

# Rockingham Dermatology, PC

## REGISTRATION

### PATIENT INFORMATION

<input type="checkbox"/> Mr <input type="checkbox"/> Miss <input type="checkbox"/> Mrs <input type="checkbox"/> Ms      Patient Name: _____		<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address: _____		City: _____	State: _____
Social Security No: _____	Date of Birth: _____	Home Number: _____	<input type="checkbox"/> List all numbers <input type="checkbox"/> check box for preferred <input type="checkbox"/> contact number
Cell: _____		Work: _____	

May we leave test results or prescription information on your voicemail?  YES  NO

**Patient Portal:** Allows you to view Allergies, Medications and Test Results. If you would like access please list your email address.

Email: \_\_\_\_\_

Primary Care Physician & Location: _____		Who referred you to our office: _____	
Race: <input type="checkbox"/> Caucasian/White <input type="checkbox"/> African American/Black <input type="checkbox"/> Hispanic <input type="checkbox"/> Russian <input type="checkbox"/> Other _____		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Other _____  Language: _____	
Employer: _____		Occupation: _____	
Retired: _____		If Student, Name of School: _____	

### RESPONSIBLE PARTY/BILLING INFORMATION

Name of person responsible for bill:  Self (If self, skip this section)  Spouse  Parent / Guardian

Billing Address (if different): _____		Date of Birth: _____
Home Number: _____	Cell: _____	Work: _____

### INSURANCE INFORMATION

Primary Insurance Company: _____		Policy / ID #: _____
Name of Policy Holder/Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent		Insured Date of Birth: _____
Secondary Insurance Company: _____		Policy / ID #: _____
Name of Policy Holder/Insured: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Parent		Insured Date of Birth: _____

### RELEASE OF INFORMATION

With whom may we discuss your medical / financial information: (Spouse, parent, etc.) \_\_\_\_\_

Name: _____	Phone #: _____
Name: _____	Phone #: _____

### CONSENT FOR TREATMENT AND FINANCIAL RESPONSIBILITY

I authorize Dr. Miller to provide medical care/treatment and to bill my insurance carrier for services provided. I understand and agree that I am responsible for the balance on my account for services rendered. I authorize the release of information necessary to process my claim and authorize all payments be made directly to Rockingham Dermatology.

**Read and Sign Back Page**

# Rockingham Dermatology, PC

**Dr. Carolyn Miller**

2061 Evelyn Byrd Ave, Ste C

Harrisonburg, VA 22801

Phone: (540) 442-8056 Fax: (540) 442-8022

## Practice Policy / Financial Agreement / Notice of Privacy Practices

We are committed to providing the best possible treatment to our patients. As a courtesy, we will bill your insurance carrier on your behalf or assist you by providing copies of statements and medical documentation required for you to bill the insurance carrier directly. We understand the high cost of health insurance and we strive to help you receive the benefits to which you are entitled. If you have questions, please do not hesitate to ask us. We are here to help you.

### INSURANCE

While we do participate with many plans, it is not possible for our staff to be aware of each plan's specific requirements and cannot guarantee coverage to any individual. Your insurance coverage is a contract between you, your employer and the insurance carrier. We are not a party to that contract. Not all services are covered benefits. Some insurance companies select certain services they will not cover. It is your responsibility to understand and comply with any predetermined benefits or referral requirements.

### PAYMENTS / COLLECTIONS

Payment for copay, account balance, Self-Pay or elective/non-covered procedures will be due at the time of service. We realize financial problems may affect timely payment of your account balance. If such problems arise, please contact our office to discuss payment plan options. All accounts over 60 days past due are turned over to our collection agency. If your account is turned over for collection, you will be responsible for an additional 25% collection service fee.

### NOTICE OF DISCHARGE

Our staff works hard at preventing a patient from being discharged, there may be instances where we have no other choice but to terminate the patient and physician relationship. Reasons for discharge include, but not limited to:

- **Misconduct:** Verbal or physical abuse by patient and/or family member, causing safety concerns for staff and/or other patients. Including improper language, threats of harm, violent behavior or anger will not be tolerated.
- **Noncompliance:** Does not or will not follow the treatment plan, repeatedly cancels appointments or No Shows for scheduled appointments.
- **Nonpayment:** If your account is continuously delinquent or you do not return our calls to discuss payment options. In the event your account is transferred to our collection agency, care may not be received until the balance is paid in full.

### ACKNOWLEDGEMENT STATEMENT

I understand and agree that I am responsible for my account balance for services rendered to me. With my consent, Rockingham Dermatology, may use and disclose my protected health information (PHI) for treatment, payment and healthcare operations (TPO). I received a copy of the Notice of Privacy Practices, explaining how my health information will be handled, and all my questions have been answered.

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Signature of Patient / Legal Representative

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Date

**Thank you for choosing our office for your care!**

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
 Reason for Visit: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

<i>Past Medical History (Check all that apply)</i>					
Condition		Details	Condition		Details
No Past Medical History	<input type="checkbox"/>		High Cholesterol	<input type="checkbox"/>	
AIDS / HIV	<input type="checkbox"/>		Hives	<input type="checkbox"/>	
Alzheimer's	<input type="checkbox"/>		Joint Replacement (Within 2 years)	<input type="checkbox"/>	Year -
Anemia	<input type="checkbox"/>		Numbness	<input type="checkbox"/>	
Anxiety / Depression	<input type="checkbox"/>		Pacemaker / Implanted Electrical Devices (Please list year)	<input type="checkbox"/>	Year -
Asthma	<input type="checkbox"/>		Parkinson's	<input type="checkbox"/>	
Autoimmune Disease: Colitis, Crohn's, Lupus, Reynaud's, Ulcer's, etc.	<input type="checkbox"/>		Polycystic Ovarian Disease / Unwanted Facial Hair Female Only)	<input type="checkbox"/>	Year -
Bleeding Disorder	<input type="checkbox"/>		Psoriasis	<input type="checkbox"/>	
Chemotherapy	<input type="checkbox"/>		Rheumatoid Arthritis	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>		Sarcoidosis	<input type="checkbox"/>	
Freestyle Libre for Diabetes	<input type="checkbox"/>	Glucose Monitoring Sys.	Seizures	<input type="checkbox"/>	
Dialysis	<input type="checkbox"/>		Thyroid Disorder	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>		Tuberculosis	<input type="checkbox"/>	
Heart Conditions - List Type	<input type="checkbox"/>		Other Conditions:	<input type="checkbox"/>	
Hepatitis (A, B, C)	<input type="checkbox"/>				
High Blood Pressure	<input type="checkbox"/>				

\* Female Patients: Are you pregnant? Yes \_\_\_\_ No \_\_\_\_

<i>Past Surgeries</i>		
Date	Surgery	Complications

\*Has a doctor advised that you require an antibiotic prior to a procedure? Yes \_\_\_\_ No \_\_\_\_

<i>Skin Cancer History</i>			
Condition		Previous Treatment	Treating Physician
No Significant History	<input type="checkbox"/>		
Actinic Keratosis	<input type="checkbox"/>		
Basal Cell Carcinoma	<input type="checkbox"/>		
Malignant Melanoma	<input type="checkbox"/>		
Squamous Cell Carcinoma	<input type="checkbox"/>		
Other Lesion	<input type="checkbox"/>		

<b>Family History (Parents, Siblings, Children)</b>			
Condition		Affected Family Member	Type
<b>No Contributing Family History</b>	<input type="checkbox"/>		
Autoimmune Diseases	<input type="checkbox"/>		
Eczema / Hayfever / Psoriasis	<input type="checkbox"/>		
Malignant Melanoma	<input type="checkbox"/>		
Skin Disease	<input type="checkbox"/>		
Thyroid Disease	<input type="checkbox"/>		

<b>Medication Allergies</b>		
Medication	Reaction	Notes

<b>Current Medications</b>

<b>Social History</b>
Do you Smoke? No _____ Yes _____ Former smoker? No _____ Yes _____ Do you use smokeless tobacco? No _____ Yes _____
How many times in the past year have you had 5 drinks (for men) or 4 drinks (for women) or more in a day? Circle your answer: None, 1, 2, 3, or More
Have you had a colonoscopy in the past nine years? No _____ Yes _____
Have you had a mammogram in the past three years? No _____ Yes _____
What pharmacy would you like prescriptions sent to? List pharmacy name and location below: