PATIENT REGISTRATION FORM

Name_____ Preferred Name_____ Age_____ Date of Birth_____

Address_____ City/State_____ Zip_____

Cell Phone_____ Daytime / Work Phone_____ Other Phone_____

Preferred method of communication: □ Phone □ Text

Email Address_____ *Would you like to receive monthly emails about cosmetic specials from our office?* Y / N

Employer_____ Occupation_____

Social Security #_____ Sex: M / F Marital Status S / M / D / W

Primary Care Physician_____ Office Phone_____

Who referred you to our office? _____

Please list any family members who also see Dr. Brown _____

Do we have permission to: Leave a message on your cell phone? _____ voicemail at home?_____ at work?_____

Discuss your medical condition with any member of your household? □ Yes □ No If yes, whom:_____

*Insurance Carrier*_____ Do you have Medicare as primary insurance? □ Yes □ No

Policy Holder Name _____ Policy Holder Date of Birth_____

Spouse Information (if applicable)

Name_____ Date of Birth _____ Cell phone _____

Employer_____ Work / Daytime phone_____

Emergency Contact (Nearest relative or friend)

Name_____ Relationship_____ Daytime Phone_____

Patient (or Guardian Signature)_____ Date_____

Guarantor Agreement / Acknowledgement of Notice of Privacy Practices

I authorize Tricia Brown MD to release any information necessary to process my claims for health care benefits. I agree to assign the benefits of my insurance carrier to Tricia Brown MD. I understand that Tricia Brown MD will file my insurance claim as a courtesy to me, and as such, is not required to wait for extended delays in payment. I understand that I am fully responsible for any non-covered services, denied services, health insurance deductibles, or unassigned portion of charges.

I have received a copy of the Notice of Privacy Practices for Tricia Brown MD. I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice. I know that if I do not consent, services cannot be provided to me.

I have read and understand all of the following:

1) **Payment** (in the form of cash, check, debit card or credit card [Visa, Mastercard]) is due for all services and/or copayments at the time of visit. Credit cards will incur a 3.5% processing fee. Please use other forms of payment to avoid this fee.
2) **Returned checks** will be charged a $30 fee to cover processing and bank fees.
3) **Overdue accounts** are subject to a $75.00 late fee after 60 days. If a delinquent account must be turned over to collections, the patient is responsible for all attorney fees, court costs and collection agency fees associated with the collection process.
4) **Cancellations:** In order to provide the best possible service and availability to all our patients, it is office policy to charge a $100 fee for any medical appointments not cancelled with the front desk by phone at least two business days prior. Complete no-show's with no significant advanced warning will incur the full cost of the visit. This fee is NOT covered by insurance and is the full responsibility of the patient. Please call us as early as possible if you know you will need to reschedule your appointment. Cancellations should be made with our front desk staff by phone, rather than by email, text, or voicemail. For surgery appointments, medical procedures, and standard cosmetic procedures, a minimum of a $200 no-show fee will apply. All appointments require a $75 deposit (or $200+ deposit for longer visits) to reserve the appointment. This will be happily refunded if the appointment is cancelled at least two business days prior. For high-demand cosmetic appointment times (i.e., holiday appointments), full prepayment is required to reserve the time. Appointments that are not cancelled at least two business days prior are subject to forfeiture of the entire payment.
5) Most insurance companies now require that all **procedures** (wart freezing, biopsies, etc.) be done **on a separate day** from the office visit. We will be happy to reschedule you for a brief follow-up appointment to complete these treatments.
6) **HMO (Managed care) patients:** It is the responsibility of HMO patients to ensure that they have obtained a referral for all appointments with this office, if needed. The patient is financially responsible for any and all services rendered that are not a part of the referral, if not covered or paid by insurance. If you did not get a referral for a specialist office visit, your insurance company will require you to pay the full amount for all services.
7) **PPO patients:** Most insurance companies consider all dermatology procedures (such as skin biopsies or freezing off warts) to be surgical in nature. They will often apply these costs to your deductible. When we verify insurance for your appointment, we are given a general idea about your coverage, but we will not know exactly what they cover until we send off the claim and receive an explanation of benefits (EOB). It is a good idea for you to become well acquainted with the specifics of your coverage. If you want to delay a particular procedure until you know these details, the front desk staff will be happy to provide you with the appropriate medical codes for you to give to your insurance company.
8) **Labwork and pathology services of biopsies:** Are sent to outside labs for testing. The lab will bill the insurance and/or patient separately for this service. We do not know the specific prices, as this is contracted between the insurance and the lab. Please notify us beforehand if you would like the lab's phone number to call them for a price quote prior to the procedure.
9) **Insurance coverage:** It is the patient's ultimate responsibility to ensure that we are covered on their health plan. While our office always checks beforehand for insurance coverage and verification as a courtesy to patients, we have found that insurance companies do not always give us accurate information and they do not guarantee coverage or payment. We do our best to determine these issues beforehand, but we also rely on the patient to directly call their insurance plan and be fully aware of their coverage. NOTE: We will gladly file your insurance claim on your behalf. We allow 3 months for the insurance company to pay and will try to appeal any payment denials. If the insurance company does not pay after 3 months, the patient will be fully responsible for the entire balance.
10) **We are no longer contracted with Medicare or Blue-Cross Blue-Shield,** but we do have discounted self-pay rates and can see patients of any age, with or without insurance. They should still cover standard medications and lab work as usual.
11) In order to provide the best care for patients, **complete skin/mole checks** are performed on an office visit separate from medical evaluations for other issues (I.e. skin rash, acne, hair loss, etc.). We are still able to refill straightforward medications during a mole check, and we will be happy to check one or two concerning lesions during a medical evaluation.
12) **Parents of young children:** While we strive to provide a safe environment for everyone, medical exam rooms can be a dangerous place for unsupervised children. Please watch your children closely, or you may prefer to keep young children at home. For their safety, it is extremely important to keep them away from the medical waste trash can, the drawers and cabinets, lasers, and the Doctor's rolling stool. At your request, we can remove some of these items from the room for you. Parents/guardians are held responsible for any damage or accidents caused by inadequately supervised children.

Patient (or Guardian) Signature_____ Date_____

Dermatology Medical History

Name_____ Date_____

Reason for today's visit:_____

Do you have any specific skin diseases?_____

Please list all medications (including over-the-counter & herbals):_____

_____

Are you allergic to any medications? □ Yes □ No Please list_____

_____

What is your occupation?_____ Hobbies?_____

Do you have now, or have you ever had any of the following diseases or conditions?

	Yes	No		Yes	No
History of Cancer (other than skin)	□	□	**Other Systemic**		
Location_____			Diabetes	□	□
Lungs / Allergies			Thyroid problems	□	□
Asthma / Wheezing	□	□	Yeast infections on antibiotics	□	□
Shortness of breath	□	□	Fainting	□	□
Bee or wasp sting allergy*	□	□	Convulsions or seizures	□	□
Cardiovascular			Arthritis/joint deformity	□	□
High blood pressure	□	□	Artificial joint	□	□
Heart attack / heart disease	□	□	Depression	□	□
Irregular heartbeat	□	□	Anxiety	□	□
Inflammation of veins	□	□	Autism spectrum disorder	□	□
Blood clots	□	□	**Gastrointestinal**		
Pacemaker	□	□	Gastric bypass, sleeve, or lap band	□	□
Current or Past use of GLP-1's	□	□	Nausea, vomiting, diarrhea when taking antibiotics	□	□
			Celiac disease, Crohn's or Ulc. colitis	□	□

List any other diseases or conditions:_____

List surgical procedures you have had in the last year:_____

Skin:	Yes	No	If yes,
Have you ever had skin cancer?	□	□	Body area & date of cancer_____
Has anyone in your family had melanoma?	□	□	Which family member? _____
Do you have problems with healing?	□	□	
Do you develop keloids (bad scars) after surgery?	□	□	
Do you bleed easily?	□	□	

Do you develop skin rashes in reaction to: □ Medications □ Food □ Environment?_____

Social History:	Yes	No	
Do you drink alcohol?	□	□	If yes, _____ drinks per week; or, _____ drinks per month
Do you smoke?	□	□	If yes, how many packs per day :_____
Does anyone around you smoke?	□	□	
Do you wear sunscreen regularly?	□	□	
Do you have or have you been exposed to HIV (AIDS)?	□	□	
Women:			
Are you pregnant?	□	□	Due Date_____
Are you breastfeeding?	□	□	
Are menstrual cycles regular?	□	□	Date of last cycle_____ □ Menopause □ Other _____

Signature_____

Prescriptions and Refills

**We now e-prescribe most medications for your convenience. Please list your pharmacy details so that we can send your prescriptions to the proper location.

Preferred LOCAL PHARMACY:

PHARMACY Name: _____ Phone: _____

Address: _____ Zip Code (required): _____

If you need to use a specific MAIL ORDER PHARMACY with your insurance:

PHARMACY Name: _____ Phone: _____

Address: _____

In order to ensure that you are receiving the most appropriate and accurate treatment, **we will only be able to prepare regular pharmacy prescriptions and refills during a scheduled office visit. Please notify the medical assistants of all possible medications that may need to refilled during the next year at the time of your appointment.** Refills for most medications last for one year, at which time we will be happy to see you again in the office for another prescription. We recommend that you take advantage of your medication refills before they expire.

During your office visit, we will write your prescriptions with adequate refills to last until your next follow-up appointment. In response to fax requests from pharmacies or call-ins for prescription renewals, we will kindly ask that you come into the office for an appointment. (Please note that this policy does not apply to compounded Retin-A or Hydroquinone lightening cream refills, since each of these refills must be authorized through our office every time).

We recommend that you schedule your recommended follow-up appointment at each visit to prevent any unexpected medication emergencies.

We apologize for any inconvenience this may cause, as we work to ensure that you are receiving proper treatment.

_____ _____ _____

Patient Name Signature Date