Email completed forms to:

results@columbiadermatology.com

Use "last name_firstname_DOB" in the subject line of your email

OR

Complete the forms and bring them to your office visit

PATIENT REGISTRATION FORM

NAME: _____ _____ _____ DATE OF BIRTH: _____
First Middle Last MM / DD / YYYY

SEX: ☐MALE ☐FEMALE ☐OTHER: _____ EMAIL: _____

ADDRESS: _____ _____ ___ _____
Street City State Zip

SELECT PREFERRED CONTACT: ☐ _____ ☐ _____
Home # Cell #

EMERGENCY CONTACT: _____ _____ _____
Name Relationship to patient Phone #

Do we have your permission to:

Leave a message on your voicemail? ☐Yes ☐No

Discuss your medical condition with any member of your household? ☐Yes ☐No

EMPLOYMENT: _____ _____ _____
Occupation Employer name / Company Phone #

PRIMARY CARE PHYSICIAN: _____ _____
Physician / Practice name Phone #

PHARMACY OF CHOICE: _____ _____ _____
Pharmacy name Address or Location Phone #

PRESENT YOUR INSURANCE CARD(S) FOR PHOTOCOPY AND COMPLETE BELOW
If no card is available, payment in full is expected

PRIMARY INSURANCE COMPANY	**SECONDARY INSURANCE COMPANY**
Ins Company _____	**Ins Company** _____
Are you the policyholder? ☐Y ☐N. **IF NO, complete below:**	Are you the policyholder? ☐Y ☐N. **IF NO, complete below:**
Policyholder Name: _____	Policyholder Name: _____
DOB: _____	DOB: _____
Relationship to patient: _____	Relationship to patient: _____

PAYMENT AND INSURANCE AGREEMENT

I attest the above information is correct and will be used for billing purposes. I authorize release of medical information to my insurance company (s), primary care or referring physician and pharmacies. Further, your signature authorizes the Doctor to release medical information necessary to process your insurance claims (if any). If my insurance company does not pay, I understand that I am responsible for my bill. I understand that I am responsible for my bill. **Charges, deductibles, copays, and/or coinsurances are due at the time of service. A charge of $25.00 may be assessed for a missed appointment. Also, if we are forced to turn your account over to our collection agency, you will be responsible for all collection fees incurred. I understand that I am responsible for obtaining a referral from my primary care doctor if required by my insurance. If I fail to obtain the referral, I will be responsible for my bill.** I authorize Columbia Dermatology Center to act as my agent in helping me obtain payment from my insurance company (s). I authorized payment directly to Columbia Dermatology Center. A copy of this can be used in place of the original.

You will be given the opportunity to review our Notice of Privacy Practices. The practice provides this information to comply with the Health Insurance Portability and Accountability Act of 1996. Please initial to confirm this opportunity.

The above is true and correct to the best of my belief.

_____ Date _____
Patient / Responsible Party Signature MM / DD / YYYY

DERMATOLOGY MEDICAL HISTORY

To help us provide you with optimal health care, please take time to accurately complete this form.

Name (print): _____

Reason for today's visit: _____

Past Medical History

Please check if you have ever had any of the following:

☐Anxiety/Depression ☐Asthma ☐Blood clotting disorder ☐Diabetes

☐Gastroesophageal Reflux (GERD) ☐Gastrointestinal Cancer ☐Glaucoma ☐Hearing Loss

☐Heart rhythm problem (atrial fibrillation) ☐Hypertension (high blood pressure) ☐High cholesterol

☐Inflammatory Bowel disease ☐Immunodeficiency (HIV) ☐Kidney Disease ☐Leukemia/Lymphoma

☐Liver disease ☐Lung disease ☐Neurological disease (MS, Parkinson's, Alzheimer's, Seizures etc.)

☐Prostate enlargement or cancer ☐Stroke ☐Tuberculosis

List any other diseases or conditions, or provide details about the above items:

_____

List any surgical procedures you have had in the past 6 months:

_____

Skin History

Have you ever had skin cancer? _____

Do you have any specific skin diseases? _____

Has anyone in your family had skin cancer? _____

Do you have problem with healing? _____

Do you develop keloids or scars after surgery? _____

Do you bleed easily? _____

Have you ever had a bad reaction to any dental anesthesia (Novocain)? _____

Please list all medications you are currently taking (prescriptions, over-the-counter, vitamins, and herbs):

_____

Please list any allergies, including allergies to medications: _____

Social History

Smoking: ☐Never ☐Current ☐Quit, Date: _____ Drink alcohol: ☐Never ☐ _____ drinks per day

Have you ever used recreational drugs? ☐Yes ☐No

The above is true and correct to the best of my belief.

_____ Date _____

Patient / Responsible Party Signature MM / DD / YYYY

Name (print): _____

Financial Policy

We are pleased that you have selected our office to provide your Dermatologic care. As part of that care, we have developed this statement of our financial policy. Please carefully read the following, initial where indicated, and sign below.

Health Insurance Participation

_____ Initials

Columbia Dermatology participates in many, but not all health insurance plans. If we do participate with your health insurance plan, you must present a valid insurance identification card at check-in. Without a valid insurance card, or if we do not participate in your health insurance plan, you may reschedule your appointment or payment for your visit will be due today.

Co-payments

_____ Initials

Some insurance plans require payment of a Co-pay. Co-payments are due at check-in. Payments can be made by check, cash, MasterCard or VISA. Without a co-payment, you may be rescheduled.

Referrals

_____ Initials

Some insurance plans require a written referral from a primary care provider. Referrals must be presented at check-in. Having a valid referral is a patient's responsibility. It is your responsibility to know how many visits are allowed on your referral and the expiration date of your referral. Without a valid referral, your appointment may be rescheduled or payment for your visit will be due today.

Financial Responsibility

_____ Initials

Patients are responsible for all co-payments, deductibles, and charges not covered by health insurance.

Account Balances

_____ Initials

All outstanding balances must be paid at time of check-in, or you must reschedule your appointment. Failure to pay outstanding balances may result in the practice forwarding your account to a Collection Agency or Collection Attorney of our choice and may result in additional fees, including an administrative fee of 30%.

Rescheduling/Canceling Appointments

_____ Initials

Please help us serve you by keeping your scheduled appointments. Should you need to change your appointment, contact our office at least 24 hours prior to your originally scheduled visit. Following two consecutively missed appointments, a $25 missed appointment fee will be charged. After three consecutively missed appointments, the scheduling of future appointments would be at the discretion of your physician.

If you are more than twenty (20) minutes late for your appointment, you will be asked to reschedule your appointment.

I have read and understand the office policies explained above.

_____ Date _____

Patient / Responsible Party Signature MM / DD / YYYY