Blue Harbor Dermatology

NEW PATIENT REGISTRATION FORM

General Information (Please Print)

Name: ______________________________ DOB: ______________________ Sex: __ M __ F

Social Security Number: ______________________ Marital Status: ___ Single ___ Married ___ Divorced ___ Widowed

Primary Address: ____

City: ______________________________ State: ______________ Zip: ____________________

Home Phone: ____________________ Work Phone: ___________________ Cell Phone: ______________________

Email: ______________________________________ Authorize E-Mail? ___ Y ___ N

Emergency Contact: _____________________ Relationship: _________________ Phone: ______________________

Pharmacy Name: _______________________ Phone: _____________________ Fax: __________________

Employment Status: ___ Employed ___ Not Employed ___ Retired ___ Student

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:

- Leave a detailed message on voicemail/machine/cell _______ YES _______ NO (initial yes or no)
- Leave a detailed message with individual answering the phone _______ YES _______ NO (initial yes or no)
- 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

x_____ 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.

x_____ 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 insurer. I understand that I am financially responsible of any services deemed non-covered by Medicare.

x_____ 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 $50 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 $150 for my office visit. I also understand that all deposits made on cosmetic services are non-refundable.

x_____ 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.

x_____ 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.

x_____ 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, 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 (38% collection fee, and 18% interest) 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: ____________________________________

Special Interests in Cosmetic Procedures

If you have an interest in cosmetic procedures and want to have a brief complimentary cosmetic consultation during this visit, please mark below:

Procedure:	Concerns:
___ Laser	___ Skin Rejuvenation
___ Body Contouring	___ Wrinkles
___ Chemical Peels	___ Acne Scars or any type of scars
___ Injectibles	___ Photo Damaging
___ Botox/Dysport	___ Brown Spots
___ Juviderm	___ Hair Removals
___ Perlane	___ Skin Tightening
___ Restalyne	
___ Kybella	

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 care 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. All biopsies and surgeries result in a specimen being sent to pathology for examination. You will 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 / cash 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 / cash visit. **Blue Harbor Dermatology** does not know the details of your individual plan and is not authorized to make guarantees regarding coverage.

DO NOT SIGN THIS FORM IF YOU DO NOT UNDERSTAND AND AGREE TO ALL THE ABOVE CONDITIONS.

Patient Signature: ____ **Date:** ___________________

Printed Name: ____ **Staff/Witness:** _____________

Staff Verification: ______

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 voice main 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

Staff Verification: ______

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. Family history of skin cancer:

__________________________ ________________________ ________________________

__________________________ ________________________ ________________________

6. History of surgery (within 5 years):

__________________________ ________________________ ________________________

__________________________ ________________________ ________________________

7. Drink Alcohol? Yes / No

If yes, please specify frequency and amount: ____

8. Do you smoke? Yes / No

If yes, please specify frequency and amount:____