4530 E. Shea Boulevard, Suite 101 ◆ Phoenix, AZ ◆ 85028 ◆ 602.867.7546

PATIENT REGISTRATION FORM

Today's Date:_________________ ☐Married ☐Divorced ☐Widowed ☐Single **☐NEW PATIENT** **☐UPDATE**

Patients Name:___________________________________ Date of Birth:__________ Age:____ Sex: ☐F ☐M

Cell #(_____) _____ - ________ Home #(_____) _____ - ________ Work #(_____) _____ - ________

Address:___________________________________ City:__________________ State:_____ Zip:__________

E-Mail Address: ____ Social Security # ______________________

Employer:____ Occupation:___________________________

Primary Care Physician:____ Phone #(______) ______ - ________

Emergency Contact Name: ______________________________________ Phone #(______) ______ - _________

Pharmacy Name: ____________________________________ Pharmacy Phone #(______) ______ - _________

Referring Provider/Person/Friend_____________________________________ Phone # ____________________

Please let us know how you found Dr. Holy:

☐Primary Care Physician ☐Family ☐Your health insurance website ☐E-mail (Newsletter)

☐ Online: ZocDoc.com ☐Online: Dr. Holy's website ☐Online: Review site (ie, Vitals.com or Yelp.com)

☐Our Fall Event ☐Mailing ☐Friend ☐Walk-in ☐Best Of Our Valley AZ Foothills ☐Ad ___________

Can we leave a message? ☐Yes ☐No If Yes - phone number (______) ______ - _________ ______**Initial**

Do you authorize the office staff to discuss your care of treatment with any other parties other than yourself?

☐Yes ☐No If Yes - then with whom?___________________________________

RELEASE AND ASSIGNMENT

I, the undersigned have insurance coverage with_____________________________ and assign directly to Adriana K. Holy, MD all medical benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by said insurance, unless assignee has executed an agreement with my insurance provider or plan. I understand that if such agreement has been executed, I may be responsible to pay any deductible and/or co-payment and non-covered services under the terms of my insurance. I understand that any payments, which are due, starting 30 days after insurance coverage has been completed, will be charged a $3.00 monthly late service charge: (or) at a rate of 1.5% interest per month on unpaid balance, whichever is larger. I understand that I am financially liable in the event of non-payment: I agree to pay the collection agency's cost and/or court cost and reasonable attorney fees.

Signature of Insured/Guardian: ____ **Date**: _________________

Name of Primary Insurance Holder: ______________________________________ **Date**: _________________

I request that payment of authorized Medicare benefits to be made directly to: Dr. Adriana Holy, MD. on my behalf for any service furnished by the physician, I authorize any holder of medical information about me to release to CMS and its agents needed to determine these benefits payable for related services. I understand that a signature request may be made to authorize the release of medical information necessary to pay a claim. In Medicare assigned cases, the physician agrees to accept the charge determination of the Medicare carrier as full charge, and the patient is responsible for full deductible, coinsurance services. Coinsurance and deductible are based upon the charge determination of the Medicare carrier.

Beneficiary Signature: ____ **Date**: _______________

THE CENTER for Advanced
Dermatology
Medical · Aesthetic · Holistic

Dermatology Medical History

Patient Name:______________________________________ Date:______________________

Reason for today's visit:____

Are you allergic to any medications? YES☐ NO☐ If yes, list:______________________________

Have you ever had dental anesthesia (Novocaine)? YES☐ NO☐ Any bad reaction? YES☐ NO☐

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):

____

____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	YES	NO
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:		
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflamation of vein	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	YES	NO
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

Skin:

When you are exposed to sun do you: Tan only ☐ Tan and burn ☐ Burn☐

Have you ever had skin cancer? YES☐ No ☐

Has anyone in your family had skin cancer? YES☐ No ☐ Type_______________

Do you have a history of any specific skin diseases? YES☐ No ☐

If yes, please list: ____

Do you develop skin rashes in reaction to: Medications☐ Food ☐ Environment☐

List any other diseases or conditions:____

List surgical procedures you have had in the last 6 months: ______________________________

Social History:

Do you drink alcohol? YES☐ NO☐ If YES_________ drinks per day

Do you use IV drugs? YES☐ NO☐ If YES, what? _______________ How much? _____________

Do you smoke? YES☐ NO☐ If YES, how much? __________

Have you had or have you been exposed ot HIV (Aids)? YES☐ NO☐

Do you bleed easily? YES☐ NO☐

(Women) Are you pregnant? YES☐ NO☐ Due Date? _________________

What is your occupation? ____

What are your hobbies? ____

Completed by: Patient ☐ Medical Assistant☐ Initials__________

Patient Signature:________________________________ Reviewed by: ___________________________

form 5-31-18

PATIENT CONSENT FORM

The Department of Health and Human services has established a "Privacy Rule" as part of "The HIPAA Act of 1996" to help insure that personal health care information is protected for privacy. The HIPAA Act was also created in order to provide a standard for health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment or health care operations.

As our patient we want you to know that we respect the privacy of your personal medical records and will do all we can to protect that privacy We strive to always take reasonable precautions to protect your privacy. When appropriate or necessary, we will provide the minimum information to only those whom we feel are in need of your health, treatment or payment information in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients) and may have to disclose personal health information for treatment, payment or health care operations. These entities are most often not required to obtain patients consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you chose to not disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken care of that relied on this or a previously signed consent.

If you have any objection to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Print Name: ____

Signature: ____ Date: ________________

COMPLIANCE ASSURANCE NOTIFICATION FOR OUR PATIENTS

To Our Valued Patients:

The misuse of Personal Health Information (PHI) has been identified as a national problem causing patients inconvenience, aggravation and money. We want you to know that our entire staff continually undergoes training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) of 1996, with particular emphasis on the "Privacy Rule." We strive to achieve the highest standards of ethics and integrity in performing services for our patients.

It is our policy to properly determine the appropriate use of PHI in accordance with governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing dilemma of improper disclosure of PHI. As part of the plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

We also know we are not perfect. Because of this fact, our policy is to listen to our employees and patients without any thought of penalization. We welcome your input regarding any service problem so we may resolve the situation promptly.

Thank you for your continued confidence in us.

THE CENTER for Advanced
Dermatology
Medical • Aesthetic • Holistic

To All Patients:

I'd like to welcome you to THE CENTER for Advanced Dermatology. With the continued changes of insurance policies and procedures, we have found it necessary to give our patients an insight into our billing policies. If at any time you have a question regarding your account, please feel free to call to alleviate any confusion. The following are some basic rules which may apply to you depending upon the insurance coverage you have. Please remember that each patient has an individual policy and coverage may vary from plan to plan. Therefore, we may direct you to your insurance company to answer further questions.

Please remember… it is your responsibility to know whether we are a preferred provider or contracted on your insurance plan. ______ **Initials**

NO SHOW POLICY: Please call to cancel or re-schedule your appointment is you are unable to come in. There will be a NO SHOW charge for missed appointments. $50.00 for routine medical appointments, $100 for biopsy or surgery appointments, and $250 for cosmetic appointments. Other patients want your appointment time! ______ **Initials**

INSURANCE: As a service to our patients and in an attempt to speed reimbursements, we will do the following with respect to your primary insurance carrier:

1. File your insurance claims promptly.
2. Cooperate with your insurance company to the fullest extent in handling questions regarding your claim.
3. Bill your secondary insurance claim as a courtesy. If they do not pay within 60 days of filing the claim, the balance will be the patient's responsibility.
4. Provide you with 3 monthly statements. Thereafter, if a balance is not paid in full, we will attempt to collect with a phone call followed by turning the account over to a collection agency.

In return, we expect our patients to do the following:

1. Provide us with accurate insurance information with completed demographics at each visit.
2. Assist in contacting your insurance on any claims past due after 45 days.
3. Pay all deductibles, copays and coinsurance due at the time of service.
4. Agree that all charges not directly paid by insurance company will be your full responsibility.

NO INSURANCE/SELF PAY: Payment is due at time of service. ______ **Initials**

COLLECTIONS: Delinquent accounts will be turned over to an outside collection agency if unpaid after 90 days without further notice. In the event that your account is turned over for collections, you are responsible for all associated collection, court, and attorney costs. You will also be responsible for a 30% increase for the collection agency fee.

CO-PAYMENTS – By law we must collect your insurance carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

DIVORCED/SEPARATED PARENTS OF MINOR PATIENT – The parent who consents to the treatment of a minor child is responsible for payment of services rendered regardless of any custody, separation, or divorce disputes.

REFERRALS – If your insurance plan requires a referral from your primary care physician, it is your responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If your plan requires a referral and you do not obtain one, you will be held responsible for the visit charges in full at the time of service.

MEDICAL RECORDS/DISABILITY/FMLA FORMS – There is a $25 fee to copy/distribute medical records and for all disability and FMLA forms that require completion by Adriana K. Holy MD. ______ **Initials**

MEDICAL RECORDS – There is a $35 fee to copy/distribute medical records. ______ **Initials**

I have read and understand the above with regard to THE CENTER for Advanced Dermatology policies and procedures. In the event of default, I agree to pay collection costs and reasonable fees as may be required to obtain collection of this account.

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