Patient Registration Form

Please bring insurance card and photo ID to your appointment

Patient Name_____ **Date of Birth**_____ **Today's Date**_____

Address_____ **City**_____ **State**_____ **Zip**_____

Home Phone_____ **Cell #**_____ **Work #** _____

Circle your contact preference: Home phone Cell phone Work phone Email
Email_____ **I do not have email** _____
May we send you an email appointment reminder? Yes_____ **No** _____

How were you referred to our practice?

- ☐ **PCP? Please indicate your PCP's name:** _____
- ☐ **Other MD? Please indicate name and reason:** _____
- ☐ **Friend?** _____
- ☐ **Web site?** _____
- ☐ **Advertisement?**_____

Please give us the following information to facilitate our communication with your Primary Care:
Primary Care Name (first/last)_____ **City**_____ **Did your doctor give you an insurance referral for our office Yes No** _____

Primary Insurance_____ **Policy #**_____ **Group** _____

Secondary Insurance_____ **Policy #**_____ **Group** _____

Policy Holder Name_____ **Policy Holder DOB**_____ **Relationship**_____

Race: White_____ **African American**_____ **American Indian**_____ **Asian**_____

Hispanic/Latino_____ **Non Hispanic/Latino**_____ **refused to answer**_____

I have been able to review the Krauss Dermatology Notice of Privacy Practices (available in our office or on our website). This notice provides information about how Krauss Dermatology may use and disclose my protected health information, what its legal duties are regarding my protected health information, and what my rights are regarding my protected health information, and how I can file a complaint about these privacy practices. I understand that if I have additional concerns, I may ask the HIPAA compliance officer at Krauss Dermatology for clarification.

Yes_____ **No**_____ **Signature**_____ **Date** _____

KRAUSS DERMATOLOGY

Financial Policy

We are committed to providing the highest quality of care to our patients. The following is a statement of our financial policy, which we require you to read and sign. All copayments, co-insurance, and deductibles are due at the time of your visit. We accept Cash, Checks, Visa, American Express and Mastercard, FSA and HAS cards.

FINANCIAL RESPONSIBILITY – REFERRAL REQUIREMENTS: It is your responsibility if your insurance requires one to obtain a referral from your Primary Care Physician (PCP) for all specialty services. If a referral is not in place for your visit you will be responsible for all services provided. By signing below, you acknowledge receipt of our financial policy and will be held financially responsible for any denied services by your insurance. **Initial: ____**

INSURANCE: As a courtesy to you, we will bill your insurance company for your visit and services; however, we do not share in the contract between you and your insurance company. You should be familiar with your own insurance terms/ contract/coverage. Please be advised that it is your responsibility to verify what your insurance will cover and what it will not (co-payments, deductibles, co-insurance, and lab contracts). **Initial: ____**

COLLECTIONS: Payment is due at the time services are rendered. Should your account become delinquent, the patient/ guarantor assumes all costs of collection. While we utilize a collection agency as a very last resort, we hope never to resort to this action. **Initial: ____**

NON-COVERED SERVICES: Cosmetic services are not covered by insurance. Your payment is due at the time services are rendered. Some medical services are also not covered by insurance (treatment of benign lesions for cosmetic reasons for example). It is your responsibility to understand whether any services will be covered. Cosmetic consultation fees are due at the time of visit but may be applied to any cosmetic service provided. **Initial: ____**

PATHOLOGY/LAB SERVICES: Based on what is done during your appointment, you may receive an additional bill from the lab service provider. We are unable to adjust these charges as they are provided by a separate entity. **Initial: ____**

CANCELLATIONS/ NO SHOWS: The physicians at Krauss Dermatology take the time necessary to treat their patients with the utmost courtesy and respect and make it a priority to tend to all needs. As such, we do not overbook MD's schedules as some physicians might do. Your appointment time is blocked for you. Therefore, a no-show fee of $50 dollars will be charged if an appointment is not cancelled/rescheduled at least 24 hours before your appointment time. Please also note that a deposit will be required for certain procedures requiring extra time, product or staff and your appointment cannot be booked without it for such procedures. **Initial: ____**

I HAVE READ AND FULLY UNDERSTAND THE FINANCIAL POLICY. I HEREBY AGREE TO RENDER PAYMENT IN ACCORDANCE WITH THE TERMS AND CONDITIONS SET FORTH ABOVE.

Patient/ Responsible

Party Signature: _____ Printed Name: _____ Date: _____

Madeline Krauss, M.D. ● Pamela Norden M.D. ●Ellen Lacomis M.D.
Michael Bosworth, M.D. ● Deborah Goddard, M.D. ● Jessica Suzanne Mosher M.D.
1 Washington Street, Suite 401 Wellesley Hills Ma 02481

Patient Name: _____ Date of Birth: _

Please read and darken the circles for the appropriate response regarding your medical history.

Female Patients Only

Currently Pregnant	O Yes	O No
Currently Breastfeeding	O Yes	O No

General

Allergies to Medication	O Yes	O No
Problems with anesthesia	O Yes	O No
History of Cancer	O Yes	O No

Constitutional

Recent fever or chills	O Yes	O No

Eyes

Vision Problems	O Yes	O No

Neurological

Frequent or Severe Headaches	O Yes	O No
Numb/Tingling Hands or Feet	O Yes	O No

Endocrine

Diabetes	O Yes	O No
Always Tired/Sluggish	O Yes	O No

Gastrointestinal: Recent or Frequent

Abdominal Pain	O Yes	O No
Nausea/Vomiting	O Yes	O No
Indigestion/Heartburn	O Yes	O No

Cardiovascular

Pacemaker	O Yes	O No
Chest Pain	O Yes	O No
Varicose Veins	O Yes	O No
High Blood Pressure	O Yes	O No
Heart Valve Problem	O Yes	O No

Musculoskeletal

Joint Replacement	O Yes	O No
Joint Pain/ Arthritis	O Yes	O No

Ear/Nose/Throat: Recent or frequent

Ear Infection	O Yes	O No
Sinus Problems	O Yes	O No
Eye Pain/Discomfort	O Yes	O No
Wheezing/ Asthma	O Yes	O No
Frequent Cough	O Yes	O No
Hay Fever	O Yes	O No

Hematologic/ Lymphatic

Bleeding Problems	O Yes	O No
Blood Clot or Stroke	O Yes	O No

Psychologic

Anxiety Disorder	O Yes	O No
Mood Swings	O Yes	O No
Depression	O Yes	O No

Have you or a family member ever had the following?

Melanoma	O Yes	O No	Family Member/self? _____
Other Skin Cancer	O Yes	O No	Family Member/self? _____
Psoriasis	O Yes	O No	Family Member/self? _____
Eczema/Dermatitis	O Yes	O No	Family Member/self? _____
Moderate or severe Acne	O Yes	O No	Family Member/self? _____

Darken the circle if the answer is yes:

O Smoke

O Drink alcohol more than 4 drinks per week?

O Currently work? Occupation_____

O Live Alone?

O Wear sunscreen Regularly?

O Tan Regularly (tanning booth or outdoors)?

Why we ask: In dermatology, many conditions may be related to work exposures such as chemicals or intense sun. Also, recuperation from some medical or cosmetic procedures may interfere with work related tasks or public appearances. In addition, patients who live alone may need to have skin exams more frequently if we are following lesions on the back, or may need assistance with dressing changes after a procedure.

Patient Name: _____ Date of Birth:_____

Please list any prescription medication you are regularly taking:

_____ _____

_____ _____

_____ _____

Please list any nonprescription medication you are regularly taking:

_____ _____

_____ _____

Please list any medication allergies (with type, such as hives, stomach upset) environmental or skin allergies:

_____ _____

_____ _____

Please describe any medical problems you checked “yes” to on the prior medical history sheet, or any other medical issues you have that were not listed:

_____ _____

_____ _____

_____ _____

_____ _____

Please list prior surgeries with approximate date of procedure:

_____ Date_____

_____ Date_____

_____ Date_____

Pharmacy Name_____**Address** _____

Phone #_____**Fax #** _____

We appreciate your time and effort in completing these forms. The information will help us treat you safely and effectively

Patient Authorization for Practice to Share Protected Health Information

For our patients over the age of 18 we are unable to discuss or disclose appointment and treatment information including all prescription and prescription refills. If there are individuals with whom you would like us to be able to discuss this information, please fill out this form

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment, and health care operations, or for other purposes permitted by law. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA).

Patient name:_____ Date of Birth:_____

Specific description of the information to be used or disclosed:

- ☐ All medical information including, results such as biopsy and blood tests, treatments, and general visit information
- ☐ Specific information only: _____

Individuals who may receive and use the disclosed information:

Name and relationship: _____

Name and relationship: _____

Expiration date of this authorization:

- ☐ No expiration
- ☐ Until date specified: _____

The above mentioned Protected Health Information may be subject to re-disclosure by the party receiving the information and may no longer be protected by the privacy rules.

By signing this form, you authorize the Practice to use and disclose Protected Health Information about you for the reasons mentioned above. You have the right to revoke this authorization at any time, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior authorization. Submit your revocation to the Privacy Officer of the Practice.

Signature of patient or representative:_____ Date_____

This authorization was signed by:_____ Date_____

Printed Name – Patient or Representative

Relationship to Patient (if other than patient): _____

Practice Representative/Witness: _____