Date:

Primary Care Physician	Referring Physician (physician who sent you to our office)

Griffith Dermatology

MR#	

Patient Name			SSN#	Birthdate	Gender
First	M.I.	Last			

Street	City	State	Zip

Mobile Phone	Home Phone	Email Address

Employer Name	Occupation	Work Phone

Marital Status	Driver's license (State and #)	Country of birth
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed		

Race	Ethnicity	Primary Language
☐ White ☐ African American/Black ☐ American Indian or Alaska Native ☐ Asian ☐ Native Hawaiian or Other Pacific Islander ☐ Unknown/Other _____ ☐ Prefer Not to Report	☐ Hispanic ☐ Non-Hispanic ☐ Prefer Not to Report	☐English ☐Spanish ☐Other ☐Prefer Not to Answer

Emergency Contact Information

First	M.I.	Last	Relationship	Mobile Phone	Home Phone

Guarantor Name ☐ SAME AS PATIENT			Mobile Phone	Home Phone	Relationship to Patient
First	M.I.	Last			

Street	City	State	Zip

PRIMARY	Insurance Company Name		Insurance Plan Name (if known)		Insurance Plan/Group ID
	Policy Holder Name ☐ SAME AS PATIENT		Birthdate	SSN	Relationship to Patient
	Policy Holder's Address				Policy Holder's Phone
SECONDARY	Insurance Company Name		Insurance Plan Name (if known)		Insurance Plan/Group ID
	Policy Holder Name ☐ SAME AS PATIENT		Birthdate	SSN	Relationship to Patient
	Policy Holder's Address				Policy Holder's Phone

Date:

Name:	

PATIENT REGISTRATION AGREEMENT AND CONSENTS

1. CONSENT TO MEDICAL CARE AND TREATMENT

The below-signed individual hereby authorizes Robert C. Griffith M.D. (the Practice) and its associated professionals to furnish medical treatment and services to the patient and consents to diagnostic and therapeutic medical care, items, services, and procedures furnished by the Practice, its professionals, and their assistants and designees.

There are potential risks and hazards to any medical treatment or service, and there is no guarantee any particular treatment or service furnished by the Practice or its professionals will be successful. It is the Practice physician's responsibility to provide adequate information concerning a proposed treatment or service and to obtain any additional necessary consent before proceeding except as limited by emergency or other time-sensitive circumstances. The Practice's staff may obtain signature for such consent. The patient has the right to question and refuse treatment; however, if a proposed treatment is refused, the undersigned agrees the Practice and their associated professionals and staff shall be released from any and all liability for failure to provide treatment to the patient.

2. EMERGENCY CONTACT

In the event of an emergency, I authorize the Practice to contact the individual identified below:

Name	Relation to Patient	Phone

3. VOICEMAIL AUTHORIZATION

If Practice is unable to contact me directly, Practice may leave information related to my treatment/diagnostic test results and information about my appointments with any voicemail system that answers at my designated phone numbers (primary and secondary).

4. RECEIPT OF NOTICE OF PRIVACY PRACTICES; CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

The undersigned acknowledges receipt of the Practice's Notice of Privacy Practices, which is incorporated into this Agreement by reference, and consents to use and disclosure of the patient's protected health information and other patient records consistent with such Notice, including without limitation, for purposes of the treatment, payment, and health care operations functions described in such Notice, whether through electronic health information exchange or otherwise; and as authorized or permitted by federal or state law.

Consistent with the above, the undersigned agrees to the Practice's disclosure of all or part of the patient's medical record for treatment purposes and to any person, corporation, or agency that is or may be liable for charges incurred at the Practice or for determining the necessity, appropriateness, amount, or other matter related to such services or charges, including, without limitation, insurance companies, HMOs, PPOs, workers compensation carriers, welfare funds, governmental health plans, the Social Security Administration, the Centers for Medicare & Medicaid Services, or any contractors of the same. The undersigned also consents to release by the patient's health plan or other insurance carrier to the Practice of any eligibility, utilization, or plan data concerning the patient's coverage that may be required.

5. PATIENT IDENTIFICATION

The undersigned acknowledges the Practice may request to take a photograph of me or specimen sites for the sole purpose of patient identification and diagnostic testing. I consent to the taking of my photograph for this purpose. I understand that the photograph will be maintained in a secure manner and will not be released except upon written authorization from me or my authorized representative or as required or permitted by law.

6. PERSONAL PROPERTY AND VALUABLES

The undersigned agrees that the Practice is not responsible for loss, theft, or damage of any money, personal property, or other valuables.

7. CONSENT TO COMMUNICABLE DISEASE TESTING

The below-signed individual consents for the patient to be tested for hepatitis, human immunodeficiency virus infection, or any other blood-borne infectious disease, as well as for any other communicable disease or condition, if and when another patient, a health care practitioner, or other individual furnishing services to patient at the Practice, a Practice employee, or an emergency aid worker has a potential exposure from the patient. If such testing becomes necessary, it will be performed at no charge to the patient.

Date:

8. CALCULATION AND PAYMENT OF CHARGES

The patient is liable and individually obligated for payment of the Practice's charges on the patient's account and the undersigned individual understands and agrees to the following:

a. The patient is liable for the uninsured portion of the Practice bill. Any amount not paid in full by insurance, for any reason, is the responsibility of the patient or designated guarantor.
b. Any specimens (e.g. blood, urine, or biopsy) collected for tests not performed by the Practice's lab may be sent to hospitals or outside laboratories. Insurance information is provided to such outside entities for billing the patient and/or their insurer for these services.
c. The undersigned acknowledges receipt of the Practice's Payment Policies, which is incorporated into this Agreement by reference, and understands the Practice may charge a "no show" or "late cancellation" fee to any patient that fails to show up (no shows) for their appointment or cancels their appointment with less than twenty-four (24) hours of notice. The Practice reserves the right to modify its payment policies at any time and will make every reasonable effort to inform the patient (e.g. posted at check-in/check-out desks, posted on web site, etc.) of these changes; however, the patient agrees to abide by the Practice Payment Policies if they are receiving services from the Practice.
d. After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. The patient agrees to pay the costs of collection, including court costs, reasonable attorney fees, collections charges, and reasonable interest charges, associated with Practice's efforts to collect amounts due.

9. MEDICARE/MEDICAID PATIENT CERTIFICATION AND ASSIGNMENT OF BENEFITS

The undersigned individual certifies that the information provided in applying for payment or reimbursement under Titles XVIII and XIX of the Social Security Act is true and correct. Further, the undersigned certifies that correct and complete information has been provided regarding the patient's insurance, HMO, health plan, workers' compensation, or other coverage for services and items furnished to the patient by the Practice, and the undersigned consents to the Practice billing such payers for items and services furnished by the Practice. The undersigned hereby irrevocably assigns to Practice all rights, title, and interest in compensation or payments otherwise payable to the patient, or received by or on behalf of the patient, for Practice items or services from any source or payer on file for the patient's account, including Medicare/Medicaid, insurance companies, HMOs, and any other third-party payer or financially responsible person, not to exceed charges for services or items rendered. Any person, corporation, or government entity having notice of this assignment is authorized and directed to pay directly to Practice all amounts due for health care items and services provided to the patient by the Practice. Except as provided in Section 7 (CALCULATION AND PAYMENT OF CHARGES) or by law, the patient is financially responsible to the Practice for the charges not covered by these authorizations. The undersigned understands there are certain items and services for which payers do not pay. Any sums not paid by a third-party payer are the patient's obligation. The patient is responsible for all health insurance or health plan deductibles and co-insurance, as well as non-covered or excluded items or services. If it is later determined the patient has an HMO or other health plan primary to Medicare and failed to inform the Practice prior to service of such election, the patient shall be responsible for paying the account. The undersigned agrees to sign such further documents as may be reasonably requested to confirm and substantiate the Practice's rights hereunder. The undersigned further agrees that a copy of this assignment may be used in place of the original copy.

10. HEALTH PLAN NOTIFICATION/AUTHORIZATION

If the patient's health plan, insurer, or other coverage requires prior authorization or precertification as a condition of payment for services, the patient must provide such documentation or notify the practice prior to services being performed. The patient hereby assumes full financial responsibility for charges incurred as a result of failure to comply with prior notification/authorization requirements. Also, the patient hereby appoints the Practice as the patient's agent for purposes of requesting prior authorization and precertification for services (e.g. lab services). The undersigned acknowledges there is no guarantee or assurance authorization will be obtained.

11. AMENDMENTS

Revisions to this Agreement are not effective or enforceable unless accepted in writing by an authorized agent of the Practice.

I HAVE READ AND UNDERSTAND THIS REGISTRATION AGREEMENT AND BY SIGNING BELOW, AGREE TO ITS TERMS. IF THE UNDERSIGNED IS NOT THE PATIENT, SUCH INDIVIDUAL HEREBY CERTIFIES THAT HE/SHE IS THE PATIENT'S AUTHORIZED REPRESENTATIVE AND HAS ALL NECESSARY LEGAL AUTHORITY TO ENTER INTO THIS AGREEMENT ON THE PATIENT'S BEHALF.

SIGNATURE: PATIENT (OR PATIENT'S LEGALLY AUTHORIZED REPRESENTATIVE)

Signature of Patient or Legal Representative	Date	
Printed Name	Patient Name (if signed by representative)	Relationship to Patient

Date:

PRINT PATIENT NAME **DATE OF BIRTH**

Past Medical History: Have you ever had or currently diseases or conditions of the following? Check here if none _____			
☐ Heart attack	☐ Chronic Bronchitis	☐ High Cholesterol	☐ Bowel
☐ Arthritis/Joint Deformity	☐ Depression, Anxiety	☐ Thyroid: hyper or hypo	☐ Bladder
☐ Asthma	☐ Diabetes	☐ Hepatitis	☐ Glaucoma
☐ Heart Murmur	☐ Rheumatoid Arthritis	☐ Phlebitis	☐ Bleeding Disorder
☐ Fainting	☐ HIV/AIDS	☐ Tuberculosis	☐ Kidney
☐ Emphysema	☐ High Blood Pressure	☐ Convulsions, Seizures, or Epilepsy	☐ Lupus
☐ Pacemaker	☐ MRSA	☐ Mood or Behavioral Disorder	☐ Stroke

Skin Disease History: Have you ever had or currently have? Check here if none _____			
☐ Actinic keratoses	☐ Dry skin	☐ Melanoma*	☐ Squamous cell cancer*
☐ Acne	☐ Eczema	☐ Blistering Sunburns	☐ Keloids
☐ Basal Cell Cancer *	☐ Psoriasis	☐ Precancerous/ Abnormal Moles	☐ Fever Blisters (Herpes)
*Provide date of diagnosis and any additional information			

Do you have a family history of melanoma? Yes No If yes, which relative? _____

Do you use a tanning bed? Yes No If yes, how often? _____

Do you use sunscreen? Yes No How often? _____

Do you smoke? Yes No If yes, how much? _____If no, have you ever smoked? Yes No

Are you pregnant or breast feeding? Yes No

Do you have any allergies to medication? Please list_____

Are you allergic to adhesive? Yes No Lidocaine? Yes No Topical antibiotics? Please list_____

Are you taking blood thinners? Yes No

Date(s)of: Last flu shot _____ Last pneumococcal vaccine _____ Last shingles vaccine_____

Your preferred Pharmacy: Name_____Location_____Phone_____

Medications: List all current medications including vitamins and supplements (include strength and frequency)

To be filled out by clinical staff:

BP	TEMP	HT/WGT	PULSE	0^2 %

Patient Signature: _____ Date: _____