THE CENTER for Advanced
Dermatology
Medical Aesthetic Holistic

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: ☐Female ☐Male

Primary #(_____) _____ - _____ Secondary #(_____) _____ - _____ Work #(_____) _____ - _____

Address:_____ City:_____ State:_____ Zip:_____

E-Mail Address: _____ Social Security # _____

Employer:_____ Occupation:_____

Primary Care Physician:_____ Phone #(_____) _____ - _____

Emergency Contact Name: _____ Phone #(_____) _____ - _____

Pharmacy Name: _____ Pharmacy Phone #(_____) _____ - _____

How did you hear about our practice?_____ Phone #(_____) _____ - _____

Can we leave a message? ☐Yes ☐No If Yes - then which 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?_____

The most important anti-aging and healthful product for your skin is **SUNSCREEN!**

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: _____

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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, vomitting, 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: _____

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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.

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To All Patients:

I'd like to welcome you to my practice. 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.

There will be a $30.00 charge that you will be responsible for paying if an appointment is not cancelled within 24 hours of the scheduled time.

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. Verify your insurance benefits; however, this is not a guarantee of payment
2. File your insurance claims promptly
3. Cooperate with your insurance company to the fullest extent in handling questions regarding your claim
4. 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
5. 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
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

COLLECTIONS: We believe it is reasonable to expect payment for services within 60 days from the date of your services. It is important to be involved with your insurance and the processing of your claims. It is our hope that a mutual effort and understanding will result in your account being paid in a timely manner.
I have read and understand the above with regard to Adriana K. Holy MD 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.

Patient Signature_____Date_____