



Blue Harbor Dermatology

NEW PATIENT REGISTRATION FORM

General Information (Please Print)	
Name: _____	DOB: _____ Sex: _____
Social Security Number: _____	Marital Status: _____
Primary Address: _____	
City: _____	State: _____ Zip: _____
Home Phone: _____	Work Phone: _____ Cell Phone: _____
Email: _____	Authorize E-Mail? -
Emergency Contact: _____	Relationship: _____ Phone: _____
Pharmacy Name: _____	Phone: Fax: _____
Employment Status: _____	
Employer: _____	Occupation: _____

Patient Phone Message Consent	
It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:	
<input type="checkbox"/> Leave a detailed message on voicemail/machine/cell	___ YES ___ NO (initial yes or no)
<input type="checkbox"/> Leave a detailed message with individual answering the phone	___ YES ___ NO (initial yes or no)
<input type="checkbox"/> Name of the individual _____	Relationship _____

Spouse, Parent, Legal Guardian or Responsible Party (if different from patient)	
Name: _____	Relationship to Patient: _____
Date of Birth: _____	Social Security Number: _____

Doctor Information	
Referring Physician: _____	Specialty: _____
Primary Care Physician: _____	Phone: _____

Blue Harbor Dermatology

PATIENT AUTHORIZATION

Please INITIAL EACH box and SIGN Where Indicated

<input checked="" type="checkbox"/>	Patient Authorization for PPO and HMO Patients
I authorize the physician and/or staff of BLUE HARBOR DERMATOLOGY to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above names insurance company to pay directly to BLUE HARBOR DERMATOLOGY the amount due for medical or surgical services. I understand that I am financially responsible of any services deemed non-covered by my insurance company.	

<input checked="" type="checkbox"/>	Patient Authorization for MEDICARE Patients
I authorize the physician and/or staff of BLUE HARBOR DERMATOLOGY to release to the social security administration, Health Care Financing Administration or its intermediaries or carriers any information needed for this or any Medicare claim. I permit a copy of this Authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who may cause Medicare payment information to cross over automatically to supplement the insurer. I understand that I am financially responsible for any services deemed non-covered by Medicare.	

<input checked="" type="checkbox"/>	Cancellation Policy for ALL Patients
I understand that it is my responsibility to call at least 24 business hours before my scheduled appointment to reschedule or cancel my appointment, otherwise I will be charged \$75 for my office visit. For surgery appointments, laser appointments, or injectable appointments, I understand that it is my responsibility to call at least 72 business hours before my scheduled appointment, otherwise I will be charged \$200 for my office visit. For Mohs surgery, I will be charged \$300 if I give less than 5 business days of advance notice for any cancellations or rescheduling Mohs. I also understand that all deposits made on cosmetic services are non-refundable.	

<input checked="" type="checkbox"/>	Patient Authorization for ePrescribe
ePrescribing is a physician's ability to electronically send an accurate, error-free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of BLUE HARBOR DERMATOLOGY to enroll me in the ePrescribe Program.	

<input checked="" type="checkbox"/>	Patient Authorization for Pharmacy Benefits Manager
I authorize the physician and/or staff of BLUE HARBOR DERMATOLOGY to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third party pharmacy payers for treatment purposes.	

<input checked="" type="checkbox"/>	Patient Authorization for ALL Patients
I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, a \$5 late fee will be applied monthly after 30 days of the 1st statement being sent out. I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt. In the event that an account is sent to a collection agency, additional fee (30% collection fee) that will be added to the ending balance of the account sent to the agency. I also authorize my physician and BLUE HARBOR DERMATOLOGY to photograph me for medically related documentation purposes.	

Patient Signature: _____ **DATE:** _____

Printed Name: _____

Blue Harbor Dermatology
PATIENT FINANCIAL AGREEMENT

Thank you for giving us the privilege of serving you and your family's skincare needs. We are committed to providing you with the best possible care and we are pleased to discuss professional fees with you at any time. Your clear understanding of the financial policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy, or your responsibilities. To keep your overall medical costs down, we provide a "pay as you go" plan. Each provider visit is charged as a separate visit. You may always ask for an estimate of your charges before a procedure is performed. Please note that each procedure has an additional cost and is not included in a regular office visit fee. These procedures include, but are not limited to, freezing, "burning-off", skin tag removal, acne surgery, peels, biopsies, surgeries, injections, Mohs surgeries, cyst drainage, mole or wart removal, etc.

Please INITIAL EACH Item and SIGN Where Indicated

X **PPO INSURANCE:** Blue Harbor Dermatology has preferred provider contracts with several insurances including **Anthem Blue Cross, Aetna, Blue Shield, Cigna, HealthNet, United Healthcare, Multiplan, etc.** We can bill these insurances only if we are in network.

X **HMO INSURANCE:** We accept some HMO plans. If we are not your HMO network and you decide to be seen outside of your plan, your visit will be considered self-pay and full payment for all services is due at the time of your visit.

X **MEDICARE:** We accept Medicare. We can bill your secondary insurance but you are responsible for all co-payments and Medicare annual deductibles.

X **SELF-PAY / NO INSURANCE:** We regularly see patients with no insurance or who self-pay. We ask that you are truthful and present your insurance card if you have medical insurance or a high deductible plan. If you elect to self-pay, please be advised that neither **Blue Harbor Dermatology** nor you can later bill your insurance.

X **CO-PAYS:** Insurance plans legally and contractually obligate all health care providers to collect you set co-pay at each and every visit. **Each time you come in, the co-pay fees will be due at check-in before your visit.**

X **DEDUCTIBLES / CO-INSURANCES / PATIENT BALANCES:** If there are previous outstanding balances due to deductibles and co-insurances on your account, the balance is expected to be paid-off at the time of your visit. **If your insurance plan has a yearly deductible that has not been met, we may ask for a deposit payment for the visit depending on the procedure. Blue Harbor Dermatology will be entitled to a service charge of one and one-half percent (1-½%) per month for patient account balances over 90 days.**

X **LAB TESTS AND PATHOLOGY CHARGES:** **If your visit includes biopsies, lab tests, or cultures, you understand that you will receive separate billings from the company performing these outside services for you. Sometimes biopsies and surgeries result in a specimen being sent out to your in-network pathology for examination. You may be billed by these laboratory and pathology services for any additional charges incurred.**

X **COSMETIC SERVICES:** Facial peels, laser treatments, Juvederm®, Restylane®, sclerotherapy (vein), Botox® injections are among the many cosmetic / insurance NON-covered services. These services are provided on a strict self-pay / cash basis and payment is due in full at the time of the procedure. **Blue Harbor Dermatology** is not permitted to bill any cosmetic services to insurance.

X **PRODUCT PURCHASES:** The purchase of all products is always self-pay in full at the time of purchase. **Blue Harbor Dermatology** does not send bills to patients for these purchases. All products purchased through Blue Harbor Dermatology are **non-refundable**, since these are health care products, we are **unable** to process refunds or exchanges on any opened merchandise.

X **INSURANCE / CHANGES:** It is the responsibility of the patient to know their financial obligations under their insurance plans, such as co-pays, deductibles, co-insurance, referral fees, etc. Your insurance card must be provided at the first visit. If not, we will consider it as a self-pay visit. If you change your insurance, it is your responsibility to inform us of the change. If we are unable to bill your insurance company for the visit due to incorrect information, then it will be considered as a self-pay visit. **Blue Harbor Dermatology does not know the details of your individual plan and is not authorized to make guarantees regarding coverage.**

Patient Signature: _____ **Date:** _____

Printed Name: _____ **Staff/Witness:** _____

Blue Harbor Dermatology
PATIENT AUTHORIZATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The notice contains a Patient 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 health care 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 about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a 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).

I understand that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- This Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Practices.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this 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.

I understand that:

- This Practice has permission to call or contact patients and/or their responsible financial guarantor for treatment, payment, or health care operations. This Practice's Policies include generally confirming patient appointments via phone or leaving messages on voicemail or answering machines.
- This Practice may call or contact patients for test, biopsy, other lab results, follow-ups, and visit reminders. This Practice may mail out periodic letters or reminder postcards. In case of medical emergency or need for urgent contact, listed patient emergency contacts may be contacted. To ensure safety of patients and staff, this Practice has a 24 hour security system in place.

PLEASE NOTE THAT THIS FORM IS Blue Harbor Dermatology's STANDARD HIPAA POLICY AND IS NOT MODIFIABLE. THE FORM MUST BE ACCEPTED IN ITS ENTIRETY FOR PROPER OPERATIONS. IF YOU DO NOT AGREE, PLEASE IMMEDIATELY ADVISE THE OFFICE AND CANCEL YOUR APPOINTMENT.

Signature of Patient or Guardian Date: _____

Printed Name Relationship to Patient

Credit Card Collection

As of March 1st, 2024, credit cards are required to be on file. Payments for all services are due at the time of treatment.

Any patient financial responsibilities will be processed on your credit card on file. If your account is more than 60 days past due, Blue Harbor Dermatology will notify you via mail of your unpaid balance.

Missed appointments:

Blue Harbor Dermatology has below cancellation policy:

- ❖ Office visit, 24 business hours, \$75 cancellation fee
- ❖ Surgery and laser visit, 72 business hours, \$200 cancellation fee
- ❖ Mohs surgery 5 business days, \$300 cancellation fee

All appointments canceled less than the required time frame will be subjected to a cancellation fee.

These charges are your responsibility and will be billed directly to you.

Please help Blue Harbor Dermatology serve you better by keeping regularly scheduled appointments.

We will request a credit card on file to process this transaction and will collect it at your next appointment.

By signing below, I acknowledge that I have fully read, understood, and agree to abide by the financial agreement made with Blue Harbor Dermatology.

Name: _____

Signature: _____

Date: _____

Blue Harbor Dermatology
NEW PATIENT INTAKE FORM

Patient Name: _____

1. Main reasons for today's' visit: _____

2. Medication Allergy:

3. Current medication lists (names only):

4. Medical history:

5. History of skin cancers and treatments: *Please include location and date(mo/year)*

6. Family history of skin cancer:

7. History of major surgery (within 5 years):

8. Drink Alcohol? Yes No

If yes, please specify frequency and amount: _____

9. Do you smoke? Yes No

If yes, please specify frequency and amount: _____