Millennium Park Dermatology – Patient Registration Form

PATIENT INFORMATION

Name_____ Date of Birth_____/_____/_____ Gender ☐M ☐F

Social Security Number_____-_____-_____

Address_____City_____State_____Zip_____

Home phone (_____) _____ Cell (_____) _____ Work (_____) _____

Email address _____Marital Status ☐Single ☐Married ☐Widowed ☐Separated

Employment status ☐Employed ☐Retired ☐Other Employer _____

Primary Care Physician _____

Emergency Contact_____ Phone (_____) _____Relationship to patient_____

May we leave phone messages regarding confidential health information such as lab or pathology results? ☐ Yes ☐ No

Please indicate which phone numbers we can use to leave confidential health information ☐ Home ☐ Cell ☐ Work

RESPONSIBLE PARTY

☐ Check here if responsible party is the same as patient

Name_____ Relationship to patient ☐Spouse ☐Parent ☐Other

Address_____City_____State_____Zip_____

Home phone (_____) _____ Cell (_____) _____Work phone (_____) _____

INSURANCE INFORMATION

Insurance carrier _____Policy #_____Group #_____

Subscriber name_____ Patient's relationship to subscriber ☐Self ☐Spouse ☐Child ☐Other

Subscriber's Date of Birth_____/_____/_____ Gender ☐M ☐F Employer_____

Subscriber's Social Security Number_____-_____-_____

Does the patient have secondary insurance? ☐Yes ☐No

Secondary Insurance carrier _____Policy #_____Group #_____

How did you hear about us? ☐ Physician referral ☐ Family member ☐ Friend ☐ Internet source ☐ Other_____

Name of physician, family member or friend who referred you _____

Patient or Responsible Party Signature_____**Date**_____

Millennium Park Dermatology – Patient Health History

Patient Name_____ Patient Date of Birth____/____/____ Gender ☐M ☐F

What is the reason for your visit today? ☐Acne ☐Rash ☐Moles/Growths ☐Warts ☐Hair loss ☐Annual skin exam ☐Other

Briefly explain the reason for your visit: _____

Drug allergies ☐No known drug allergies ☐Yes, I have drug allergies (please list) _____

Other allergies ☐No known allergies ☐Yes, I have other allergies (please list) _____

Medications – please list all medications you currently take including prescriptions, over-the-counter, vitamins, etc.: _____

_____

Dermatologic History – please indicate those conditions with which you have been previously diagnosed:

Acne	☐	Hair Loss	☐
Actinic Keratosis	☐	Hay Fever/ Allergies	☐
Basal Cell Carcinoma	☐	Lupus	☐
Blistering Sunburns	☐	Poison Ivy	☐
Chicken Pox (Varicella)	☐	Precancerous Moles	☐
Dry Skin	☐	Psoriasis	☐
Eczema	☐	Squamous Cell Carcinoma	☐
Flaking or Itchy Scalp	☐	Other	☐ _____

Have **YOU** or a **RELATIVE** been diagnosed with Melanoma? ☐ No ☐ Yes, Self ☐ Yes, Relative_____

Medical History – please indicate those conditions with which you have been previously diagnosed:

☐ Anxiety	☐ COPD	☐ Hypertension	☐ Prostate Cancer
☐ Arthritis	☐ Coronary Artery Disease	☐ HIV/AIDS	☐ Radiation Treatments
☐ Asthma	☐ Depression	☐ Hypercholesterolemia	☐ Seizures
☐ Atrial Fibrillation	☐ Diabetes	☐ Hyperthyroidism	☐ Stroke
☐ Benign Prostatic Hypertrophy	☐ End Stage Renal Disease	☐ Hypothyroidism	☐ Other _____
☐ Bone Marrow Transplant	☐ Gastric Reflex	☐ Leukemia	
☐ Breast Cancer	☐ Hearing Loss	☐ Lung Cancer	
☐ Colon Cancer	☐ Hepatitis	☐ Lymphoma	

Important Information– this information is particularly important for us in case you undergo a procedure:

☐ Pacemaker	☐ Require premedication	☐ Rapid heartbeat with epinephrine
☐ Defibrillator	☐ Allergy to adhesive	☐ Yeast infections with antibiotics
☐ Artificial joints	☐ Allergy to lidocaine	☐ GI upset with antibiotics
☐ Artificial heart valve	☐ Allergy to topical antibiotics	☐ Problems with bleeding

Recent Symptoms – please indicate those symptoms you are currently experiencing or have experienced in the past year:

☐ Abdominal pain	☐ Fever or chills	☐ Night sweats	☐ Weight loss (unexplained)
☐ Bloody stool/urine	☐ Headaches	☐ Seizures	☐ Weight gain (unexplained)
☐ Blurry vision	☐ Joint aches	☐ Shortness of breath	
☐ Chest pain	☐ Muscle weakness	☐ Sore throat	
☐ Cough	☐ Neck stiffness	☐ Thyroid problems	

Women: Are you pregnant ☐Yes ☐No ☐Trying

Women: Date of last period _____/_____/_____

Do you smoke? ☐ Never ☐ Former ☐ Current

Do you sunbathe? ☐Yes ☐No

Do you use sunscreen? ☐Yes ☐No SPF_____

Do you use tanning beds? ☐Yes ☐No

Do you have problems with skin/wound healing? ☐Yes ☐No

Do you develop keloids or thick scars? ☐Yes ☐No

Please list any surgeries:_____

Please indicate if you would like more information on any of the following cosmetic services:

☐ Chemical peels/microdermabrasion	☐ Restylane/Perlane/Juvederm fillers for facial wrinkles
☐ Latisse (for longer, fuller, darker lashes)	☐ Removal of skin tags or "flesh moles"
☐ Botox/Dysport for facial wrinkles	☐ Other_____

Patient or Responsible Party Signature_____ Date_____/_____/_____

Millennium Park Dermatology – General Consent Form

Consent for treatment – I voluntarily consent to receive medical and health care services by Dr. Victoria H. Barbosa and/or her assistants that may include examinations, routine office procedures, diagnostic procedures, and other treatments deemed necessary by Dr. Barbosa. I agree to communicate any questions or concerns about my treatment to Dr. Barbosa and/or her staff prior to being treated. I agree to inform Dr. Barbosa and/or her staff before services are rendered about any health problems I may have, possible drug allergies, current medications I am taking, or any other information that may be pertinent to my treatment.

No guarantees – I understand that the practice of medicine is not an exact science and results vary among patients. I understand there is no contract, warranty, guarantee or promise concerning the results of any medical or cosmetic services provided by Dr. Barbosa and/or her assistants.

Limited release of information – I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Assignment of benefits – I authorize Millennium Park Dermatology, S.C. to accept assignment/payment from my insurance carrier(s) for services rendered. I authorize used of my signature below on all my insurance submissions.

Pathology services for non-Medicare patients – I authorize Dr. Barbosa and/or her assistants at Millennium Park Dermatology to send my tissue or other specimens to Richfield Laboratory of Dermatopathology or other laboratories deemed appropriate by Dr. Barbosa for microscopic slide processing and interpretation.

Medical Photography – I understand that photographs may be taken and added to my medical record. I understand that if I request release of my medical records these photographs may be included. I understand that these photographs may be used for the following purposes: education, training, medical or scientific publication, in which case my identity will be protected.

Communication – I understand that Millennium Park Dermatology may need to communicate with me for any number of reasons, for example: to confirm appointments, to deliver test results or to inform me of new staff, medical or cosmetic treatments, services, products, promotions, events, discounts or other news that I may find of interest. I understand that Millennium Park Dermatology may use the address, email address, cell phone number or home phone number that I provide for these purposes. I understand that Millennium Park Dermatology will not provide or sell any of my demographic information to a third party for marketing purposes.

_____ _____ _____/_____/_____

Patient or Responsible Party Signature **Print Name** **Date**

Millennium Park Dermatology – Financial Policy

We know that this isn't much fun to read. And Holy Cow, it's so long!

We believe that being completely transparent about our Financial Policy will make your visit with us easier. Take a few minutes to read this now so there will be no unpleasant surprises for you down the road, and just ask us if you have any questions.

Methods of Payment
Millennium Park Dermatology accepts cash, checks and all major credit cards. Payments may be made in person, by mail or over the phone.

Insurance
Payment for all services rendered are the patient's responsibility. Millennium Park Dermatology bills a patient's insurance as a courtesy. In order for us to do so, patients must provide proof of insurance at each visit. If the patient does not have his or her insurance card, or if coverage cannot be verified, the patient will be responsible for payment in full at the time of service. We make every attempt to accurately confirm our participation in various plans, but it is ultimately the patient's responsibility to know their insurance coverage and benefits. We recommend calling your insurance carrier prior to your visit to verify coverage. Rejection of all or part of your medical insurance claim by your insurance company does not relieve your financial obligation to Millennium Park Dermatology. If we cannot collect insurance payment within 90 days of service, the balance will be assigned to the patient.

Co-Payments and Co-Insurance
Co-payments (a fixed dollar amount that is assigned to the patient) and co-insurance (a percentage of total charges that are assigned to the patient) are due at the time of visit. We are obligated by our contracts with insurance companies to collect these fees. They cannot be waived.

Outstanding Balances
Millennium Park Dermatology mails billing statements out to patients. Payment for outstanding balances is due upon receipt. Outstanding balances may result from remaining patient balances after insurance has been billed. For instance, unmet deductibles, additional co-payments, non-covered services or any other charge the insurance carrier may assign to the patient will be billed to the patient. In addition, any fees incurred as outlined in this Financial Policy will be billed to the patient. On occasion, a patient has a follow-up visit before they have received a statement in the mail. In this case, a patient will be informed of his or her outstanding balance and payment is due at the time of visit.

Credits and Refunds
Any credits owed to your insurance company will be returned to the insurance company by check.
Any credits or refunds owed to a patient will first be used to pay any outstanding balance. Remaining patient credits and refunds can be left on the account to be used towards future charges or can be returned to the patient (or responsible party who made payment) by check or applied back to the credit card used to make payment. Please allow 2-3 weeks for processing check and credit card transactions.

Self-Pay Patients
Payment is due in full at the time of service for self-pay patients. We do offer discounts to many of our medical services for people who pay out-of-pocket. The cost of any recommended procedures or services in excess of the basic office visit fee will be discussed with patients in advance of provision of service.

Cosmetic Procedures and Services
Payment is due in full at the time of service for cosmetic procedures and services provided by our physician, physicians assistant, and aestheticians.

Patient Initials_____

Millennium Park Dermatology – Financial Policy (cont.)

Children and Adult Patients on their Parents' Insurance
When a patient is under 18 years of age, the parent or guardian who signs the Millennium Park Dermatology Registration Form is responsible for all fees incurred by the minor. In this instance, it is the parent or guardian who would be sent to collections if an account was past due. When a patient becomes 18 or older, he or she is responsible for any outstanding balance not covered by insurance, regardless of if he or she is covered by a parent or guardian's insurance. If a parent prefers to assume complete financial responsibility for an adult offspring, Millennium Park Dermatology must be notified in writing.

Referrals
Some insurance plans require a referral from the patient's primary care physician in order to be seen by a specialist. It is patient's responsibility to know if his or her plan requires a referral. It is also the patient's responsibility to obtain a referral, if needed, in advance of the visit to our office. If you are not sure of your plans requirements, please contact our Billing Manager for assistance prior to your visit. Patients who do not have a valid referral that meets their plans requirements will be given the option to either pay out-of-pocket for the visit on the day of service, or to reschedule the appointment.

Cancellations, Rescheduled Appointments and No-Shows
We understand that plans change and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. Millennium Park Dermatology has a 24 hour cancellation policy. This means that missed appointments ("no shows"), same-day cancellations and same-day rescheduled appointments are subject to a $50.00 cancellation fee for physician visits, physician assistant visits and aesthetician visits. These fees are applied whether or not you receive a reminder call, text or email from our office. They also apply to appointments made just one day in advance.

Returned Checks
If a check is returned by the bank for any reason, the unpaid outstanding balance will be reposted to the patient account along with a $35.00 Returned Check Fee to cover our bank and labor costs. Patients who have had a check returned may be asked to use only cash or credit cards for all future payments.

Collections
If you have an outstanding balance that requires special arrangements, please call Jess, our Office Manager for assistance. It is our sincere desire to help you meet your financial obligations without being sent to collections. Outstanding balances that are not paid within 90 days will be sent to a collections agency. Once a patient's account is sent to collections he or she is responsible for the original balance on the account in addition to a Collections Fee of 35% of the outstanding balance plus any interest, service fees and/or legal fees that accrue while the account is in collections.

I understand and agree to the terms of Millennium Park Dermatology's Financial Policy:

_____ _____ _____/_____/_____

Patient or Responsible Party Signature **Print Name** **Date**