BLUEGRASS DERMATOLOGY AND SKIN SURGERY CENTER, PSC

Date: _____ **Registration Patient Information (Please Print)** Chart Number: _____

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

Sex: _____ DOB: _____ / _____ / _____ SSN: _____ (please provide for insurance purposes)

The following are required: Race: _____ Preferred Language: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Home Address: (Primary) _____

City: _____ State: _____ Zip Code: _____

Occupation: _____ Employer: _____

Preferred Contact Method [ ] Phone [ ] Email [ ] Letter [ ] Fax
Email Address: (List only if you wish to be contacted via email) _____

Person to notify in case of an emergency: _____ Phone: _____

How did you hear about our practice? [ ] Referring Physician [ ] Friend [ ] Phone Book [ ] Other_____

Primary Physician: _____ Phone Number: _____

Referring Physician: _____ Phone Number: _____

Bluegrass Dermatology utilizes an automatic electronic system for prescriptions. Please fill in the following info:

Primary Pharmacy Name: _____ Phone Number: _____

Primary Pharmacy Address: _____ City/State: _____ Zip Code: _____

NAME & DOB OF INSURED: (If Different from the Patient) Name: _____ DOB: ____/____/____

Insurance companies require this information for claim processing. SSN: _____

PARENT and/or GUARDIAN (If Patient is under the age of 18) or POA:
****Please note. If you are the patient's POA and are responsible for managing the patient's medical care as well as billing, please fill out this section and sign the registration form.**

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

Relationship to Patient [ ] Parent [ ] Guardian [ ] POA

Home Address: (Primary) _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

DOB: ___/____/____ SSN: _____ Sex: (Circle) FEMALE MALE Employer: _____

I authorize the 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. I also authorize payment of medical benefits to the physician. I understand that I am responsible for any charges deemed not medically necessary by my insurance company or otherwise not covered by my insurance company, including, but not limited to co-pays, deductibles and co-insurance payments.

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan with which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of CASH, CHECK, VISA, MASTERCARD, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing. All balances due that do not get paid within the first 30 days are subject to finances which will accrue interest monthly.

PATIENT Signature (or Parent/Guardian or POA): _____ Date _____/_____/_____

Bluegrass Dermatology and Skin Surgery Center, PSC
3475 Richmond Road - Suite 200 - Lexington, KY 40509
Tel: (859) 296-4400 Fax: (859) 296-4300

BLUEGRASS DERMATOLOGY OFFICE POLICIES CONSENT FORM

Patient Name: _____ Patient D.O.B.: _____ Chart Number: _____

The following is a review of our office policies. Please review and sign below. Some policies may not pertain to your treatment today, but may for future treatments / procedures.

- **PRESCRIPTION REFILL POLICY:** Our physicians prescribe their patients sufficient refills to last until their next follow-up appointment; therefore, we are unable to refill prescriptions by telephone. If you would like refills of any medications prescribed by one of our physicians, please ask the physician you are seeing today during your exam.
- **Payment options** (For procedures not covered by insurance or balance dues): CASH, CHECK, VISA, MASTERCARD, CARE CREDIT VISA, DEBIT CARDS, MONEY ORDERS, and CASHIERS CHECKS.
- Payment plans can be arranged with CareCredit Visa by GE Moneybank. All balances due that do not get paid within the first 30 days are subject to finances which will accrue interest monthly. Please ask for details. You can apply for CareCredit in our office today.
- **The patient is responsible for all insurance deductibles, co-pays and services subject to plan limitation, and exclusions.**
- **Network Providers:** It is your responsibility to know if your physician is considered "In-network" by your insurance. Please call your insurance to verify and contact our Business Office, if there are any questions regarding network eligibility. Some insurance companies change their policy administrator and this can be difficult to identify from your insurance card. We encourage you to confirm your In-network status with our office each time you receive a new copy of your insurance card.
- **The patient is responsible for all balances due with all out-of-network insurance companies.** Bluegrass Dermatology asks that any patient with out of network insurance file a separate claim for full reimbursement. This includes all secondary out of network plans. We are not a Medicaid provider and Medicaid does not offer out of network benefits; therefore patients will not receive reimbursement from their Medicaid plan.
- **Controlled Substances:** I understand that Bluegrass Dermatology occasionally will need to prescribe a controlled substance for my psychical complaints and/or pain, as part of their surgical/medical treatment. Because of the new prescription drug law, Bluegrass Dermatology will obtain information from the patient and obtain an eKASPER report prior to prescribing any controlled substances to a patient. Effective July 20, 2012, Kentucky prescribers and dispensers authorized to prescribe or dispense controlled substances must be registered and utilize the enhanced Kentucky All Schedule Prescription Electronic Reporting (eKASPER) system in compliance with the new prescription drug law.
- **All Cosmetic and Private Pay visits fees are due at time of service.**
- There is a $25 fee assessed if you fail to cancel or reschedule an appointment at least 24 hours prior or you no-show the appointment. Some cosmetic procedures that have a longer appointment time with the provider, may incur a higher cancellation/no show fee.
- Treatment fees are estimates only and could be altered if your treatment plan needs to be changed. The patient would be notified of any change(s) in treatment.
- Minors under the age of 18 will receive medical care and/or treatment with a parent, legal guardian or an authorized accompanying adult only. Minors under 18, who are not accompanied, will not be seen.
- Cosmetic removal of benign lesion(s) such as skin tags, age spots, and normal moles is considered a cosmetic procedure. Bluegrass Dermatology does not bill insurance companies for cosmetic procedures.
    - I am responsible for the full cost of the procedure.
    - No coded receipt will be provided for this service unless you have a cosmetic rider on your insurance policy.
    - Bluegrass Dermatology does not bill insurance companies for cosmetic procedures, since the physician would not receive any payment from the carrier for services rendered.
    - I understand that this fee includes only this procedure (This procedure is in addition to any co-payment / co-insurance that you may owe at the time of services rendered. All additional office evaluations will be charged to your insurance.)
- All surgical pathology and other lab specimens are submitted to outside laboratories for processing and analysis, which may represent an additional fee that you may be charged outside of our office.
    - I understand that I may receive a separate bill from the laboratory that processes my specimen.
    - We use the following labs: Dermatopathology Reference Laboratory (DAK); Advanced Dermatology, P.S.C; LabCorp; Lexington Clinic; DermatoPathology Alliance of Kentucky; Quest Diagnostics; ProPath Laboratories; and University of Kentucky Hospital.
- It is your responsibility to let us know if your insurance company requires that we send your labs to a specific pathologist in order for you to receive full benefits.

Many of the above procedures require a review of your allergy history. Please be advised, if you will need a procedure, you may be required to list any medication, anesthesia, and latex allergies that you have.

Signature of Patient or Responsible Party: _____ Date: _____

Bluegrass Dermatology and Skin Surgery Center, PSC
3475 Richmond Road - Suite 200 – Lexington, KY 40509 – (859) 296-4400

Name: _____ CHART #: _____

Consent for the Use or Disclosure of Protected Health Information

As required by the Health Insurance Portability and Accountability Act of 1996, this practice may use your health information for the purposes of treatment, payment, or health care operations. The specific uses and disclosures that we intend to make are described in our Notice of Information Practices. You have the right to review the Notice of Information Practices prior to signing this consent form. You may request restrictions on the uses and disclosures described in the Notice of Information Practices by describing the restrictions in the "restriction request" section of this form. You may revoke this consent at any time by signing and dating the revocation section on your copy of the form and returning it to this office.

CONSENT SECTION:

I hereby consent to the use and disclosure of my personal health information for the purposes of treatment, payment and health care operations. My signature below indicates that I have been given an opportunity to read the Notice of Information Practices and to have any questions answered before signing.

I understand that I may request restrictions on the uses and disclosures of my health information at any time by completing and signing the restriction request section of this form. I further understand that the practice is not required to accept my restriction request.

I understand that I may revoke this consent at any time by signing the revocation section of my copy of this form and returning it to this practice. I further understand that any such a revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this consent.

May we leave information regarding your diagnosis, treatment, and follow-up on your home answering machine?	□ YES □ NO
May we leave information regarding your diagnosis, treatment, and follow-up on your work answering machine?	□ YES □ NO
May we communicate information regarding your diagnosis and treatment \ through email?	□ YES □ NO
May we call you with an automated system to remind you of your appointment?	□ YES □ NO
Is there anyone (i.e. spouse, parent, guardian or family member) you authorize us to share any medical information with, if you are not available? If yes, please provide their name & contact information below: Name: _____ Relationship: _____ Home Phone: _____ Cell Phone: _____	□ YES □ NO

RESTRICTION REQUEST SECTION:

I hereby request the following restrictions on the uses and disclosures of my health information (please describe the requested restrictions in detail):

_____

_____ _____

Patient or Responsible Party Signature * **Today's Date**

**** If you are over 18 years of age and under your parent's insurance policy, please check the box:*** ☐

REVOCATION REQUEST SECTION: I hereby revoke the use and disclosure of my health information.

_____ _____

Patient or Responsible Party Signature* **Today's Date**

EMA History and Intake Form

Patient Name: _____**Chart #:** _____

Height: _____ feet _____ inches **Weight:** _____ lbs

Past Medical History: (please circle all that apply) [ ] NONE

Anxiety	Coronary Artery Disease	Hyperthyroidism
Arthritis	Depression	Hypothyroidism
Asthma	Diabetes	Leukemia
Atrial Fibrillation	End Stage Renal Disease	Lung Cancer
Bone Marrow	GERD	Lymphoma
Transplantation	Hearing Loss	Prostate Cancer
BPH	Hepatitis	Radiation Treatment
Breast Cancer	Hypertension	Seizures
Colon Cancer	HIV / AIDS	Stroke
COPD	Hypercholesterolemia	

Other: _____

Family History: [ ] None DO NOT INCLUDE YOURSELF OR SPOUSE
(Please circle all that apply & list family member who had the condition)

Arthritis (family member: _____) Heart Disease (family member: _____)
Cancer (family member: _____) Melanoma (family member: _____)
Diabetes (family member: _____) Psoriasis (family member: _____)
Eczema (family member: _____) Skin Cancer (family member: _____)

Other Pertinent Family History: _____

Past Surgical History: **(please circle all that apply)** [ ] NONE

Appendix Removed	Heart Valve Replacement	Prostate Removed
Bladder Removed	Hysterectomy	Ovarian Cancer
Breast Biopsy	Joint Replacement	Ovarian Cyst
Breast Reduction	Kidney Biopsy	Ovaries Removed
Breast Implants	Kidney Removed	Skin Biopsy
Colectomy	Kidney Stone	Skin Cancer Surgery
Gallbladder Removed	Kidney Transplant	Spleen Removed
Heart Bypass	Mastectomy	Testicles Cancer
Heart Transplant	Prostate Biopsy	Uterine Cancer

Other: _____

Skin Disease History: (please circle all that apply) [ ] NONE

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Cancer	Hay Fever / Allergies	Squamous cell cancer
Blistering Sunburns	Melanoma	

Other: _____

Patient or Responsible Party Signature: _____ Date ___ /___/ ___

Patient Name: _____ **Chart #:** _____

Medication Information:

[ ] I am NOT Currently Taking Any Medication(s) (Check only if applicable)

List all medications you are currently taking (include over-the-counter medicines, herbals, & vitamins / minerals):

Medication(s)	Medication(s)

Pharmacy Information:

Bluegrass Dermatology utilizes an electronic system that will send your prescription(s) directly to your pharmacy.

Please fill in the following information, so that we can expedite any prescriptions that we may give you.

Medicare patients will be required to send all their prescriptions via electronic means.

Pharmacy Name: _____ Phone Number: ( ) _____

Pharmacy Address: _____ City/State: _____ Zip Code: _____

Allergy Information: [ ] NONE **(Please complete thoroughly, list your allergy information below)**

Medication/Allergy	Reaction	Medication/Allergy	Reaction

Social History: (Check all that apply) [ ] NONE

[ ] Alcohol [ ] Caffeine [ ] Drug user [ ] Smoker/Tobacco User [ ] Former Smoker/Tobacco User

Caffeine Use: [ ] Never [ ] Several times a day [ ] Once a day [ ] Few times a week [ ] Few times a month

Exercise Regularly: [ ] Never [ ] Several times a day [ ] Once a day [ ] Few times a week [ ] Few times a month

Patient or Responsible Party Signature: _____ Date ___ /___/ ___

Patient Name: _____ **Chart #:** _____

Review of Systems: Note: For follow-up patients, review of systems should be related to the chief complaint.

Please Answer Yes or No to all of the following Review of Systems.

Are you currently experiencing any of the following? (Please mark yes or no for the following):

SYMPTOMS			SYMPTOMS		
Abdominal Pain	☐ No	☐ Yes	Rash	☐ No	☐ Yes
Blurry Vision	☐ No	☐ Yes	Problems with Bleeding	☐ No	☐ Yes
Chapped Lips	☐ No	☐ Yes	Problems with Scarring/Healing	☐ No	☐ Yes
Depression	☐ No	☐ Yes	Changing Mole	☐ No	☐ Yes
Dry Skin	☐ No	☐ Yes	Thyroid Problems	☐ No	☐ Yes
Headaches	☐ No	☐ Yes	Sore Throat	☐ No	☐ Yes
Joint Pain	☐ No	☐ Yes	Muscle Weakness	☐ No	☐ Yes
Sunburns	☐ No	☐ Yes	Night Sweats	☐ No	☐ Yes
Fever and Chills	☐ No	☐ Yes	Seizures	☐ No	☐ Yes
Cough	☐ No	☐ Yes	Heartburn	☐ No	☐ Yes
Nausea and Vomiting	☐ No	☐ Yes	Wheezing	☐ No	☐ Yes
Unintentional Weight Loss	☐ No	☐ Yes			

Caution Alert Questions: (Please mark Yes or No for the following):

Do you have an allergy to Latex Products?		☐ No	☐ Yes
Do you have an allergy to Lidocaine?		☐ No	☐ Yes
Do you have an allergy to Adhesives?		☐ No	☐ Yes
Do you have an allergy to Topical Antibiotic Ointments?		☐ No	☐ Yes
FEMALES ONLY: Are you trying to get pregnant ☐ (Check only if you are currently pregnant)	☐ N/A	☐ No	☐ Yes
FEMALES ONLY: Are you currently nursing?	☐ N/A	☐ No	☐ Yes
Do you take a blood thinning medication? Common blood thinning medications are: Aspirin, Coumadin (Warfarin), Plavix, Pradaxa, Xerelto.		☐ No	☐ Yes
Do you have an artificial heart valve?		☐ No	☐ Yes
Do you require antibiotics prior to a surgical procedure?		☐ No	☐ Yes
Do you have a defibrillator?		☐ No	☐ Yes
Have you had an artificial joint replacement within the past two (2) years? If yes, when and what body locations? _____		☐ No	☐ Yes
Do you have a pacemaker?		☐ No	☐ Yes
Have you been diagnosed as having human immunodeficiency virus (HIV)		☐ No	☐ Yes
Have you been diagnosed as having Hepatitis B or C		☐ No	☐ Yes
Have you recently traveled to or have had contact with anyone who traveled to West Africa?		☐ No	☐ Yes

Skin Cancer / Melanoma Family History Questions:

Do you wear Sunscreen? If yes, what SPF? _____	☐ No	☐ Yes
Do you or have your ever tanned in a tanning salon/tanning bed?	☐ No	☐ Yes
Do you have a family history of Melanoma? - If yes, which relative(s)? _____	☐ No	☐ Yes

Patient or Responsible Party Signature: _____ Date ___ /___/ ___