseases or conditions:_____

List surgical procedures you have had within the last 6 months:_____

Have you ever had skin cancer? □ YES □ NO

If YES, please check type: □ Actinic Keratosis (pre-cancer) □ Basal Cell □ Squamous Cell

□ Melanoma □ Don't Know □ Other _____

Has anyone in your family had skin cancer? □ YES □ NO

If YES, please check type: □ Actinic Keratosis (pre-cancer) □ Basal Cell □ Squamous Cell

□ Melanoma □ Don't Know □ Other _____

Do you have a history of any specific skin disease? □ YES □ NO

If YES, please check type: □ Eczema □ Psoriasis □ Other _____

Do you have a history of other types of cancer (besides skin cancer)? □ YES □ NO

If YES, what type? _____

Do you develop keloids (thick scars) after surgery? □ YES □ NO

Do you develop skin rashes in reaction to □ Medications □ Food □ Environment □ Bandages □ Topical Polysporin

□ Other_____

Do you drink alcohol? □ YES □ NO If YES, please circle: 1 per week / 2-6 per week / >6 per week

Do you use IV drugs? □ YES □ NO If YES, what? _____

Do you smoke? □ YES □ NO If YES, how much? _____

Have you had or have you been exposed to HIV (AIDS)? □ YES □ NO Hepatitis C? □ YES □ NO

(Women) Are you pregnant? □ YES □ NO Due Date:____/____/_____ Breastfeeding? □ YES □ NO

What is your occupation? _____ Hobbies? _____

Completed by: □ Patient □ Guardian □ Med. Assist (initial's) _____

Signed: _____ Date:_____

PATIENT/GUARDIAN SIGNATURE

Reviewed By: _____ Date:_____

GEORGE DERMATOLOGY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, George Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO) (available upon request). Please refer to the George Dermatology 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 the consent. George Dermatology 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 the Privacy Officer at 8888 Ladue Rd., Suite 120, St. Louis, MO 63124.

With my consent, George Dermatology may email, fax, mail, or verbally send to my home (or other designated locations) any items that assist the practice in carrying out TPO, such as appointment card reminders, financial, or medication information. I have the right to request that George Dermatology restricts how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

I authorize the release of medical information necessary to process my claim and also authorize payment of medical benefits to George Dermatology. I understand that I am responsible for any and all balances remaining after insurance pays. I will be responsible for all balances if I do not have insurance.

By signing this form, I am consenting to George Dermatology's use and disclosure of my PHI or carry out TPO.

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, George Dermatology may decline to provide treatment to me. With my consent, Dr. George and/or staff may call my home or other designated locations and leave a message on voicemail.

If I am unavailable, I give Dr. George and/or staff consent to discuss my medical or financial status with:

1._____
(Include names, relationship, and phone number)

2._____
(Include names, relationship, and phone number)

_____
Please PRINT Patient's Name

_____ _____
Signature of Patient or Legal Guardian Today's Date

_____
Patient's Email Address

GEORGE DERMATOLOGY FINANCIAL POLICY

Thank you for choosing George Dermatology. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential element of your care. Please read the following carefully and sign at the bottom to confirm your understanding.

1. Insurance: It is the responsibility of the patient to provide accurate insurance and personal information. Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to our office by another physician does not guarantee that your insurance will cover our services.

2. **Co-Pays and Outstanding Balances:** It is the policy of George Dermatology that payment is due at the time of service. Co-Pays must be paid in full. All balances on your account must be paid prior to, or at the time of your visit. This includes, but is not limited to co-insurance and deductibles. If you cannot pay your balance at the time of visit, you will need to reschedule your appointment. Our office does not offer payment plans.

3. **Self-Pay and Cosmetic Appointments:** Payment is expected in full at the time of service.

4. **Cancellations and Missed Appointments**:

Office Visits: I understand that it is my responsibility to cancel my appointment at least 1 business day before the scheduled date and time; otherwise a $50.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.

Surgical, Procedural Appointments, Cosmetic Consultations: I understand that it is my responsibility to cancel my appointment at least 1 business day before the scheduled date and time; otherwise a $150.00 fee will be billed to my account, which will not be covered by my insurance plan. All outstanding balances must be paid in full before your next visit.

5. **Referrals:** If your insurance requires a referral, it is your responsibility to provide the referral ***prior to your visit.*** Failure to obtain a referral renders the patient responsible for all charges pertaining to the medical visit.

6. **Pathology:** On occasion, pathology is ordered by physicians to properly diagnose certain skin disorders. To provide quality care for our patients, we utilize an independent licensed lab with analysis performed by a Board-Certified Dermatopathologist who specializes in the microscopic diagnosis of skin disorders. **Charges for these services are in addition to your office visit and procedure charge.**

7. **Requests for Medical Records / Forms (FMLA):** There is a $25.00 fee for medical records, plus the cost of mailing and/or electronic devices. FMLA, medical, and other such policy forms that need to be filled out by our office will require a $10.00 fee. These fees must be paid before the records/forms will be sent.

8. **Accepted Payment Methods:** George Dermatology accepts cash, Visa, Mastercard, Discover, and personal checks with proper identification (valid Driver's License or photo ID), checks can be made payable to "George Dermatology". There will be a $30.00 charge for any returned checks.

9. **Past Due Balances:** Patients that have an unpaid balance beyond 4 months of 1st notification of payment due will have their account placed with an external collection agency. A 25% service charge will be added to the unpaid patient balance to cover collection costs. Patients who fail to pay the collection agency in a timely manner may incur additional fees including reasonable attorney fees if incurred by the collection agency. Patients who fail to pay their debt may be dismissed from the practice.

I have read the above financial policies and understand my financial responsibilities as a patient at George Dermatology. I understand that failure to make a payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees. If I do not sign this consent, George Dermatology may decline to provide treatment to me.

_____

Please PRINT patient's name

_____ _____

PATIENT/GUARDIAN SIGNATURE Date

GEORGE DERMATOLOGY
CREDIT CARD ON FILE POLICY

☐ If you have Medicare and Supplemental Insurance you do not need to leave a credit card on file.
Instead, please check this box and print & sign your name at the bottom of the page.

Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. Many policies have large deductibles and/or copayments that won't be known until after your services are submitted to your insurance carrier. Even if a procedure is covered by insurance, you may still receive a bill. These external factors make it necessary for George Dermatology to maintain a credit card on file for all patients. The card information is stored in a confidential, secure, Payment Card Industry (PCI) compliant payment gateway.

By signing this document, I authorize George Dermatology to automatically charge my card for any outstanding balance with George Dermatology after my insurance company determines my responsibility. Prior to charging my credit card, George Dermatology will send me an invoice via email with details about my balance. I will have two (2) weeks to pay the invoice online or ask any questions. I understand that the credit card on file with George Dermatology can be changed at any time upon my request. Declined credit cards may be subject to an office fee.

Note that we do not accept American Express or Care Credit at this practice.

Credit Card on File

Name as it appears on credit card: _____ Card expiration date: _____

Cardholder's Signature: _____ Last 4 digits of card: _____

Relationship to patient: _____

Send Statements To: _____
Email Address

_____
Please PRINT patient's name

_____ _____
PATIENT/GUARDIAN SIGNATURE Date