Liberty Dermatology

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www.libertydermatology.com

Welcome to Liberty Dermatology ….

Attached is our Patient Registration Package. Please complete these forms to help us maintain accurate contact and medical records. We realize that you have a choice of where to be treated. We also understand and respect the great deal of trust in your physician. We want to provide you with the most advanced treatment options in the most caring manner. We do appreciate and value the trust you have placed in us.

The dermatologists at Liberty Dermatology specialize in the diagnosis and treatment of skin, hair and nail disease, skin cancer surgery, as well as cosmetic dermatology. We provide our patients and their families with full-service, comprehensive skin care.

We hope to deliver care in a congenial and happy environment and that you find this experience to be a satisfying one. We value patient feedback and would love it if you communicate with us your experience with the practice. If you have any questions or concerns, please do not hesitate to ask any member of our team.

ITEMS THAT WILL BE REQUESTED

- **Insurance Cards** If you have health insurance, we cannot see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician if required by your insurance plan.
- **Co-pay** or **Deductible** is collected at the time of visit
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Driver's License or State Issued Photo ID**

PATIENT INFORMATION

First: _____**Last:** _____ **MI:** _____

PLEASE FILL THIS OUT AS WE WILL NEED THIS INFORMATION TO FILE TO YOUR INSURANCE

INSURANCE POLICY HOLDER INFORMATION

Primary Insurance Company (Name): _____
Insurance Policy Number:_____Group Number:_____
Name of Policy Holder: _____
Policy Holder SSN: _____/_____/_____Policy Holder **Date of Birth:** _____/_____/____
Policy Holder Address: _____Apt#: _____
City: _____State: _____ Zip Code: _____ Gender: Male / Female
Home Phone: _____ Work Phone: _____
Relationship to the Patient: ❑Self ❑Spouse ❑Parent ❑Other:_____

Secondary Insurance Company (Name): _____
Insurance Policy Number:_____Group Number:_____
Policy Holder is same as above? ❑ Yes ❑ No
Name of Policy Holder: _____
Policy Holder SSN: _____/_____/_____**Policy Holder Date of Birth:** _____/_____/____
Policy Holder Address: _____Apt#: _____
City: _____State: _____ Zip Code: _____ Gender: Male / Female
Home Phone: _____ Work Phone: _____
Relationship to the Patient: ❑Self ❑Spouse ❑Parent ❑Other:_____

Patient (Guardian) :_____ **Date:** _____

Patient Information

First: _____Last: _____ MI: _____
Address: _____Apt#:_____
City: _____State: _____Zip Code: _____ Date of Birth: ____/____/____
Age: _____ Gender: ❑Male ❑Female Social Security Number: _____-_____-_____
Driver's License #: _____
Occupation: _____ Employer: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Other Phone: _____
Are you a FULL-TIME college student? ❑Yes ❑No
Marital Status: ❑ Single ❑Married ❑Other: _____
E-mail: _____

Race: ☐Caucasian ☐Hispanic ☐African American ☐East Asian ☐South Asian Other:_____
Can staff leave a message with lab results and appointments? (Please specify if not both)
Home Phone: ❑ Yes ❑ No: (specific instructions)_____
Cell Phone: ❑ Yes ❑ No (specific instructions)_____
Work Phone: ❑ Yes ❑ No (specific instructions)_____
Other Phone: ❑ Yes ❑ No (specific instructions)_____

Any restrictions on contacting you?: _____
The medical information below shall only be released to the following person(s):
1._____Relationship: _____ Phone number: _____
2._____Relationship: _____ Phone number: _____
❑ All medical information, including but not limited to: appointments, billing, test results, diagnosis, and procedures.
❑ Only the following types of information: _____

Do you consent to mail, fax, or verbally give the results of lab work, pathology results, and medical consultation letter to your primary care physician or any other physician or hospital who requests it?
☐Yes ☐Yes with restrictions below ☐No (If no, we will have to contact you to get verbal or written consent before any information can be released)
Any restrictions?_____
_____

Pharmacy _____ Street _____ City _____

How did you hear about us? ☐ Physician referral ☐ Yellow Pages ☐ Friend/Family
☐ Internet Search ☐ Insurance website ☐ Friend/Family ☐ Other _____

Referring Physician (if any): _____ Phone: _____
Primary Care Physician: _____ Phone: _____

Patient (Guardian) Signature: _____ Date: _____

MEDICAL INFORMATION AND PATIENT HISTORY

Patient Name: _____ **Date:** _____/_____/_____

CC: Reason for visit? _____

HPI: When did this start? _____

What treatments have you had? _____

ROS: Currently itchy? ❑ Yes / ❑ No || Any Fever/Chills currently? ❑ Yes / ❑ No

|| Any Pain currently? ❑ Yes / ❑ No || Short of Breath? ❑ Yes / ❑ || No Other symptoms: _____

Meds: All medications currently taking: _____

_____

Medical History:

❑ Asthma ❑ Acid Reflux ❑ Cancer ❑ Cataracts ❑ High Cholesterol ❑ Diabetes

❑ Glaucoma ❑ Hay Fever ❑ Heart Dz ❑ High Blood Pressure ❑ Kidney Dz ❑Liver Dz

❑ Nail Disorder ❑ Osteoarthritis ❑ Osteoporosis ❑ Rheumatoid arthritis ❑ Seizures

❑ Thyroid Dz ❑ Other: _____

Pregnant? ❑ No ❑ Yes Due Date: _____ **Breast feeding?** ❑ No ❑ Yes

Past Personal History of Skin Cancer? ❑ No Skin Cancer History

❑ Basal Cell Carcinoma Location:_____ When?_____

❑ Squamous Cell Carcinoma Location:_____ When?_____

❑ Melanoma Location:_____ When?_____

Do dentists give you antibiotics before dental procedures?	❑No	❑Yes
Heart valve or heart murmur problem?	❑No	❑Yes
Artificial heart valve?	❑No	❑Yes
Metallic or artificial implants anywhere (ie. spine, skull, knee shoulder, etc?)	❑No	❑Yes
Pacemaker?	❑No	❑Yes
Implantable Cardioverter Defibrillator (AICD)?	❑No	❑Yes
Do you form keloids (really big scars)?	❑No	❑Yes
Problems with immune system?	❑No	❑Yes

Other Medical History: _____

Medication Allergies: ❑ No Known Allergies ||Medication:_____ Reaction: _____

Allergic to anesthetic (lidocaine/procaine)? ❑ No ❑ Yes

Allergic to epinephrine? ❑ No ❑ Yes

Allergic to latex? ❑ No ❑ Yes

Past operations or Scheduled Surgeries: _____

FH: ❑ Family History of Skin Cancer? ❑ No skin cancer ❑BCC ❑SCC ❑Melanoma ❑Unknown Type

SH: Circle one: Smoke: ❑No ❑Yes Drink Alcohol: ❑No ❑Yes If yes, how much?_____

Used a tanning bed in the past year: ❑No ❑Yes Illegal drugs: ❑No ❑ Yes Type:_____

Patient (Guardian) Signature: _____ **Date:** _____

OFFICE POLICY ATTESTATION

I understand that, regardless of my assigned insurance benefits, I am financially responsible for payment of services rendered to me. In addition, I will be financially responsible for my spouse and my child/children that is/are born or treated. I hereby assign the benefits from any insurance or third party to Liberty Dermatology, P.A. and the medical provider for medical services provided to me. I understand that Liberty Dermatology has the right to decline or accept assignment of such benefits. If these benefits are not assigned to Liberty Dermatology, I agree to forward to the practice, upon receipt, any insurance or third-party payments I receive for services rendered to me. I authorize my insurance company, governmental program, or other entity to make payment directly to Liberty Dermatology, PA and Dr. Kien Tran. I consent and allow Liberty Dermatology, PA to disclose health information to third-parties including financial institutions to obtain payment for the health care services provided. If I am injured and receive treatment at Liberty Dermatology, PA I agree to assign to Liberty Dermatology my interest in any lawsuit or settlement to the extent necessary to fully pay Liberty Dermatology, PA for this treatment. I certify that the information given by me in applying for payment under any medical insurance program, including Medicare and Medicaid, is correct. If I am a patient with Medicare for insurance, 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 to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply for patients with Medicare insurance.

If you are a patient who has insurance and whose skin sample was sent to pathology, you might (or might not) receive a bill from the pathology laboratory for the processing and diagnosis of the pathology at the contracted rate with your insurance. Whether you receive a bill or not from the laboratory will depend on your insurance and whatever deductibles or coinsurances you have.

Please ignore this paragraph unless you are a self-pay patient: If you are a self-pay patient and had a biopsy or a surgical procedure where your pathology specimen was sent to a lab, you will receive a bill from the pathology lab separately. The charges for pathology can range depending on what services are performed. You will receive a bill from the pathology lab separately.

To the best of my knowledge, the information filled in this registration packet is complete and correct. I understand that it is my responsibility to inform the facility of any changes to my contact and/or insurance information. I, the undersigned, the patient (or the patient's duly authorized representative) do hereby voluntarily consent to and authorize medical care encompassing all diagnostic and therapeutic treatments considered necessary or advisable in the judgment of the physician, his assistants or designees. I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guarantees have been made to me as to the results of treatment or examinations performed. This registration form has been fully explained to me and I certify that I understand and accept its contents.

Patient (Guardian) Signature: _____ Date: _____

OFFICE POLICY SUMMARY

Co-payments, co-insurance, and deductibles are required for all services at the time they are rendered for patients with insurance. For self-pay patients, payment in full is required at the time of service. Procedures and evaluations, which are excluded from coverage including cosmetic procedures and cosmetic evaluations will also be patient responsibility in its entirety. If we can determine with reasonable certainty that your insurance company is likely to leave a balance for you to pay (ie. apply it to a deductible), payment will be required on the day of service. Standard office policy requires that you must present your drivers' license (or ID), insurance card (if applicable) and a credit/debit card for verifications. If you request an office visit without a referral authorization, your insurance plan may deem this as "out of network" or "non-covered" treatment, and you will be responsible for a larger amount or all of the charges. By signing below, the patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any service deemed to be non-covered or not authorized by the plan. The patient consents to release of protected health information to third parties, insurance companies, financial parties, credit card entities, banks, and financing companies to facilitate payment. For appointments which are missed or cancelled with less than 24 hour notification, there may be a $25.00 missed appointment fee added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

MINORS

Liberty Dermatology, PA requires minors (<18) to be accompanied by their legal guardian. Liberty Dermatology, PA reserves the right to cancel or reschedule the visit if this is not met. On occasion, a legal guardian may sign our "Minor Consent Release Form." If this form is signed, a minor who is an established patient may return for care without a guardian, if allowed by state law; however, the legal guardian takes full responsibility for any decisions the minor makes without the guardian present. The parent/guardian who is accompanying the child to the visit is responsible for any payment due at the time services are rendered and any amount not covered by insurance or other amounts determined by the insurance company to be the patient's responsibility

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PAYMENTS AND PAST DUE AMOUNTS

Payment is due on the date of service. If Liberty Dermatology, PA can determine your estimated deductible and estimated fees, payment for services applied to the deductible may be required on the date of service. Any additional payment not collected during your visit is required on receipt of your 1st bill from Liberty Dermatology, PA. Balances that are outstanding for >30 days will automatically incur a $10 administration fee. Liberty Dermatology, PA reserves the right to turn over to collections any balance outstanding for over 60-90 days. If an account is turned over to a collections agency, an additional administration fee of $25 and applicable interest will be added along with possible fees from the collection agency. Returned checks will result in a $25 service charge. The check amount plus the service charge is to be paid within 10 days of notification. By signing below, the patient agrees and consents that services that are performed that are paid with a credit card, debit card, or financing third-party are not eligible for payment challenges after services are provided. The patient agrees and consents that this non credit card challenge agreement is irrevocable. By signing this form, the patient is irrevocably consenting to allow Liberty Dermatology, PA to use and disclose protected health information to any Credit Card Entity, Bank, or Financing Company when they request such information to process an account and assist with payment. The patient agrees to not challenge such credit, debit, or financing card payments once the services are provided. For such disputes, the practice encourages complete care and follow-up interaction to address any issues that might arise.

I have read the above information and agree to abide by the policies set forth above and I understand that I am responsible for payment of services I receive. I understand that I cannot be seen at Liberty Dermatology, PA if I do not sign this document. This document and all documents signed on this date may supercede any previously signed office policy at Liberty Dermatology, PA.

Patient (Guardian) Signature: _____ **Date:** _____

NOTICE OF PRIVACY PRACTICES

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 or guardian 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.

Acknowledgement for Consent to Use and Disclosure of Protected Health Information (PHI)

By signing below, I acknowledge that Liberty Dermatology, P.A. has made the Notice of Privacy Practices available to me. I authorize release of medical information to my primary care or referring physician, to consultants if needed, and as necessary to process insurance claims, insurance applications and prescriptions.

The patient consents that the Protected Health Information will be used by Liberty Dermatology, P.A. or disclosed to other physicians, hospitals, pathology labs, insurance companies, billing agencies, financial institutions, or pharmacies for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of this office. Under certain circumstances, we may use and disclose medical information for research purposes. However, all information will be de-identified (names, phone numbers, and addresses will be removed) and will not allow for the researchers or anyone else to determine that the information is related to you. The patient should review the Notice of Privacy Practices for a more complete description of how your Protected Health Information (PHI) may be used or disclosed. The patient may request a copy of the Notice at the Front Desk. The patient may request a restriction on the use or disclosure of your Protected Health Information. This office may or may not agree to restrict the use or disclosure of your Protected Health Information. The patient may revoke this consent to the use and disclosure of your Protected Health Information. The patient must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation of consent is received will not be affected. This office reserves the right to modify the privacy practices outlined in the Notice.

By signing below, I acknowledge that I have received the Notice of Privacy Practices.

Patient (Guardian) Signature: _____ **Date:** _____

CONSENT FOR TREATMENT OF MINOR CHILD

I am aware that the practice of medicine and surgery is not an exact science and acknowledge that no guaranties have been made to me as to the result of treatment or examinations performed. I hereby authorize Liberty Dermatology, P.A., Dr. Kien Tran, MD, PhD, and whoever may be employed or assistant in administration, to administer care as is deemed necessary to the child below:

CHILD'S NAME: _____ **DATE OF BIRTH:** _____

I warrant that I am the party responsible for making medical decisions for the child represented in this medical record. I acknowledge that payment is due at the time of service. I assume financial responsibility for any and all healthcare services provided to this patient. I understand that the provider of service will not get involved in matters involving third party personal billing whether result of custody, court order, or personal circumstances. The parent/guardian who is accompanying the child to the visit is responsible for any payment due at the time services are rendered and any amount not covered by insurance other amounts determined by the insurance company to be the patient's or guardian's responsibility and any collection/attorney fees incurred in collecting that balance.

_____

Please check one:

[ ] I also authorize Liberty Dermatology, P.A., Dr. Kien Tran, MD, PhD, and whoever may be employed or assistant in administration, to administer care as is deemed necessary to the child above **in case the child or teenager arrives or drives to the clinic unaccompanied.** I am aware that I am financially responsible for my child in regards to payment for services at the time of treatment and will either leave information for a form of payment with the clinic or the child will carry a form of payment with them if they arrive unaccompanied.

[ ] I do not authorize and do not wish my child to be treated if the child arrives at my clinic for a routine visit (not an emergency) without me present or an authorized representative (below). (If you check this and the child arrives or drives by themselves to the clinic, we will NOT be able to treat them unless it is an emergency.)

_____

MEDICAL RELEASE SPECIAL AUTHORIZATION

I authorize the following name person(s) to authorize (medical) treatment for my child by Liberty Dermatology, PA. and to have access to my child's health information. I understand that I am responsible for services rendered for treatment and payments authorized by my personal representatives. If I choose to terminate the authorization of this form, I understand I must do so in writing. Please list anyone who has the legal authority to bring the child to the clinic:

NAME OF PERSON BRINGING CHILD	RELATIONSHIP	PHONE NUMBER
_____	_____	_____
_____	_____	_____

I have read and agree with the above information:

Signed by: _____ **Date:** _____

Print Name:_____ **Relationship to Child:** _____