Rockingham Dermatology, PC REGISTRATION

□ PATIENT INFORMATION								
☐ Mr ☐ Miss ☐ Mrs ☐ Ms Patient Nam	۵'				☐ Male	۵.	☐ Female	
Address:	С.	City:		State:			□ i emale	
		,				Zip:		
Social Security No:	Date of Birth:	Home Number: _					numbers	
		Cell: Work:					ck box for preferred tact number	
		WOIR.					Tariber	
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:		1	Who referre	ed you to our	office:			
Race:					Employer:			
☐ Caucasian/White ☐ African American/Black ☐ Hispanic		☐ Not Hispanic o	I Hispanic or Latino I Not Hispanic or Latino I Other		Occupation:			
□ Russian □ Other		Language:		Retired:				
				If Student, Name of School				
RESPONSIBLE PARTY/BILLING INFORMATION								
Name of person responsible for bill: Self (If	self, skip this section)	☐ Spouse ☐ Parer	nt / 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 ☐ Spou	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. Read and Sign Back Page								
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Rockingham Dermatology, PC Dr. Carolyn Miller

2061 Evelyn Byrd Ave, Ste C

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 an additional 25% collection service fee.

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 collection 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).
received a copy of the Notice of Privacy Practices, explaining how my health information will be handled, and all my questions have
been answered.

seen disweled.	
Signature of Patient / Legal Representative	Date

Thank you for choosing our office for your care!

Medical History

Patient:				_Date of Birth:			Age: Weight:		
		Me	dical Histor	y (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 Pacemaker / Implanted					
Anxiety / Depression				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 A	Rheumatoid Arthritis				
Diabetes				Sarcoidosis					
Freestyle Libre for Diabetes		Glucose Mo	onitoring Sys.	Seizures					
Dialysis				Thyroid Disorder					
Eczema				Tuberculosis					
Heart Conditions - List Type				Other Conditions:					
Hepatitis (A, B, C)									
High Blood Pressure									
Female Patients: Are you	preg	gnant? Yes		Surgeries					
Date			Surgery			Complications			
*Has a doctor advised that y	ou r	equire an a	ntibiotic prior	to a procedure	? Yes	No			
			Skin Co	ancer History	,				
Condition				Previous Treatment			Treating Physician		
No Significant History									
Actinic Keratosis									
Basal Cell Carcinoma									
Malignant Melanoma									
Squamous Cell Carcinoma									
Other Lesion									

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Medical History

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Family History (Parents, Siblings, Children)							
Condition		Affected Family Member	Туре				
No Contributing Family History							
Autoimmune Diseases							
Eczema / Hayfever / Psoriasis							
Malignant Melanoma							
Skin Disease							
Thyroid Disease							
		Medication Allergies					
Medication		Reaction	Notes				
		Current Medications					
Social History							
Tobacco user (circle answer): Never	Current	Former					
How many times in the past year have Circle your answer: None, 1, 2,			vomen) or more in a day?				
What pharmacy would you like prescriptions sent to? List pharmacy name and location below:							