Dermatology Consultants Of Short Hills
Dr. Richie Lin, Dr. Rachel Farley Loftus & Dr. Charlotte Vuong
Diplomate, American Board of Dermatology

636 Morris Turnpike, Suite 2H
Short Hills, NJ 07078
Telephone: (973) 232-6245
Facsimile: (973) 232-6247

PATIENT REGISTRATION

Welcome To Our Office!! Please print and answer all questions.

Patient Information (please complete using your name as listed on your insurance card):

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City:_____ State:_____ Zip:_____ Home Phone: _____

Cell Phone: _____ Email Address: _____

Occupation/Employer: _____ Work Phone: _____

Date of birth: _____ SS# _____ Sex: M / F

Marital Status: ☐ Single ☐ Married ☐ Civil Union ☐ Divorced ☐ Widow

Race: ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American
☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Decline to specify

Preferred Language: _____ Ethnicity: ☐ Hispanic or Latino ☐ **Not** Hispanic or Latino

Pharmacy Name: _____ **(*REQUIRED* WE SEND PRESCRIPTIONS ELECTRONICALLY)**

Address: _____City _____Zip Code _____Phone: _____

How did you hear about us? (please check one)
☐ Our Website ☐ Other Website ☐ Internet Search ☐ Friend/Family Member ☐ ZOCDOC
☐ Other Doctor _____ (name)

Referring Physician Information (*INCLUDE FIRST AND LAST NAME*):

Referring Physician: _____ City _____ Zip Code_____ Phone # _____

Primary Care: _____City _____ Zip Code_____ Phone # _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone # _____

Insurance Responsibility (Please fill out with the **insurance policy holder's information**):

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City:_____ State:_____ Zip:_____ Date of birth: _____ Sex: M / F

Cell Phone: _____ Home Phone: _____

Work Phone: _____ Email Address: _____

Patient Release - Must be signed by patient if over 18 or by legal guardian of patient under 18.

I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits of the provider.

I certify that I hereby authorize Dermatology Consultants of Short Hills, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures that require separate consent such as surgery, biopsy, or wart destructions. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

Signature: _____ Today's Date: _____

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PATIENT ACKNOWLEDGEMENTS OF DERMATOLOGY CONSULTANTS OF SHORT HILLS OFFICE POLICIES
PLEASE READ THE FOLLOWING CAREFULLY BEFORE INITIALING

Insurance Information – Copayments and Responsibility

Payment is required for all services at the time they are rendered. **I understand that regardless of insurance enrollment, I am ultimately responsible for all costs of treatment rendered and it is my responsibility to understand my healthcare coverage including copayments, deductibles and coinsurance.** Checks returned for insufficient funds will be charged an additional $50 fee. An administrative fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account is turned over for collections, you agree to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 30% of the debt, and all costs and expenses, including reasonable attorneys' fees, which we incur in such collection efforts. Your signature below signifies your understanding and acceptance of this policy.

Patient / Guardian Initials: _____

Referral Information

If a referral is required by my health insurance plan, **I understand that it is my responsibility to obtain the referral from my Primary Care Provider and assure it is available to be presented at the time of my visit.** I further understand it is my responsibility to keep track of the number of visits I have used on my referral, the expiration date of my referral, and obtain new referrals as needed. I understand that should I fail to have a valid referral for my visits, my insurance company will deny my claim. The office will reschedule my appointment or the cost of the visit will become my responsibility.

Patient / Guardian Initials: _____

Insurance Cards

New patients or those with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. If I am unable to present one, I may pay in full at the time of service and submit a claim to my insurance carrier at my convenience. I understand by signing below that I am responsible for notifying the office of any changes to my insurance/contact information**.**

Patient / Guardian Initials: _____

Cancellation Policy

Should you be unable to keep your appointment, please call the office no less than 24 business hours prior to your appointment to cancel. **Missed appointments will result in a $50.00 fee ($100 for extended procedure appointments).** This fee is not reimbursable by your insurance company. If you are running late, but plan on keeping your appointment, out of courtesy to us and other patients, call the office ASAP. We will do our best to adjust our schedule accordingly.

Patient / Guardian Initials: _____

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits Dermatology Consultants of Short Hills or our staff from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. **If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below.** Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

Name of Individual _____Relationship to Patient _____

Name of Individual _____Relationship to Patient _____

I acknowledge the practice's adherence to the Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 and may request a personal copy at any time.

Signature: _____ Today's Date: _____

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PATIENT MEDICAL HISTORY

Please print and answer all questions.

Patient Information (please complete using your name as listed on your insurance card):

First Name: _____ Middle Initial: _____ Last Name: _____

Date of birth: _____

If you (the patient) is 13 years old or older, please note your smoking status:

☐ Current every day smoker ☐ Current some day smoker ☐ Former smoker ☐ Never smoked

Medical History (please provide a brief list of your past diagnoses or surgeries)**:**

_____

_____

_____

_____

Medications

(please provide a list of all current **1. <u>Medications</u>, 2.<u>Dosage</u>, 3. <u>Frequency</u>** and **4. <u>Route of administration</u>**):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies (please provide a list of all known drug allergies):

_____

Signature: _____ Today's Date: _____