Insurance Copay $ ___________

Self-pay Patient ___________

New Patient Registration Form (please print)

Name: ____ DOB __________________ Sex: __M __F

Social Sec # __________________________ Marital status: Single___ Married___ Divorced ___Widowed ___

Primary address ____

City _______________________________________ State ______________ Zip __________________

Home phone _____________________________________Work phone __________________________

Cell phone ___________________________ Height _______________ Weight ___________________

Emergency contact _____________________ Relationship ________________ Phone _______________

E-mail ____ Authorize E-mail? ___Y ___N

Pharmacy name _____________________________ Phone ______________ Fax _______________

Employment status: ___employed ___not employed ___retired ___student

Employer: _____________________________________ Occupation ____________________________

Patient Phone Message Consent

It is our policy to notify you of test results ordered by this office and to call you to confirm appointments. This is to acknowledge that you authorize us to:

- Leave a detailed message on voice mail/machine/cell YES _________ NO ________ (initial yes or no)
- Leave a detailed message with individual answering the phone YES _________ NO ________ (initial yes or no)

Sharing of Medical Information

I give the physician and office staff of COASTAL DERMATOLOGY INSTITUTE permission to discuss my medical condition with the following individuals:

Name:____ Relationship:_______________________

Name:____ Relationship:_______________________

Doctor Information

Referring Physician ___________________________________ Specialty _______________________

Primary Care Physician ________________________________ Phone __________________________

Primary Insurance

Insurance name ___________________________________ Subscriber's name ______________________

Insurance ID#:____

Social Sec # _______________________ DOB _____________ Relationship to insured ________________

Secondary Insurance

Insurance name ___________________________________ Subscriber's name ______________________

Insurance ID#:____

Social Sec # _______________________ DOB _____________ Relationship to insured ________________

Patient Authorization for ePRESCRIBE

ePrescribing is a physician's ability to electronically send an accurate, error free, and understandable prescription directly to a pharmacy from the practice. ePrescribing greatly reduces medication errors and enhances patient safety. Understanding all of the above, I hereby authorize the physician and/or staff of COASTAL DERMATOLOGY INSTITUTE to enroll me in the ePrescribe Program.

Patient signature ____ Date ____________________________

Patient Authorization for PHARMACY BENEFITS MANAGER

I authorize the physician and/or staff of COASTAL DERMATOLOGY INSTITUTE to request and obtain my prescription medication history from other healthcare providers, the pharmacy benefit manager and/or any third-party pharmacy payors for treatment purposes.

Patient signature ____ Date ____________________________

Patient Authorization for PPO and HMO PATIENTS

I authorize the physician and/or staff of COASTAL DERMATOLOGY INSTITUTE to release to my insurance company or its representative any information including the diagnosis and records of any treatment or examination rendered to me during medical or surgical care. I authorize and request my above-named insurance company to pay directly to COASTAL DERMATOLOGY INSTITUTE the amount due for medical or surgical services. I understand that I am financially responsible for any services deemed non-covered by my insurance company.

Patient signature ____ Date ____________________________

Patient Authorization for ALL PATIENTS

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances. Any appointment which is not canceled 24 hours in advance and is missed will be considered a “no show” and will be subject to $25 fee for a regular dermatology visit, $100 for a surgical visit and $200 for a Mohs visit. Please be aware if a biopsy is required at your visit, you will receive a separate pathology bill for this service. I understand that I am financially responsible for services in the office and that refunds from services charged on a credit card will be returned to the same credit card. Furthermore, I also understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency, I understand that I will be financially responsible for any and all cost and fees relating to the collection of my debt. I also authorize my physician and COASTAL DERMATOLOGY INSTITUTE to photograph me for medically related documentation purposes.

Patient signature ____ Date ____________________________

Special Accommodations

If a patient requires an accommodation for their appointment, the individual or his/her representative must notify COASTAL DERMATOLOGY INSTITUTE of the needed accommodation one week prior to the first new patient appointment. Subsequent appointments also require one week’s notice. Under the American with Disabilities Act, “Providers are responsible for incurring all costs of providing reasonable aid and cannot pass that charge onto the patient or to his/her insurance company.” If a patient who has requested accommodations does not provide a minimum of 24 hours’ notice to cancel the appointment or does not show to the scheduled appointment, all charges incurred by COASTAL DERMATOLOGY INSTITUTE is the patient’s responsibilities.

Patient signature ____ Date ____________________________

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES

Notice to patients: We are required to provide you with a copy of our Notice of Privacy Practices which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the notice. You may refuse to sign the acknowledgement, if you wish*. **I acknowledge that I have received a copy of the COASTAL DERMATOLOGY INSTITUTE’S Notice of Privacy Practices.***

____________________________ ____ _____________________

Printed name Signature Date signed

PERSONAL MEDICAL HISTORY

NAME: ____ **DATE**: _________________________

PERFERRED PHARMACY: ____

REASON FOR TODAYS VISIT: ____

____

CURRENT MEDICATIONS:

__________________________ __________________________ __________________________

__________________________ __________________________ __________________________

If you brought a list of your medications, please provide that when checking in at the front desk – skip this section.

Please list any Allergies: ☐ **No drug allergies**

Medical/Allergy	Reaction

Tobacco Use: Never Current Previous (Years: _____________ to _____________)

Alcohol Use: Never Socially Daily

Pregnancy Status: Currently Pregnant Planning Nursing

Pacemaker: No Yes **Defibrillator:** No Yes

Family History:

Relative	Condition	Currently Living?	Age if deceased

NAME: ______________________________________ **DOB:** ____________________

CIRCLE ALL THAT APPLY: ☐ **None**

cancer kidney disease/dialysis thyroid disorder cataracts diabetes

organ transplant arthritis lupus glaucoma dementia

joint/valve replacement hearing loss multiple sclerosis tuberculosis PCOS

Crohn's disease heart disease gout stroke hypertension

Hepatitis B Hepatitis C HIV Tuberculosis asthma/allergies

depression/anxiety fibromyalgia liver disease

PRIOR SURGERIES:

Surgery/Hospitalization	Date	Notes

Personal Dermographic History: **Circle all that apply** ☐ **None**

actinic keratoses atypical moles acne eczema psoriasis rosacea

cold sores shingles cutaneous lymphoma seborrheic dermatitis

Other: ____

Have you ever been seen by a dermatologist? No Yes
If yes, date of last visit and name/location: ____

History of Melanoma? No Yes
If yes, date / body location: ____

History of basal cell, squamous cell, or other skin cancer? No Yes
If yes, date/body location: ____

Skin Cancer Assessment **Circle all that apply** ☐ **None**

Exposure:
history of sunburn outdoor work walk/run/bike motorcycle/convertible

golf tennis fishing/boating yard work pool beach tanning bed- past/current use

Do you wear sunscreen?
Never Rarely Usually Always Face only Protective clothing /hat

Family History: **Circle all that apply** ☐ **None**
melanoma psoriasis eczema autoimmune disease other: ____________________

Name: ____ DOB: _______________________

Preferred Contact Method

At COASTAL DERMATOLOGY INSTITUTE, we have the ability to send notifications regarding appointment reminders. using the Electronic Health Record services. These include Email, phone, and text messages (message and data rates may apply).

Please choose which contact methods you prefer (you may select more than one):

Email: ☐

Phone: ☐

Text Message: ☐

Patient Name *(Print)*____

Signature____

Date_____________________________

Patient Portal Access

COASTAL DERMATOLOGY INSTITUTE has the option of accessing your information in a safe, secure way through the web-based Patient Portal. You can access your health information including any educational documents that were discussed during your visit with our provider(s).

You have the choice to opt-in for access to your Patient Portal by providing your e-mail address and signing below. If you choose to access the Patient Portal, a confirmation will be sent to the provided e-mail address with instructions how to sign up / log in. You can request access at any time in the future.

☐ Yes, I wish to sign up for access to my patient portal.

Email Address: ____

☐ No, I DO NOT wish to have access to the patient portal.

Patient Name *(Print)*____

Signature ____

Date _____________________________

HIPAA CONSENT

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Practice reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Consent

This Consent was signed by:

______________________________ ______________________________

Patient Name (PRINT) Patient or Legal Guardian Signature

___________________________________ __________________

Relationship to Patient (if other than patient) Date

CARD ON FILE CONSENT FORM

For your convenience, we have implemented a policy which enables you to maintain your credit/debit card information on file with us. With your consent, this information will be securely held to cover future charges and additional fees. There is a 2% fee for using credit card payments. There is no charge for debit cards, cash or check.

Signing this consent in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

I hereby authorize Coastal Dermatology Institute, LLC to keep my Card information on file for payment of any and all charges for medical services for which I am financially responsible and that remain unpaid after two (2) statements have been mailed.

I understand that you will send me a receipt reflecting any amount charged to my Card.

If my card information changes for any reason, I will notify you. This consent shall remain in effect until I give you written notification of termination.

Agreed to:

Print Name ______________________________ DOB: ___________________

Signature ______________________________

O VISA O MASTERCARD Credit Card #: ____________________________________
We currently do not accept American Express

Name as if appears on the card: ____

Expiration Date (MM/YY) ____________ / ____________ Security Code: _______________

Mailing address for this card: ____

Office Notice: Bottom section of this form is not to be scanned into patients chart. Credit card information is to be shredded immediately after encryption into database.