PATIENT REGISTRATION

(Please Print)

Date:_______________ Acct:_______________

Name_______________________________________ Home Phone_______________________________
Last, First, (MI)

Street_______________________________________ Work Phone_____________Cell Phone______________

City___________________State______Zip____________ E-Mail Address_________________________________

Patient SSN_______________________________________ Date of Birth_____________________Male or Female

Occupation_______________________________________ Spouse's/Parent's Name________________________

Employer_______________________________________ Spouse's/Parent's Employer_____________________

Emergency Contact: Name/relationship ________________________ Phone #______________________

Personal Physician__________________Address___________________________ Phone#______________________

Preferred Pharmacy____ Phone#______________________

Referred by whom?(Name & Phone #)____

Language spoken_________________________Race_____________________ Ethnicity________________________

PAST/FAMILY/SOCIAL HISTORY

Drug Allergies____
Current Medications____
Chronic Illnesses____
Past Surgeries____
Do you have any artificial joints? Yes / No Mitral valve prolapse or artificial heart valve? Yes / No
Do you have a pacemaker/defibrillator? Yes/ No
Alcohol Intake_____________________________________ Illicit Drug Use__________________________________
Smoking Status/History____
Family Diseases____
Family/Personal History of Skin Cancer____

REVIEW OF SYSTEMS

Do you have any recent problems with the following? If yes, please describe in this space.

Fevers/Chills/Weight loss?	Yes/No
Sore eyes/Dry eyes?	Yes/No
Sores in mouth or nose?	Yes/No
Chest Pain/Leg swelling?	Yes/No
Nausea/Diarrhea?	Yes/No
Burning urination/Frequent urination?	Yes/No
Muscle or joint pain?	Yes/No
Numbness of feet/Dizziness?	Yes/No
Depressed/Anxious Mood?	Yes/No
Fatigue/Cold Intolerance?	Yes/No
Swollen lymph glands?	Yes/No

PLEASE COMPLETE THIS FORM FRONT AND BACK(TURN OVER TO CONTINUE)

BILLING INFORMATION

Payment of insurance co-pay/or for any cosmetic services is expected the day services are rendered. We accept MC/VISA/Discover/American Express/Check/Cash.

RESPONSIBLE PARTY:___________________Relationship____________Date of Birth_________

Phone #________________________________SSN_________________

Street Address____________________________City_________________State_______Zip______

PRIMARY INSURANCE:________________________Amount of Deductible/co-pay_____________
Policyholder's Information:

Name__________________________________Relationship___________Date of Birth__________

Member ID#_____________________________Phone #_______________

Street Address____________________________City__________________State______Zip______

SECONDARY INSURANCE:______________________
Policyholder's Information:

Name__________________________________Relationship____________Date of Birth_________

Member ID#_____________________________Phone #__________________

Street Address________________ ____________City__________________ State _______Zip_____

ASSIGNMENT OF INSURANCE BENEFITS

I hereby authorize direct payment of surgical/medical benefits to Distinctive Dermatology, LTD, for services rendered by the physician in person or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance. If we have to refer your account to a collection agency, you agree to pay all of the collections costs which are incurred.

ALL INSURANCE AND MEDICARE

I hereby authorize Distinctive Dermatology to release any medical or incidental information that may be necessary for either medical care or in processing applications for financial benefit.

NO-SHOW APPOINTMENT POLICY

I hereby authorize Distinctive Dermatology to charge my account $25.00 if I do not show for a scheduled appointment without calling and cancelling/rescheduling the appointment within 24 hours of the appointment date.

PROTECTED HEALTH INFORMATION

I hereby authorize Distinctive Dermatology to release or obtain from other physicians and medical facilities whatever records are necessary for my continued care.

SIGNATURE:
PATIENT, PARENT OR LEGAL GUARDIAN______________________________**DATE**_________

I hereby authorize Distinctive Dermatology to release any medical information for the treatment of my care.
Person(s) to whom information may be disclosed:

____ ____________________________________
Name of Person/relationship Name of Person/relationship

SIGNATURE:
PATIENT, PARENT OR LEGAL GUARDIAN_______________________________**DATE**_________

SUSAN L. JOURNAGAN, M.D.
COURTNEY A. TOBIN, M.D.
TERRI D. FURFARO, DNP, APN, FNP-BC

Consent for Release and Use of Confidential Information and
Receipt of Notice of Privacy Practices Form

I, ___________________________________, hereby give consent to Distinctive Dermatology, Ltd.
(Name of Patient or Authorized Agent)

("DD") to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of _________________________________.
(Patient's Name)

I acknowledge receipt of DD's Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how DD may use and disclose my confidential information.

I understand that DD has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me on my next visit.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to DD. I also understand that I will not be able to revoke this consent in cases where DD has already relied on it to use or disclose my health information. Written revocation of consent must be sent to DD office.

Signed:_____________________________________Date:______________

If you are not the patient, please specify your relationship to the patient:______________

CONSENT FORM DEFINITIONS

"Health care operations" refers to a large number of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guideline, provided that the obtaining of generalizeable knowledge in not the primary purpose of any studies resulting from such activities; population-based activities relating

2. Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which student, trainees, or practitioners in areas of health care learn under supervision to practice or improve their

3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss

4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies;

6. Business management and general administrative activities including but not limited to: (a)management activities relating to HIPPA privacy rule compliance;(b)customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that protected health information is not disclosed to such policy holder, plan sponsor, or customer;(c)resolution of internal grievances;(d)due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a covered entity or, following completion of the sale or transfer, will become a covered entity; (e)creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to the individual to who health care if provided and include, but are not limited to:

1. Determination of eligibility coverage(including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

"

k

y

)

o o

u

y