Patient Registration

DERMASURGERY CENTER
230 Harrisburg Ave, STE 4, Lancaster, PA 17603
717-399-9800

Full Name_____ **Date:**_____

Date of Birth:_____ **Sex**: ☐M ☐F **Marital Status**: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Street Address :_____

City/State/Zip Code:_____ **Home Phone w/Area Code:**_____

Social Security#_____ **Cell Phone w/Area Code:**_____

Patient's Employer:_____ **Work Phone w/Area Code:**_____

EMAIL Address:_____ **Preferred Phone:** ☐Home ☐Cell ☐Work

In case of emergency, contact:_____

Emergency Contact Phone Number w/Area Code:_____ **Relationship to Patient:**_____

Primary Care Physician Name & Phone Number:_____

Referring Physician's Name & Phone Number:_____

*****How did you hear about our practice?* ☐*Doctor* ☐*Friend/Relative* ☐*Newspaper* ☐*Online Ad/Search* ☐*Phonebook* ☐*Insurance***

PLEASE PRESENT INSURANCE CARD(S) FOR SCANNING AND COMPLETE THE REQUESTED INFORMATION

Responsible Party:_____ **Relationship:** ☐Self ☐Spouse ☐Parent ☐Other_____

Insurance Company # 1:_____

>>Insured/Subscriber Name:_____ **>>Date of Birth:**_____

Policy #:_____ **Group #:**_____ **Relationship:**_____

Insurance Company # 2:_____

>>Insured/Subscriber Name:_____ **>>Date of Birth:**_____

Policy #:_____ **Group #:**_____ **Relationship:**_____

If patient is a Minor, are parents ☐Married ☐Divorced ☐Custodial Parent_____

Custodial Parent's Home Phone w/Area Code:_____ **Work Phone w/Area Code:**_____

Custodial Parent's SS #:_____ **Date of Birth:**_____

- **I hereby authorize the payment of medical benefits to DermaSurgery Center for services rendered. I understand that I am financially responsible for any services not covered by my insurance carrier.**
- **I further agree to pay collection costs that may be incurred to enforce the collection of overdue amounts outstanding.**
- **I hereby authorize DermaSurgery Center to release any medical information necessary to complete and process my insurance claims.**
- **I am also aware that no show appointments may incur a fee.**

_____ _____

Patient's OR Insured's Signature (If patient is a Minor, must have Responsible Party Signature) **Date**

DERMASURGERY CENTER FINANCIAL POLICY 717-399-9800

Dear Patient:

Thank you for choosing the DermaSurgery Center. **Please complete all forms** and bring the forms to your scheduled appointment.

We would like to share the following policies with you so that you understand your responsibility regarding the charges for services rendered to you by Dr. S.Teri McGillis.

MEDICARE:
We are a participating provider. We bill Medicare and Medigap carriers. We also bill most Medicare Advantage Plans.
You will be responsible at the time of service for payment of:

- COPAYMENTS / DEDUCTIBLES
- CHARGES FOR NONCOVERED OR COSMETIC SERVICES
- (*You will be asked to sign an Advanced Notice of Liability Form in the event that a service is provided which we know is not covered by Medicare)

COMMERCIAL PLANS:
If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all medically necessary services rendered. We will bill both your primary and secondary for contracted plans.
You will be responsible at the time of service for payment of:

- COPAYMENTS / DEDUCTIBLES
- CHARGES FOR NONCOVERED OR COSMETIC SERVICES

In the event that you, as the patient, or we, as the physician, are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

**For patients who have insurance coverage with an insurance carrier with which we do not have a contractual relationship, please note the following:
We will bill your carrier for surgical procedures only.
Payment for the office visit portion of your visit must be paid at the time of service.
Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits.

SELF PAY:
For patients that do not have medical insurance we require payment in full at the time of service. If surgery is required you will be given an estimate of charges before services are rendered. We accept cash, checks, credit cards, and we also offer financing through Care Credit.

COSMETIC PROCEDURES:
Our policy for cosmetic procedures is payment in full at time of service. Please note that we do not accept personal checks for cosmetic services. Payment must be made with cash, credit card or money order.

PLEASE SIGN BELOW TO ACKNOWLEDGE THAT YOU HAVE READ AND UNDERSTAND OUR FINANCIAL POLICY:

_____ _____

Signature **Date**

_____

Print Name

DERMASURGERY CENTER, P.C.

Patient Consent for Use and Disclosure
Of Protected Health Information

With my consent, DermaSurgery Center, P.C. may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to DermaSurgery Center, P.C.'s Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. DermaSurgery Center, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to DermaSurgery Center, P.C.'s Privacy Officer, 230 Harrisburg Ave, Suite 4, Lancaster, PA 17603

With my consent, DermaSurgery Center, P.C. may call my home or other designated location and leave a message in reference to any items that assist the practice in carrying out TPO (such as: appointment reminders, insurance items, and any call pertaining to my clinical care, including but not limited to laboratory results).

With my consent, DermaSurgery Center, P.C. may mail to my home or other designated location any items that assist the practice in carrying out TPO (such as: appointment reminder cards and patient statements).

With my consent, DermaSurgery Center, P.C. may e-mail to the address I have provided any items that assist the practice in carrying out TPO (such as: appointment reminder cards and patient statements). I have the right to request that DermaSurgery Center, P.C. restrict how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to DermaSurgery Center, P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, DermaSurgery Center, P.C. may decline to provide treatment to me.

I have been offered a copy of the DermaSurgery Center, P.C.'s Notice of Privacy Practices.

_____ _____

Signature **Date**

_____

Print Name

DermaSurgery Center, P.C.
230 Harrisburg Avenue • Suite 4 • Lancaster PA 17603
(717) 399-9800 • Fax (717) 399-7613 • www.dscskin.com

Patient Name: _____ DOB: _____

Unhealthy Alcohol Use: Screening & Brief Counseling
How many times in the past year have you had 4 or more alcoholic drinks in 1 day? _____

Influenza Vaccine
Check the one that best fits:

- ☐ Received/planning on receiving a flu vaccine this flu season
- ☐ Did not receive a flu vaccine this flu season because of medical reasons
- ☐ Did not receive a flu vaccine this flu season because I did not want one

Pneumococcal Vaccine (For Patients 65 and older ONLY)
Check the one that best fits:

- ☐ Received a pneumococcal vaccine (Pneumovax)
- ☐ Did not receive a pneumococcal vaccine

Advanced Directives
We are going to call 911 regardless of what is checked below. We would like to notify the emergency personnel of your wishes upon their arrival.
Advance directives are designed to respect your autonomy and determine your wishes about future life-sustaining medical treatment if you are unable to indicate your wishes. Key interventions and treatment decisions are: resuscitation procedures such as Cardiopulmonary Resuscitation (CPR), and mechanical respiration (breathing tube)
Which statement(s) **best reflect** your wishes on advanced care recommendations?

- ☐ I want full cardiopulmonary resuscitation efforts to be made (Full Code)
- ☐ I do not wish to have a breathing tube, even if necessary to save my life (Do Not Intubate)
- ☐ If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if it's necessary to save my life (Do Not Resuscitate)

Living Will/HealthCare Proxy

- ☐ I have a living will
- ☐ I have a health care proxy whose name is: _____.

  Their contact information is _____.

Medication Reconciliation:
I give consent to the staff of DermaSurgery Center to retrieve my prescribing history through Surescripts.

_____ _____
Patient signature Date