Dermatology Consultants Of Short Hills
Dr. Richie Lin, Dr. Rachel Farley Loftus , Dr. Charlotte Vuong, Dr. Amanda Dunec & Dr. Vitaly Terushkin
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 **legal** name):

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***) ☐ **(check box ONLY if it has NOT changed)**
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*): ☐ **(check box *ONLY* if it has NOT changed)**
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**): ☐ (**check box *ONLY* if it has NOT changed**)

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 legal name):

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)**:**

☐ **(<u>check box ONLY if it has NOT changed</u>)**

____

____

____

____

Prescription Medications please provide a list of all current ☐ **(<u>check box ONLY if it has NOT changed</u>)**

1. Prescription <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): ☐ **(<u>check box ONLY if it has NOT changed</u>)**

____

Signature: ____________________________________ Today's Date: ______________________