REGISTRATION FORM

PLEASE PROVIDE DRIVER'S LICENSE AND INSURANCE CARD(S) AT THE TIME OF CHECK IN.
ALL COPAYS/DEDUCTIBLES AND COINSURANCES WILL BE COLLECTED AT THE TIME OF SERVICE.

General Patient Information:

Last Name:_____First Name:_____M.I._____ Address:_____

_____Apt#:_____City:_____State:_____Zip:_____

Date of Birth:_____/_____/_____Marital Status: Single / Married / Divorced / Widow

Social Security #: _____ Gender: ☐ Female ☐ Male

Primary Phone:_____[ ] *if cell phone, check to receive text messages for appointments & prescriptions filled*

Secondary Phone: _____

Email:_____*you will receive appointment reminders and access to the portal*

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic or Latino Race: ☐ Asian ☐ Native American or another Pacific Islander ☐ White ☐ American Indian ☐ Black or African American ☐ Other

Insurance Information: Please fill in only the subscriber information if you have already presented us your insurance card.

Primary Insurance: _____

Policy#:_____Group#:_____

Subscriber's Name:_____Date of Birth:_____SS#:_____

Best Contact number for subscriber: (_____)_____Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Secondary Insurance: _____

Policy#:_____Group#:_____

Subscriber's Name:_____Date of Birth:_____SS#:_____

Best Contact number for subscriber: (_____)_____Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other

Responsible Party Information (whoever is bringing the patient)

Person Responsible for Patient Account: _____

Date of Birth:_____ Relationship to Patient: _____

Address if different from above:_____City:_____State:_____Zip: _____

Emergency Contact

Name:_____Phone:_____

Relationship: _____

Primary Care Physician: Last Name:_____First Name: _____

Practice Name: _____

Pharmacy Name:_____Phone#: (_____) _____

How did you hear about Commonwealth Dermatology? ☐Social media ☐Radio☐Family/Friend ☐Physician ☐OTHER: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance not covered by my insurance. I also authorize COMMONWEALTH DERMATOLOGY or insurance company to release any information required to process my claims.

I HAVE BEEN NOTIFIED THAT A COPY OF THE NOTICE OF PRIVACY PRACTICES IS AVAILABLE TO MY UPON REQUEST.

The patient has the rights to revoke this authorization at any time and inspect the protected health information to be disclosed as described in this document. Revocation is not effective in cases where the information has already been disclosed, but will be effective going forward. Information used or disclosed as a result of this authorization may be subject to disclosure by the recipient and may no longer be protected by federal or state law.

_____ _____

Patient / Guardian Signature **Date**

Treatment &Financial Policy

Please initial after reading each section

PATIENT NAME: _____

OUR COMMITMENT

COMMONWEALTH DERMATOLOGY, PC WILL PROVIDE THE BEST CARE POSSIBLE CONSISTENT WITH THE PREVAILING STANDARDS OF MEDICAL PRACTICE, BUT THAT THE PRACTICE OF MEDICINE IS NOT AN EXACT SCIENCE AND THAT DIAGNOSIS AND TREATMENT MAY INVOLVE RISK OF INJURY OR EVEN DEATH. NO ASSURANCE OR GUARANTEES HAVE BEEN MADE AS TO THE RESULTS OF EXAMINATION OR TREATMENT. YOU HAVE THE RIGHT TO CONSENT, OR TO REFUSE TO CONSENT, TO ANY PROPOSED PROCEDURE OR THERAPEUTIC COURSE OF TREATMENT. ANY CHILD UNDER THE AGE OF 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN. THE PHYSICIANS AND/OR PHYSICIAN EXTENDER AND ITS CLINICAL AND TECHNICAL EMPLOYEES MAY ADMINISTER ANY TREATMENT OR PERFORM ANY PROCEDURES DEEMED ADVISABLE DURING YOUR CARE AND TREATMENT._____INITIAL

PATIENT SAFETY

The Code of Virginia (32.1-45.1) authorizes health care providers to test patients for HIV, Hepatitis B virus and Hepatitis C virus when a health care provider is directly exposed to blood or bodily fluids of a patient in a manner which may transmit these viruses. In the event of such exposure, the patient will be deemed to have consented to such testing and to have consented to the release of the test results to the health care provider who has been exposed.
In response to serious public health concerns related to prescription drug abuse, Virginia's Prescription Monitoring Program collects prescription data for specified drug schedules into a central database. This can be accessed by authorized users to promote the appropriate prescribing and dispensing of controlled substances for legitimate medical purposes while deterring the illegitimate use of these drugs. As authorized users of the program, prescribers in this practice may request information from the program on all Schedule II-IV prescriptions previously dispensed to a patient in order to establish a treatment history of the patient to assist them in making future treatment decisions. The information collected in this program is maintained by the Department of Health Professions. Only those persons authorized by law can be provided information from the database.
_____Initial

IDENTIFICATION REQUIREMENTS

This practice is committed to safeguarding your identity. Federal regulations require verification of your identity at each visit to verify the identity of anyone presenting medical insurance identification. To satisfy the federal requirements, your driver's license will be scanned into your electronic file. This allows us to verify your identity for future visits. Refusal to provide the required identification may delay or prevent your being seen by our physician. _____Initial

ASSIGNMENT OF BENEFITS

I request that payment of authorized Medicare or applicable private insurance benefits be paid directly to Commonwealth Dermatology, PC for services provided under their care. _____Initial

HEALTH INSURANCE ELIGIBILITY, POLICY UPDATES & NEW INSURANCES

It is your responsibility to keep us updated with your correct insurance information. If the insurance company you designate is incorrect, you will be responsible for payment of the visit. In your agreement with your insurance plan, you are responsible for any and all co-payments, deductibles, and coinsurances. It is your responsibility to understand your benefit plan. All prior balances must be paid prior to your visit. We DO NOT participate with all insurances. If we do not accept your insurance, and you wish to be seen at our office, you may elect to pay for services in accordance with the FINANCIAL RESPONSIBILITY listed below. It is important to note that any money paid on your self-pay account will not be applied to your insurance deductible. _____Initial

REFERRALS & AUTHORIZATIONS

I understand if my insurance company requires a referral, I am responsible for obtaining a referral prior to my visit. If I do not have a referral at the time of my scheduled appointment, I will be required to reschedule or self-pay. _____ Initial

PATHOLOGY & LAB SERVICES

Some services, such as blood work, tissue obtained from biopsies or surgical specimens require an outside laboratory for processing and evaluation. Billing for these services will be directly handled by these outside laboratories. While we do attempt to route specimens to the proper lab based on your insurance, we cannot guarantee their participation. By initialing you are giving us permission to provide your insurance information to the lab on your behalf. It is your responsibility to provide accurate and correct insurance information. _____ Initial

ABN *(Advanced Beneficiary Notice)*

The Federal Medicare program, administered through the Center for Medicare and Medicaid Services (CMS), does not cover many services they consider medically unnecessary or inappropriate. You're responsible for all fees related to these services. You'll be notified and your signature will be required prior to receiving any potentially uncovered services. Supplemental or secondary insurances to Medicare will not cover services denied by Medicare. Please check with your insurance carrier prior to treatment if you're concerned about these issues. _____Initial

Treatment &Financial Policy

Please initial after reading each section

MISSED & CANCELED APPOINTMENTS

We require at least 24 business hours' notice if you must cancel an office appointment. Failure to do so will result in a $50.00 cancellation fee. The office is open Monday through Thursday (8am – 5pm) and Friday (8am-12pm). _____Initial

COSMETIC PROCEDURE

All cosmetic procedure fee(s) will be collected in full at the time of service. There is a $85 consultation fee which will be applied to any products or services received. _____Initial

COLLECTION OF CO-PAYS & DEDUCTIBLES

Per your agreement with your insurance carrier, you are required to pay all applicable co-payments, coinsurance and deductibles at the time of service. In addition, if you are insured with a high deductible insurance plan and have not met your deductible, we will collect $120 for new patients and $85 for established patients*. This will be applied to your visit. *Established is defined as being seen at Commonwealth Dermatology within 3 years or less. _____Initial

RETURNED CHECKS

There is a $50 fee for any check that is returned for insufficient funds or due to a closed account. _____Initial

FINANCIAL RESPONSIBILITY

I understand that Commonwealth Dermatology, PC, as a courtesy, will file my insurance claims with insurance companies that the Practice participates with; however, I am ultimately responsible for the full payment of all charges. Should collection proceedings or other legal action become necessary to collect an overdue account, the patient or the patient's responsible party, understands that Commonwealth Dermatology, PC has the right to disclose to an outside collection agency all relevant personal and account information necessary to collect payment for service rendered. The patient, or the patient's responsible party, understands and agrees to pay all collection fees including the total unpaid balance due and filing fees of 33 1/3% incurred by Commonwealth Dermatology, PC.

All patient balances are billed immediately upon receipt of your insurance plan's Explanation of Benefits. Your remittance is due within 10 business days of your receipt of your bill. Payment plans are accepted for a six (6) month period, beginning on the first date of service with a balance. If payment arrangements have not been made with our billing department, any account balance outstanding longer than 90 days will be forwarded to a collection agency. Any patient account balance over 90 days past due, that does not have a payment arrangement, will be turned over to an outside collection agency. This also includes any patient account balances that have defaulted from their payment arrangement. _____Initial

CONSENT FOR THE RELEASE OF MEDICAL RECORDS

I authorized Commonwealth Dermatology, PC to release necessary medical information to my insurance company, its agents, or any third-party payer in order for payable benefits for these services to be determined.

If you would like to request copies of your medical record there will be an administrative Flat Fee of $15.00, or$ 0.50 per page; whichever is gre ater. A separate CONSENT FOR THE RELEASE OF MEDICAL RECORDS Form must be completed before your request can be honored.

If you would like the office to complete Medical Forms there will be an administrative Flat fee of $25.00. _____Initial

OVERPAYMENTS/REFUNDS

Once ALL insurance payments have been received and it is deemed you have made an overpayment, we will refund the overpayment to you promptly. Refunds will be processed either by check or credit card used at the time of service. _____Initial

I acknowledge that Commonwealth Dermatology, PC will scan this document and destroy the original, and agree that the scanned document is the same as the original.

_____ _____

Signature of Patient or Responsible Party Date

_____ _____

Printed Name of Signature Relationship to Patient

Protected Health Information (PHI)

Communication Consent Form

Patient Information

Patient Full Name:_____DOB: _____

Disclosure: I authorize Commonwealth Dermatology to discuss with the following individual(s) PHI regarding my current care and treatment:

Name_____ Name_____

Phone #_____ Phone #_____

Relationship to Patient _____ Relationship to Patient _____

Information to be Released/Accessed

The following information may be communicated verbally to the individual(s) named in Section above.

☐ Laboratory/Medical Results ☐ Billing, Insurance, and Payments

☐ Medical Instructions or Advice ☐ Medical Records

☐ Appointment Information ☐ Prescription/Medication information

Methods of Communication

I authorize Commonwealth Dermatology to send/leave messages regarding health information

☐ Primary Phone: _____ ☐ Secure Messages via Online Portal

☐ Secondary Phone: _____ Email: _____

☐ Cell Phone: _____ ☐ Text: _____

I Understand That

- The information to be released verbally may not include a diagnosis or reference to the following condition(s):
- Behavioral Health services/psychiatric care; genetic testing; acquired immune deficiency syndrome (AIDS) or human immunodeficiency virus (HIV);
- Without my express revocation, this authorization will automatically expire 1 year from the date signed below, unless I request an expiration date less than 1 year.
- I may revoke this authorization in writing at any time, except to the extent that action has already been taken to comply with it.
- Information disclosed pursuant to the authorization may be subject to disclosure by the recipient and is no longer protected by the HIPAA Privacy rule.

_____ _____

Patient Name Patient Date of Birth

_____ _____

Patient Signature or Parent/Guardian Relationship to Patient

_____

Today's Date