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**BLUEGRASS DERMATOLOGY
Patient Registration Form**

Date: _____

Chart Number: _____

PATIENT DEMOGRAPHIC INFORMATION

Name: _____	Social Security Number (required): _____	Birth Date: _____
Address: _____ Apt. / Suite: _____ City/State/Zip: _____		
E-mail Address: _____ (REQUIRED FOR PATIENT PORTAL ACCESS)		
Home Phone: (____) _____	Cell Phone: (____) _____	Height: _____ Weight: _____
Preferred Number: <input type="checkbox"/> Home <input type="checkbox"/> Cell Can we leave a detailed Message: <input type="checkbox"/> Yes <input type="checkbox"/> No Method for reminders? <input type="checkbox"/> Phone call <input type="checkbox"/> Text <input type="checkbox"/> E-mail <input type="checkbox"/> All Three		
Race: <input type="checkbox"/> Caucasian <input type="checkbox"/> African American <input type="checkbox"/> Hispanic / Latino <input type="checkbox"/> Asian <input type="checkbox"/> American Indian <input type="checkbox"/> Other		
Ethnicity: <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic Gender Identity: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Other: _____ Pronoun: _____		
Marital Status: <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Primary Language: _____		
Employer: _____ Address: _____		
City/State/Zip: _____ Work Phone: (____) _____		
Emergency Contact Name: _____ Relationship: _____ Phone: (____) _____		

RESPONSIBLE PARTY BILLING INFORMATION Relationship to Patient: Self Parent Guardian POA Other _____

Name: _____ Birth date: _____ Address: _____
City/State/Zip: _____ Social Security Number: _____

INSURANCE INFORMATION

Please double-check your insurance card to see if a referral is required by your PCP (your PCP's name will be printed on the front copy of your card or you may see "referral required") in order to be seen by a specialist. If so, the referral authorization must be received by our practice PRIOR to your appointment. Insurance plans will NOT accept a referral request by our office.

Primary: _____	I.D. #: _____	
Group #: _____	Effective Date: _____	Subscriber Birth Date: _____
Subscriber Name: _____	Gender: _____	Relationship to Patient: _____
Secondary: _____	I.D. #: _____	
Group #: _____	Effective Date: _____	Subscriber Birth Date: _____
Subscriber Name: _____	Gender: _____	Relationship to Patient: _____

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, DISCOVER, AMERICAN EXPRESS, MASTERCARD, MONEY ORDERS, and CASHIERS CHECKS. We also participate with Care Credit Financing.

PHARMACY AND PRIMARY CARE PROVIDER (Per Medicare and most insurances, you are required to list a primary care provider [PCP])

Pharmacy Name: _____ Address: _____
City/State/Zip: _____ Phone: (____) _____
Primary Care Provider: _____ City/State/Zip: _____ Phone: (____) _____

BLUEGRASS DERMATOLOGY
Patient Medication/Allergy History Form

Patient Name: _____ Birth Date: _____ Chart Number: _____

ALLERGY INFORMATION [] I do not have any allergies to any medications

Medication	Allergic Reaction

Do you have an allergy to Latex Products? No Yes Do you have an allergy to Adhesives? No Yes
Do you have an allergy to Lidocaine? No Yes Do you have an allergy to Topical Antibiotic Ointments? No Yes

SOCIAL HISTORY (Please answer **ALL** of the following questions)

[] Never smoker and/or tobacco user [] Former smoker and/or tobacco user [] Current smoker and/or tobacco user

Surrogate Decision Maker (i.e. Living Will, POA, or family member / friend who can help you in medical emergencies)

[] I have a surrogate decision maker [] I do not have a surrogate decision maker [] I have a living will [] I have a POA

If you have a surrogate decision maker, who is it? _____ Phone: (_____) _____

FAMILY HISTORY (circle all that apply) [] I do not have a family history of any medical conditions

Please do not include yourself and/or spouse and only list family member(s) who had the medical condition

Melanoma (family member _____) Cancer (family member _____)
Other Skin Cancers [unknown type] (family member _____) Diabetes (family member _____)
Eczema or Psoriasis (family member _____)
Other Pertinent Family History _____

BLUEGRASS DERMATOLOGY
Patient Review of Systems Questionnaire Form

Patient Name: _____ Birth Date: _____ Chart Number: _____

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

SYMPTOMS

Abdominal Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Blurry Vision	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Chapped Lips	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Depression	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Dry Skin	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Headaches	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Joint Pain	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Swollen Lymph Nodes	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Fever and Chills	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Cough	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Nausea or Vomiting	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Unintentional Weight Loss	<input type="checkbox"/> No	<input type="checkbox"/> Yes

SYMPTOMS

Rash	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Problems with Bleeding	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Problems with Scarring/Healing	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Changing Mole	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Thyroid Problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Sore Throat	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Muscle Weakness	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Night Sweats	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Seizures	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Heartburn	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Wheezing	<input type="checkbox"/> No	<input type="checkbox"/> Yes

Please mark Yes or No for the following:

- **Do you take a blood thinning medication?** Common blood thinning medications are: Aspirin, Brilinta (Tricagrelor), Coumadin (Warfarin), Plavix, Pradaxa, Xarelto, Imbruvica (Ibrutinib) 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 and/or pacemaker?** No Yes
- **Have you had an artificial joint replacement within the past two (2) years?** No Yes
If yes, when and what body locations? _____
- **Have you been diagnosed as having human immunodeficiency virus (HIV)?** No Yes
- **Have you been diagnosed as having Hepatitis B or C?** No Yes

FEMALE PATIENTS PLEASE ANSWER THE FOLLOWING QUESTIONS:

- Are you trying to become pregnant? N/A No Yes Maybe
- Are you currently pregnant? N/A No Yes Maybe
- Are you currently nursing? N/A No Yes
- If you are of child-bearing potential, are you using contraception? N/A No Yes
If yes, what contraception are you currently using? _____

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

Bluegrass Dermatology
HIPAA (Health Insurance Portability and Accountability Act) Consent Form

Patient Name: _____ **Date of Birth** _____ **Chart #** _____

As required by the **Health Insurance Portability and Accountability Act (HIPAA) 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.

- 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.
- **Acknowledgement of Receipt of Privacy Practices:** I acknowledge the practice has a copy of the Notice of Privacy Practices which provides a detailed description of the uses and disclosures allowed, as well as other rights I have regarding my protected health information, and that I can obtain a copy per request.
- **Consent to Treat:** I hereby authorize examination and treatment by Bluegrass Dermatology. I authorize the release of any medical information necessary to process claims to insurance carriers (and/or the Social Security Administration/CMS or intermediaries). I permit a copy of this authorization to be used in place of the original. All information gathered will remain confidential by our HIPAA policy.

CONSENT: 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 disclosure 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.
- 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? YES NO

○ If yes, please provide their name & contact information below:

Name: _____ Relationship: _____

Home Phone: _____ Cell Phone: _____

RESTRICTION REQUEST SECTION *If you do NOT want the physicians or staff at Bluegrass Dermatology to leave test result; appointment; or billing/account information on your personal voicemail, please make note in the Restriction detail below.**

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

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

Signature of Responsible Party: _____ Date: _____

Bluegrass Dermatology Office Policies Consent Form

Patient Name: _____ Birth Date: _____ Chart Number: _____

The following is a review of our office policies. Please review and sign below.

PAYMENT RESPONSIBILITY: The patient is responsible for all insurance deductibles, co-pays and coinsurance on the day of service (subject to plan limitation, and exclusions).

PAYMENT OPTIONS: We accept CASH, CHECK, VISA, DISCOVER, AMERICAN EXPRESS, MASTERCARD, CARECREDIT, MONEY ORDERS, and CASHIERS CHECKS. You can apply for CareCredit in our office today. All balances that are not paid within the first 90 days are subject to being transferred to an outside collection agency.

INSURANCE POLICIES THAT REQUIRE A REFERRAL FROM THE PCP: Some insurance plans require a referral from the patient's primary care provider (PCP). The PCP will need to initiate the referral by contacting the insurance company. It is the patient's responsibility to make sure this has been done prior to each appointment date. Otherwise, the patient is responsible for ALL charges.

NETWORK PROVIDERS: It is your responsibility to know if your physician is considered "in network" with your insurance policy. Some insurance companies change their policy administrator. We encourage you to confirm in network status with our office each time you receive a new copy of your insurance card or contact your insurance company.

MEDICAID NON-PARTICIPATION POLICY: Our physicians are not participating Medicaid providers and Medicaid does not cover services provided by our physicians. Similarly, Medicaid does not cover items or services ordered by our physicians such as, but not limited to, prescription medications, lab work, outside pathology services, diagnostic testing, etc. **Medicaid recipients are responsible for payment of services provided and/or ordered by our physicians.**

COSMETIC AND SELF-PAY SERVICES: 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. The patient is responsible for the full cost of the procedure. **All cosmetic and self-pay visits are due at check in on the date of service.**

TREATMENT FEES: 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.

CANCELLATION FEE: A missed appointment fee of \$200 will be assessed for surgical and laser appointments, and \$50 for office visits that are cancelled with less than 48 hours' notice, or if you fail to show up for your appointment.

TREATMENT OF MINORS: 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.

PRESCRIPTION REFILL POLICY: Our physicians prescribe sufficient refills for their patients until their next follow-up appointment; therefore, we are unable to refill prescriptions by telephone. Patients should contact their Pharmacy if refills are needed prior to their next follow-up appointment.

CONTROLLED SUBSTANCES: Bluegrass Dermatology occasionally will need to prescribe a controlled substance for patient's physical complaints/pain, as part of their medical treatment. Because of Kentucky's prescription drug law, we will submit patient information to obtain a report (Kentucky All Schedule Prescription Electronic Reporting (eKASPER) prior to prescribing any controlled substances to a patient.

LABORATORY FACILITIES: All surgical pathology and other lab specimens are submitted to outside laboratories for processing and analysis. The patient may receive a separate bill from the laboratory that processes and tests specimens. It is the patient's 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.

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



Driving Directions to the Office

Hours of Operation:

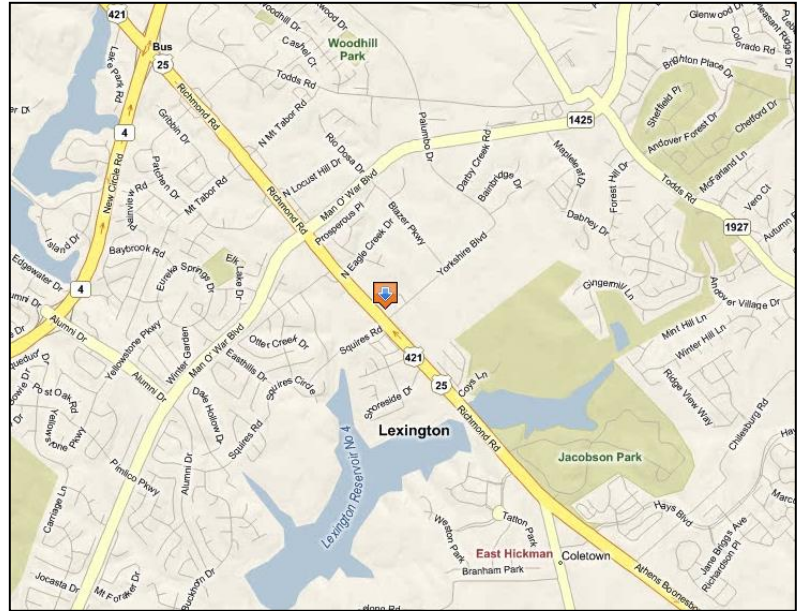
Monday – Thursday: 8 am – 6 pm

Friday: 8 am – 5 pm

Closed: Weekends and Major Holidays

Coming From Interstate 75 South:

1. At exit 104, take the exit ramp for KY-418 toward Lexington / Athens.
2. Turn left onto SR-418 / Athens Boonesboro Rd
3. Road name changes to US-25 North / US-421 North / Richmond Rd.
4. Turn right onto Yorkshire Blvd, our parking lot is the first drive to your left.



Coming From Interstate 75 North:

1. Take the Man O'War Blvd exit #108 – KY-1425W.
2. Stay straight on Man O'War Blvd and turn left onto Palumbo Drive.
3. Stay straight on Palumbo Dr, there will be a sharp turn to the right and the road name changes to Yorkshire Blvd.
4. Stay on Yorkshire Blvd to the end. Our parking lot is the last drive on your right.

Coming from New Circle Road:

1. Take the US-25S./US-421S. exit #15 towards Richmond / Interstate 75.
2. Stay on Richmond Rd heading towards Interstate 75.
3. After crossing Man O'War Blvd, turn left at the 2nd traffic light, onto Yorkshire Blvd.
4. Our parking lot is the first drive to your left.

Coming from the Bert T. Combs Mountain Parkway:

1. Take the Mountain parkway to Interstate 64 W.
2. Merge onto I-75 S. via exit 81 on the left towards Richmond / Knoxville.
3. Take the Man O'War Blvd exit#108 – KY-1425W.
4. Stay straight on Man O'War Blvd and turn left onto Palumbo Drive.
5. Stay straight on Palumbo Dr, there will be a sharp turn to the right and the road name changes to Yorkshire Blvd.
6. Stay on Yorkshire Blvd to the end. Our parking lot is the last drive on your right.