



JANE T. CHEW, M.D.
Columbia Dermatology Center

PATIENT REGISTRATION FORM

NAME _____ DATE OF BIRTH _____
First Middle Last SEX: M F

MARITAL STATUS _____
 SS #: _____

ADDRESS _____
Street City State Zip

HOME #: _____ WORK#: _____ CELL #: _____

E-MAIL _____ OCCUPATION _____ EMPLOYER _____

Primary Care Physician _____ Do they want a report of your visit? Y N

PRESENT YOUR INSURANCE CARD (S) FOR PHOTOCOPY AND COMPLETE BELOW

If no card is available, payment in full is expected.

PRIMARY INSURANCE COMPANY

Company Name _____
 Policyholder: Yourself Y N If No, complete below
 Policyholder Name: _____
 Address, if different _____

 Employer _____
 Work # _____ Home # _____
 SEX: M F Birthdate: _____
 SS #: _____ RELATIONSHIP _____

SECONDARY INSURANCE COMPANY

Company Name _____
 Policyholder: Yourself Y N If No, complete below
 Policyholder Name: _____
 Address, if different _____

 Employer _____
 Work # _____ Home # _____
 SEX: M F Birthdate: _____
 SS #: _____ RELATIONSHIP _____

Do we have your permission to:

Leave a message on your answering machine at home? _____yes _____no

Leave a message at your place of employment? _____yes _____no

Discuss your medical condition with any member of your household? _____yes _____no

Pharmacy of choice _____

In case of Emergency, who should be notified? _____

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. **Charges and co-pays are due at the time of service. A charge of \$25.00 may be assessed for a missed appointment. Also, if my account is turned over to a collection agency, I 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.

Signature _____ Date _____

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. _____



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DERMATOLOGY MEDICAL HISTORY

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

Name (print): _____ Date: _____

Reason for today's visit: _____

Are you allergic to any medications? If yes, please explain: _____

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

Social History & Habits:

Have you ever smoked? _____ Have you ever used IV drugs? _____

Do you drink alcohol? ____ If yes, ____ drinks per day. Have you been exposed to HIV (AIDS)? _____

Have you been exposed to hepatitis? _____ Are you pregnant? _____

Please check if you have now or have had any of the following problems:

HEART / LUNGS: Persistent cough _____ Shortness of breath _____ Asthma _____ Chest pain _____
High blood pressure _____ Heart murmur _____ Irregular heart beat _____ Blood clots _____
Inflammation of veins (phlebitis) _____ Heart attack _____ Pace maker _____

GUT / KIDNEYS: Stomach problems _____ Diabetes _____ Liver problems _____

BONES / JOINTS: Arthritis _____ Osteoporosis _____ Artificial joint replacement _____

Have you ever had a blood transfusion? _____ Have you ever fainted? _____

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? _____

Has anyone in your family had skin cancer? _____

Do you have a history of any specific skin diseases? _____

Do you have a problem with healing? _____

Do you develop keloids or scars after surgery? _____

Do you bleed easily? _____

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

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

Signature _____

Date _____



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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, you may reschedule your appointment 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. We offer the convenience of having your credit card information securely filed to automatically cover any outstanding balances on your account. 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.

Patient/ Responsible Party Signature

Date

071707



JANE T. CHEW, M.D.
Columbia Dermatology Center

To Our Patients:

As any of you who have checked into a hotel lately know, you are asked for a credit card at the time of check in. This is an advantage for both you and the hotel, since it makes checkout faster and more efficient. We have implemented a similar policy for this office.

You will be asked for a credit card at the time of check-in and the information will be held securely until your insurance(s) have paid and made their determination of the amount of your co-pay. At that time, any remaining balance owed by you will be charged to your credit card, and a receipt will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. This will benefit everybody in keeping the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or an insurance company's determination of payment.

Co-pays due at the time of visit will still be due at the time of the visit.

Sincerely yours,
Columbia Dermatology Center
Jane Chew, MD

I authorize Columbia Dermatology Center to charge outstanding balances on my account to the following credit card:

Card Type (please circle) VISA / MASTERCARD

Card Account Number _____

Exp. Date _____

Name on Card _____

Signature _____

Date _____