COMMONWEALTH DERMATOLOGY

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.

Today's date:_____

PATIENT INFORMATION

Patient's last name: **First:** **Middle:** **Marital status (circle one)**

_____ Single / Mar / Div / Sep / Wid

Street address: **City:** **State** **Zip** **Birth date:** **Age:** **Sex:**

_____ _____ _____ _____ / / ____ ❑ M ❑ F

Employer: **Employer phone#** **Home phone#** **Cell phone#**

_____ ( )_____ ( )_____ ( )_____

Race: _____ **Ethnicity:** ____ **Hispanic** _____**non Hispanic** **Social Security#**

_____

Responsible Party (whoever brings the patient or self): **Birth date:** **Address (if different):** **Home phone no.:**

_____ / / _____ (___)_____

SS# of Resp. party:_____ Employer_____ Work ph#_____

Primary Insurance:_____ **Subscriber:**

_____

Subscriber's address: **Subscriber's SS#:** **Birth date:** **Group#** **Policy no.:** **Co-payment:**

_____ _____ / / ____ _____ $_____

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

Secondary insurance: **Subscriber's name and address:** **Group no.:** **Policy no.:**

_____ _____ _____ _____

Patient's relationship to subscriber: ❑ Self ❑Spouse ❑ Child ❑Other Subscriber's DOB:

IN CASE OF EMERGENCY

Name of local friend or relative: **Phone#** **relation:** **Alt phone no.:**

_____ _____ _____ _____

Primary Care Physician: _____

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.

Acknowledgement of Receipt of Notice of Privacy Practices:

I have been Notified that a copy of the Notice of Privacy Practices is available to me upon my request for the above named practice.

_____ _____

Patient/Guardian Signature ***Date***

Updated 02/07/2017

Commonwealth Dermatology, PC

TREATMENT AND PAYMENT POLICIES

Please review and sign the following statement of our Treatment and Payment Policies prior to receiving treatment. For purposes of this document, the terms "you" and "your" shall mean the Patient or the Patient's Guardian. The patient's Guardian is a parent or individual who accepts financial responsibility for services rendered to the Patient and is legally authorized to consent and take action on the Patient's behalf.

Treatment Policy: You understand and consent to the following:

- You have the right to consent, or to refuse 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 extenders of Commonwealth Dermatology, P.C. and its clinical and technical employees may administer any treatment or perform any procedures deemed advisable during your care and treatment;
- Commonwealth Dermatology, P.C. 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 assurances or guarantees have been made as to the results of examination or treatment; and
- The Code of Virginia (32.1-45.1) authorizes health care providers to test patients for HIV (Human Immune Deficiency Virus), 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.

Payment Policy: You understand and agree to the following:

- By signing this document, you agree to assign to Commonwealth Dermatology, P.C. any and all health care benefits to which you are entitled under any policy of insurance and authorize, to the extent permitted by law, payment of those benefits directly to Commonwealth Dermatology, P.C.;
- Appointment cancellations are required in advance of scheduled appointments; you will be responsible for a $50 cancellation fee if you do not contact our office 24 hours prior to your scheduled appointment to make changes.
- You are required to pay, and agree to pay, at the time of service any required co-payment, co-insurance and deductibles, as well as charges for non-covered services; and you will pay all fees and charges for the provided services and are financially responsible for cost of care that your insurance company determines is not covered under your insurance policy and for which you may be held liable under applicable law; non-covered services include services provided in the absence of a referral for patients whose insurance policies require referrals and services provided to patients with insurance in which the practice does not participate, when such insurance involves a limited network; patients are responsible for obtaining their referrals in advance of scheduled appointments;
- Commonwealth Dermatology, P.C. may release, by facsimile or otherwise, any medical or incidental information to any requesting insurance company, third party vendor associated with obtaining prior authorizations, federal agency and other physicians as necessary; and
- The information given to Commonwealth Dermatology, P.C. is complete and correct to the best of your knowledge.

I, the undersigned, have read, understand and agree to the policies described above, and understand that Commonwealth Dermatology, P.C. will render medical services in consideration of and reliance on my authority to agree and my agreement to the above terms. I further understand and agree that a photocopy or facsimile of this agreement shall be as valid as the original and that any attempted modification of the above terms shall be void and without effect.

Print Patient's Name	Patient's Signature	Date	Witness
Print Guardian's Name (If patient is a minor or dependent)	Guardian's Signature	Date	Witness

Updated 3/28/2017

Authorization for Release of Information

Communication Release

Patient: Last Name: _____ First:_____ Date of Birth: _____/_____/_____

Commonwealth Dermatology is authorized to release protected health information about the above named patient in the following manner and to the identified persons named:

Permission to Leave Information:

☐ Voicemail: ph: (_____) _____-_____ ☐ Results of Lab tests/xrays/ biopsies ☐Other:_____

3rd Party: Who Can We Communicate with:

Name: _____ **PH:** _____ ☐ **Financial** ☐ **Medical** ☐ **Can Pick up Items**

Name: _____ **PH:** _____ ☐ **Financial** ☐ **Medical** ☐ **Can Pick up Items**

Name: _____ **PH:** _____ ☐ **Financial** ☐ **Medical** ☐ **Can Pick up Items**

Text/Email Communication:

For text or email communication to occur accept the disclosure below:

☐ **For email and or Text Communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to receive email and/or text communication if selected.

Text Communication: PH: (_____) _____-_____ ☐Appointment Reminder

Email Communication: _____ ☐Appointment Reminder

Photos:

☐Photos of patient received by patient or legal guardian: We can receive and upload photos of patient that you send to us into the patient's medical record.

☐Photo taken by staff: We may want to photo document a spot or rash as a part of the patient's medical record.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy 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 redisclosure by the recipient and may no longer be protected by federal or state law.
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will remain in effect until revoked by the patient.

_____

Signature of Patient or Personal Representative Date

*Description of Personal Representative's Authority (attach necessary documentation)

_____ Updated 3/28/2017