

# Medicare Patient Registration

Name: \_\_\_\_\_  Female  Male  
*First Middle Last*

Date of Birth: \_\_\_\_\_ Social Security # \_\_\_\_\_  
*Month / Day / Year*

Address: \_\_\_\_\_  
*Street # Street Name Apt#*  
\_\_\_\_\_  
*City State Zip*

Home Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

## Emergency Contact

Name of Spouse or Close Relative or Friend \_\_\_\_\_  
Phone (\_\_\_\_) \_\_\_\_\_

## PRIMARY INSURANCE

Policy Name \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
DOB \_\_\_\_\_ Relation \_\_\_\_\_

## SECONDARY/SUPPLEMENTAL INSURANCE

Policy Name \_\_\_\_\_  
Insured's Name \_\_\_\_\_  
DOB \_\_\_\_\_ Relation \_\_\_\_\_

**Please present your insurance card(s) and your photo identification to the receptionist. The receptionist will make a copy and return them to you promptly.**

**Answer questions below by placing a check in the appropriate column:**

YES NO

- |                          |                          |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Are you in a Medicare HMO other Senior Medicare Plan?<br>If yes, Identify: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you recently joined a Medicare Advantage Plan?<br>If yes, identify: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work in a company which has more than 20 employees<br>and have coverage through the insurance at that job? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by a commercial HMO/PPO which makes Medicare secondary?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness covered by the VA (Veteran's Administration)?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness covered by the Federal Black Lung or End Stage Renal Disease<br>Program?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness due to an automobile accident?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness due to an injury at work?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you receiving Medicaid?  |

**Please turn over your authorization is needed to file claims on your behalf**

## Payment Policy

**Medicare:** We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$155.00 deductible and paying for the 20% copayment. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.

### **Medicare Authorization:**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

*I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature as it appears on Medicare card Date

### **Supplement Insurance or Medicare Advantage**

If you have a supplemental policy and it is a supplemental policy to which your Medicare carrier automatically "crosses over" or a **Medicare Advantage Plan** we are required to keep a separate signature on file:

*I request authorized supplemental benefits and/or **Medicare Advantage Plan** be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related services.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature as it appears on insurance card Date

### **Commercial Insurance Primary to Medicare:**

If you have a commercial insurance policy that is primary to Medicare, we are required to have your signature on file authorizing us to file claims for you and to release information to that payor if they require it for proper consideration of a claim.

*I request authorized benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above primary carrier any information needed to determine these benefits or the benefits payable for related services.*

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Signature as it appears on insurance card Date

## Office Policies

**APPOINTMENTS:** Patients are seen by appointment. For urgent and acute situations we often schedule “work-in” appointments. Work in appointments are made to address one acute problem only so that patients with scheduled appointments are not kept waiting. Except in emergencies, patients with scheduled appointments will be seen before “work-in” patients.

We work very hard to keep our appointment schedule. However, because we see emergencies in the office there will inevitably be delays. We apologize in advance.

We will call to confirm most appointments two days in advance. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment. **We charge \$25.00 for missed appointments.**

**SOCIAL SECURITY NUMBERS:** We handle patient’s social security numbers and personal information in a confidential manner but we may release personal and medical information to another doctor’s office in the event of a referral. We use social security numbers for insurance and billing purposes at Atlantic Dermatology Associates. This required information we ask from each of our patients.

**INSURANCE:** Insurance is a contract between you and your insurance company. We are actually not involved in that contract, therefore, we cannot become involved in disputes between you and your insurance company regarding deductibles, co-payments, labs, or other charges. Currently we file claims for BCBS plans that can be filed through NC, United Health Care, Medcost, Cigna, NCTA, and Aenta. For all other insurance, we will provide you with the required information so you can file your claim with your insurance company. If we are non-participating with your insurance plan, then you will be responsible for payment at the time the services are provided. If you have an insurance that has a co-payment, our office policy is to collect this before services are rendered. Also, if there is any change in your insurance carrier, it is your responsibility to inform us prior to your appointment.

You must have a current insurance card for us to file your insurance. If you do not have your card at the time of your appointment, you will be expected to pay in full if you wish to be seen, or your appointment can be rescheduled.

At Atlantic Dermatology Associates, P.A. we have opted out of Medicare, Champus, and Tricare which means we do not file them and you are unable to file to them for services received here. Patients who have Medicare, Champus, and Tricare as their primary insurance will not be reimbursed by them or other insurance. If at any point you receive Medicare, Champus, or Tricare we will still be glad to help you through your dermatology problems but please notify us, as these insurances request that a special form be filled out.

**MINORS:** All children under the age of 18 must be accompanied by a parent or guardian. If the parent or guardian is not present, the appointment will be rescheduled. Please do not leave children unattended in the waiting area.

**PAYMENT:** Payment is due from each patient at the time of service. We accept cash, check, VISA, and MasterCard. We do not bill parents or guardians not present in the office at the time of their appointment. Patients with co-pays, deductibles, percentages, etc are expected to pay at the time of their appointment. Simply put, payment of any portion of your bill that you are responsible for “out of pocket” is expected at the time of your appointment. There will be a \$35.00 service fee on all returned checks.

**PHONE CALLS:** You may need to contact the office with questions. Most call may not be returned for up to several hours. Please provide a return phone number that can be reached for several hours, or provide additional phone numbers. In an emergency dial 911 first.

**AFTER HOUR PROBLEMS:** We are on call 24 hours a day, available only for urgent issues that cannot wait for the office to open the next business day. To contact us, please call the office number.

**ACKNOWLEDGEMENT:** I have read, understand, and agree to follow the above office policies.

Patient/Guardian signature \_\_\_\_\_ Date \_\_\_\_\_

Printed name of patient \_\_\_\_\_

Printed name of guardian and  
relationship to patient if applicable \_\_\_\_\_

# Medical History

Today's Date \_\_\_\_\_

Patient: \_\_\_\_\_ Date of Birth: \_\_\_/\_\_\_/\_\_\_ Age \_\_\_\_\_

How were you referred to Atlantic Dermatology Associates, P.A.? \_\_\_\_\_

Who is your Family Physician? \_\_\_\_\_

Referring physician & possibly your other physicians will be updated of your care unless you circle: Do Not Update

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

- 1. \_\_\_\_\_ 3. \_\_\_\_\_ 5. \_\_\_\_\_
- 2. \_\_\_\_\_ 4. \_\_\_\_\_ 6. \_\_\_\_\_

Are you allergic to any medications?  YES  NO If YES, please list below:

### Past Medical History: (Please check YES or NO)

	YES	NO		YES	NO
Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/GI problems	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Eye Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Allergies (seasonal or food)	<input type="checkbox"/>	<input type="checkbox"/>	Ear, Nose, Throat Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disorders	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy/Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Infectious Diseases	<input type="checkbox"/>	<input type="checkbox"/>
Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>
Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	Surgeries	<input type="checkbox"/>	<input type="checkbox"/>
			Other	<input type="checkbox"/>	<input type="checkbox"/>

If yes to any of the above, please explain: \_\_\_\_\_

\_\_\_\_\_

**Skin: Have you ever had skin cancer?**  YES  NO If yes, \_\_\_\_\_

Do you have a history of any specific skin diseases?  YES  NO If yes, \_\_\_\_\_

Any family history of specific skin diseases?  YES  NO If yes, \_\_\_\_\_

Has anyone in your family had melanoma?  YES  NO

Do you have problems with healing such as keloids?  YES  NO

Do you develop skin rashes in reaction to:  Medications  Food  Environment  Bandages  Neosporin  Other \_\_\_\_\_

### Are you currently experiencing any of the following symptoms? (Check only if yes)

Fever /Chills  Change in Weight  Cough  Headaches  Blurry Vision  Heart Palpitations

Joint Pain  Nausea/Vomiting  Diarrhea  Mood Swings  Night Sweats

\*\*If yes to any of these symptoms, please follow up with your primary care provider as we only treat dermatological conditions.

### Social History:

Do you drink alcohol?  YES  NO If YES \_\_\_\_\_ drinks per day

Do you use illegal drugs?  YES  NO If YES, what? \_\_\_\_\_ How often? \_\_\_\_\_

Do you smoke?  YES  NO If YES, how much: \_\_\_\_\_

**Are you interested in Cosmetic or Esthetic Services?**  Yes  No

If yes, please complete the reverse side of this form.

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Patient Signature Date

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Physician/Nurse Date

Pharmacy of Choice: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE: \_\_\_\_\_

## COSMETIC SKIN CARE SERVICES

*Dear Patient:*

*New technologies have expanded the range of products and procedures available to enhance the appearance of your skin. To help us provide you with the services you desire and the best treatment possible, we would like you to answer a few questions regarding your skin, hair and nail needs. So please take a few minutes to give us this important information.*

*Thank You,*

The following is a list of the various cosmetic services we provide to our patients. Please indicate the procedures in which you may be interested, or for which you would like more information from the doctor or our nurses.

- "AGE SPOT" REMOVAL
- BOTOX THERAPY-for crows feet and forehead lines
- COSMETIC MAKEOVER/COSMETIC PRODUCTS/SUNSCREENS
- FACIAL PEELS-for lines and spots
- INDIVIDUALIZED TOTAL SKIN CARE REGIMENS
- LASER HAIR REMOVAL
- LASER REMOVAL OF FACIAL VEINS, SUN OR AGE SPOTS
- MICRODERMABRASION-for smoothing facial lines and evening skin color
- ALPHA HYDROXY ACID PRODUCTS-topical therapy anti-aging/wrinkles
- SCLEROTHERAPY-leg "spider" vein removal
- TATTOO REMOVAL
- THERAPY FOR BRUISED SKIN/DARK EYE CIRCLES
- JUVEDERM AND RESTYLANE FILLERS-for nasal folds and lip and mouth lines

ADDITIONAL COMMENTS:

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