Rockingham Dermatology, PC

REGISTRATION FORM

❑ PATIENT INFORMATION

❑ Mr ❑ Miss ❑ Mrs ❑ Ms Patient Name: ❑ Male ❑ Female

Address:	City:	State:	Zip:

Social Security No:	Date of Birth:	Home Number: _____❑ List all numbers then Cell: _____❑ check box for preferred Work: _____❑ contact number

May we leave test results or prescription information on your voicemail? ❑ YES ❑ NO

Patient Portal: Allows you to view Allergies, Medications and Test Results. If you would like access please list your email address.

Email:_____

Primary Care Physician & Location: Who referred you to our office:

Race: ❑ Caucasian/White ❑ African American/Black ❑ Hispanic ❑ Russian ❑ Other _____	Ethnicity: ❑ Hispanic or Latino ❑ Not Hispanic or Latino ❑ Other_____ Language:_____	Employer:_____ Occupation:_____ Retired:_____ If Student, Name of School:_____

❑ RESPONSIBLE PARTY/BILLING INFORMATION

Name of person responsible for bill: ❑ Self (If self, skip this section) ❑ Spouse ❑ Parent / Guardian

Billing Address (if different):		Date of Birth:
Home Number:	Cell:	Work:

❑ INSURANCE INFORMATION

Primary Insurance Company:	Policy / ID #:
Name of Policy Holder/Insured:❑ Self ❑ Spouse ❑ Parent	Insured Date of Birth:
Secondary Insurance Company:	Policy / ID #:
Name of Policy Holder/Insured:❑ Self ❑ Spouse ❑ Parent	Insured Date of Birth:

❑ RELEASE OF INFORMATION

With whom may we discuss your medical / financial information: (Spouse, parent, etc.)

Name:	Phone #:
Name:	Phone #:

❑ CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I authorize Dr. Miller to provide medical care/treatment and to bill my insurance carrier for services provided. I understand and agree that I am responsible for the balance on my account for services rendered. I authorize the release of information necessary to process my claim and authorize all payments be made directly to Rockingham Dermatology.

Patient/Guardian Signature_____ Date_____

Read and Sign Back Page

Rockingham Dermatology, PC

Dr. Carolyn Miller

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Harrisonburg, VA 22801
Phone: (540) 442-8056 Fax: (540) 442-8022

Practice Policy / Financial Agreement / Notice of Privacy Practices

We are committed to providing the best possible treatment to our patients. As a courtesy, we will bill your insurance carrier on your behalf or assist you by providing copies of statements and medical documentation required for you to bill the insurance carrier directly. We understand the high cost of health insurance and we strive to help you receive the benefits to which you are entitled. If you have questions please do not hesitate to ask us. We are here to help you.

INSURANCE

While we do participate with many plans, it is not possible for our staff to be aware of each plan's specific requirements and cannot guarantee coverage to any individual. Your insurance coverage is a contract between you, your employer and the insurance carrier. We are not a party to that contract. Not all services are covered benefits. Some insurance companies select certain services they will not cover. It is your responsibility to understand and comply with any predetermined benefits or referral requirements.

PAYMENTS / COLLECTIONS

Payment for copay, account balance, Self-Pay or elective/non-covered procedures will be due at the time of service. We realize financial problems may affect timely payment of your account balance. If such problems arise please contact our office to discuss payment plan options. All accounts over 60 days past due are turned over to our collection agency. If your account is turned over for collection, you will be responsible for all collection service fees, interest and all legal fees associated with collecting the account, including but not limited to attorney fees and all court costs.

NOTICE OF DISCHARGE

Our staff works hard at preventing a patient from being discharged, there may be instances where we have no other choice but to terminate the patient and physician relationship. Reasons for discharge include, but not limited to:

- **Misconduct:** Verbal or physical abuse by patient and/or family member, causing safety concerns for staff and/or other patients. Including improper language, threats of harm, violent behavior or anger will not be tolerated.
- **Noncompliance:** Does not or will not follow the treatment plan, repeatedly cancels appointments or No Shows for scheduled appointments.
- **Nonpayment:** If your account is continuously delinquent or you do not return our calls to discuss payment options. In the event your account is transferred to our collections agency, care may not be received until the balance is paid in full.

ACKNOWLEDGEMENT STATEMENT

I understand and agree that I am responsible for my account balance for services rendered to me. With my consent, Rockingham Dermatology, may use and disclose my protected health information (PHI) for treatment, payment and healthcare operations (TPO). I received a copy of the Notice of Privacy Practices, explaining how my health information will be handled, and all my questions have been answered.

_____	_____	_____
Patient/Guarantor Signature	**Print Patient Name**	**Date**

Thank you for choosing our office for your care!

Rockingham Dermatology, PC **Medical History**

Patient: _____ ***Date of Birth:*** _____ ***Age:***_____
Reason for Visit:_____ ***Height:***_____ ***Weight:***_____

Past Medical History (Check all that apply)					
Condition		Details	Condition		Details
No Past Medical History	□		High Cholesterol	□	
AIDS / HIV	□		Hives	□	
Alzheimer's	□		Joint Replacement (Within 2 years)	□	Year -
Anemia	□		Numbness	□	
Anxiety / Depression	□		Pacemaker / Implanted Electrical Devices (Please list year)	□	Year -
Asthma	□		Parkinson's	□	
Autoimmune Disease: Colitis, Crohn's, Lupus Reynaud's, Ulcer's, etc.	□		Polycystic Ovarian Disease / Unwanted Facial Hair (Female Only)	□	Year -
Bleeding Disorder	□		Psoriasis	□	
Chemotherapy	□		Rheumatoid Arthritis	□	
Diabetes	□		Sarcoidosis	□	
Dialysis	□		Seizures	□	
Eczema	□		Thyroid Disorder	□	
Heart Conditions - List Type	□		Tuberculosis	□	
Hepatitis (A, B, C)	□		Other Conditions:	□	
High Blood Pressure	□				

*** Female Patients: Are you pregnant? Yes ____ No _____**

Past Surgeries		
Date	Surgery	Complications

***Has a doctor advised that you require an antibiotic prior to a procedure? Yes ____ No ____**

Skin Cancer History			
Condition		Previous Treatment	Treating Physician
No Significant History	□		
Actinic Keratosis	□		
Basal Cell Carcinoma	□		
Malignant Melanoma	□		
Squamous Cell Carcinoma	□		
Other Lesion	□		

***** Please complete back of this form *****

Medical History

Family History (Parents, Siblings, Children)			
Condition		Affected Family Member	Type
No Contributing Family History	□		
Autoimmune Diseases	□		
Eczema / Hayfever / Psoriasis	□		
Malignant Melanoma	□		
Skin Disease	□		
Thyroid Disease	□		

Medication Allergies		
Medication	Reaction	Notes

Current Medications

***Preferred Pharmacy Name and Location: _____**

Social History
Do you Smoke? No ____ Yes ____ Former smoker? No _____ Yes _____
Do you use smokeless tobacco? No ____ Yes ____
Do you consume alcohol? No ____ Yes ____ How often? Daily ____ Socially ____
Have you ever had or been treated for a Sexually Transmitted Disease? No _____ Yes _____
Do you use Illegal or Recreational Drugs? No ____ Yes ____