Farmington Valley Dermatology & Surgery, LLC

Patient Registration Form

Patient Information: ***Please use ink when completing this form***

Patient' Legal Name: ____ Preferred Name:______________________

First MI Last

Home Address:____

Street City State Zip

Email Address:_______________________________________ Occupation:______________________________________

Sex: M F Social Security #: ___________________________ Birthdate: ______________________

Cell Phone #:______________________ Home Phone #:____________________ Work Phone #:________________

Emergency Contact: ____________________________ Relationship______________ Phone#_____________________

Primary Care Doctor:________________________________City:_________________________________State________

Referring Doctor: __________________________________ City:_________________________________State________

FVDerm has permission to: 1) Leave Message on: Home / Work / Cell 2) Send Text Message YES / NO

Would you like to be contacted regarding Specials, offers, events? Text / Phone / Email

How did you hear about our office: _________________________ Are you interested in a cosmetic consult? Yes/No

Primary Insurance Name: _____________________________ Subscriber Name:_________________________

Relation to Patient: Self Spouse Dependent Other Birthdate:_______________

Secondary Insurance Name: _________________________ Subscriber Name:__________________________

Relation to Patient: Self Spouse Dependent Other Birthdate:________________

Notice of Privacy Practices: (If the patient is a minor a separate form is required)

A Notice of Privacy Practices has been provided to me from FVDerm. Signature_________________________________
(A copy is located at our front desk for your convenience)

Do you give our office permission to discuss your medical information with family member? ____Yes _____No

Name:____Relationship____________________Phone #___________________

Name:____Relationship____________________Phone #___________________

Financial Agreement:

I certify that the information I provided is correct. I authorize the release of medical information necessary to process claims to insurance companies (including Medicare), for the purpose of filing and payment of medical claims. I authorize payment of medical benefits to Farmington Valley Dermatology & Surgery, LLC.

I agree to pay any co-payments and any past amounts at the time of service. Payments can be made in the form of cash, check or charge card. A $25.00 fee will apply for each returned or NSF check. I understand that if my account is in default, an appointment will not be made until my account becomes current. Also, I will be responsible for any cost associated with collecting a past due debt, including 15% collection agency fees. Your signature below signifies your understanding and willingness to comply with these policies.

I understand that my insurance is a contract between my insurer and myself. Claim submission provided by Farmington Valley Dermatology is a courtesy. I am responsible for understanding the terms of my policy, including deductibles, co-pays, coinsurances and referrals. I am responsible for obtaining any required referrals or prior authorizations, and in absence of such, I will be held responsible for the cost of service provided. I understand that if FVDS does not participate with and insurance carrier, they will not file a claim for me and I am responsible for full payment.

_____________________________________ _________________________________

Your Signature Today's Date

Name:____ **Date:**_____________________________

Primary Care Physician:______________________________ City:__________________________ State:________

When was your last visit to your Primary Care Physician? Month/Year________________

Referring Physician:_________________________________ City:__________________________ State:________

Past Medical History:

	Yes		Yes		Yes
Anxiety	Y	Depression	Y	Hypothyroidism	Y
Arthritis	Y	***Diabetes***	Y	Leukemia	Y
Asthma	Y	End Stage Renal Disease	Y	Lung Cancer	Y
Atrial fibrillation	Y	GERD	Y	Lymphoma	Y
Bone Marrow Transplantation	Y	Hearing Loss	Y	Prostate Cancer	Y
BPH	Y	***Heart Disease***	Y	Radiation Treatment	Y
Breast Cancer	Y	Hepatitis A B C (circle)	Y	Seizures	Y
Colon Cancer	Y	High Blood Pressure	Y	Stroke	Y
COPD	Y	HIV/AIDS	Y	Other:________________	Y
Coronary Artery Disease	Y	Hyperthyroidism	Y	NONE	Y

Past Surgical History: (please list all)____

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Past Skin History

Acne	Y	Dry Skin	Y	Poison Ivy	Y
Actinic Keratosis	Y	Eczema	Y	Precancerous Moles	Y
Asthma	Y	Flaking or Itchy Scalp	Y	Psoriasis	Y
Basal Cell Skin Cancer	Y	Hay Fever	Y	Squamous Cell Skin Cancer	Y
Blistering Sunburns	Y	Melanoma	Y	Other:____________________	Y

Do you wear sunscreen?	Y	If yes, what SPF?
Do you use a tanning salon?	Y	
Family History of Melanoma? Mother Father Sister Brother Daughter Son Other		

Current Medications:

Name	**Dose/Pill**	**# and type**	**# times per day**
Example: Ibuprofen	*200mg*	*2 tablets*	*3 times a day*

Name:____ **Date:**____________________________

Pharmacy Name: ___________________________ **Street:**___________________________ **City:**_____________________

Mail Order Pharmacy:____

❑ I allow Farmington Valley Dermatology to access my prescription history from healthcare providers and pharmacies.

Allergies to Medications: (specify type of reaction, example: anaphylaxis, rash, GI upset, etc…)

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Other Allergies:____

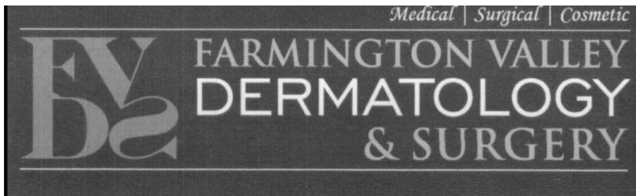
Cigarette/Tobacco Use: Daily Less Than Daily Quit: When: Never (Please circle)
Did you receive the flu vaccine this flu season? Yes No (October thru March)
Have you ever received a pneumonia vaccine? Yes No
Do you have a Health Proxy? Yes No

Current Medical History:

PRIMARY		Night Sweats	Y
Immunosuppression	Y	Bloody Urine	Y
Hay Fever	Y	Sore Throat	Y
Rash	Y		
Changing Mole	Y	ALERTS	
Healing Problems	Y	Premedication prior to procedures	Y
Scaring Problems (Keloid/Hypertrophic)	Y	Allergy to Adhesives	Y
Bleeding Problems	Y	Allergy to topical antibiotic ointments	Y
Thyroid Problems	Y	Allergy to lidocaine	Y
Wheezing	Y	Allergy to Latex	Y
Shortness of Breath	Y	Blood Thinners	Y
Cough	Y	Currently Pregnant	Y
Headaches	Y	Planning a Pregnancy	Y
Seizures	Y	Currently Breast Feeding	Y
Blurry Vision	Y	Pacemaker	Y
Chest Pain	Y	Defibrillator	Y
Abdominal Pain	Y	Artificial Joints within the past years	Y
Bloody Stool	Y	Artificial Heart Valve	Y
Joint Aches	Y	Rapid Heartbeat with epinephrine	Y
Neck Stiffness	Y	GI Upset with Antibiotics	Y
Muscle Weakness	Y	Swollen Lymph Nodes	Y
Anxiety	Y	Yeast Infection with Antibiotics	Y
Depression	Y	MRSA	Y
Unintentional Weight Loss	Y	HIV/AIDS	Y
Fever/Chills	Y	Hepatitis A B C (please circle type)	Y

I give Farmington Valley Dermatology permission to leave test results on a voicemail: ❑Y ❑N

Phone number to leave test result messages: __________________________



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Avon, CT 06001-3735
Phone 860-674-9900
Fax 860-678-0036
fvderm.com

Consent for Financial/Office Policies

Please remember that your health insurance is a contract between you and your insurance company. It is YOUR responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, and lab contracts. As a courtesy to you, we will submit a claim to those insurances that we have a contract with for all medical visit charges. Your ID and insurance card is needed in order to file a claim for you. You will be asked to present your insurance card at every visit.

Recent shifts in the healthcare industry have resulted in insurance companies increasingly shifting costs to patients, you, the insured. Farmington Valley Dermatology has financial policies to enable efficient operational processes. Please review the information below to acknowledge your financial obligation:

In Network Coverage: For insurance companies that we are contracted with, we will determine your copay at the time of the visit. Co-payments and co-insurance amounts, deductibles and all non-covered items and charges are the insured/patient's responsibility and are **DUE AT THE TIME OF SERVICE**. Failure to produce payment will result in your appointment being rescheduled. Balances on accounts will also be collected at the time of an appointment.

Out of Network Coverage: For these plans, you will be considered a self-pay patient. Payment in full is DUE AT THE TIME OF SERVICE. You can submit your bill for reimbursement to your insurance company if they allow you to do so. Please check with your carrier.

Self-Pay Patients: Uninsured patients are considered self-pay and are responsible for payment in full DUE AT THE TIME OF SERVICE.

Non-covered Services: Cosmetic services cannot be submitted to insurance and payment is DUE AT THE TIME OF SERVICE by credit card, Care Credit or cash only, no checks will be accepted. Health Savings Cards are not permitted as a form of payment.

Credit Card on File Policy: (Deductible Plans)If you choose not to pay directly after the services are provided, we ask that you keep a credit/HSA card on file to be used for any unpaid balances. Please keep in mind, we will not charge your card if you do not owe anything.

Once your credit card information is entered, it is encrypted and cannot be viewed or accessed by our organization. InstaMed is registered with Visa and Mastercard and is independently certified as a PCI-DSS Level One Service Provider.

Outstanding Balances: Are due upon receipt. If you have a balance at the time of your appointment it will be collected at that time. If your account is not paid within 30 days of the first bill, you will receive a past due notice. If the account balance is not paid within 60 days, your account will be turned over to a collection agency and a fee of 15% of the outstanding balance will apply. Failure to pay bills will result in dismissal from the practice.

Online Payments: Please visit our website at fvderm.com to pay outstanding balances online via InstaMed. InstaMed is registered with Visa and Mastercard and is independently certified as a Level One Provider.

Return Check Fee: A fee of $25.00 will be added to your account for each check returned by your bank for insufficient funds. Any future payments must be made in the form of credit card or cash. Checks will no longer be accepted as a form of payment.

Referrals: Your insurance plan may require an insurance referral before seeing a specialist. It is your responsibility to obtain the proper referral, prior to your appointment, in order to be seen for your appointment. If you do not have a referral at your appointment time, your appointment may be rescheduled, and you could be charged a missed appointment fee of $50.00. The patient will be responsible for services denied by insurance due to “No Referral Obtained”.

Prescription Policy: If you need a prescription refill, please contact your pharmacy. They will contact us for refill authorization.

Missed/Cancelled Appointments: Appointment reminder calls/texts are a courtesy our office provides. It is your responsibility for having your correct contact information on file with us. If you fail to cancel your appointment within 24 hours or failure to show up for an appointment will result in a $50 fee for regular medical appointments, $75.00 fee for procedure and cosmetic appointments. Three consecutive missed appointments in one family will result in dismissal from our practice.

Late Arrivals:
>New Patients: If you arrive 10 minutes late for your appointment, you will be asked to reschedule.
>Established Patients: If you arrive 15 minutes late for your appointment, you will be asked to reschedule.

Medical Records: Medical records can be obtained by accessing your chart through fvd.ema.com. Please allow 30 days for record requests to another entity. There may be a fee associated with all records released via mail or fax.

Pathology/Laboratory Services: Our office uses third parties for our laboratory work and pathology services. They will bill your insurance and/or you for the services they provide. We are unable to discuss these charges as they are provided by a separate entity. All tissue removed will be sent to a lab for further testing.

Medical Questions: When calling the office with medical questions, you will be directed to a voicemail if a medical assistant is not available. We will do our best to return calls before 5pm. Messages left after 4pm will be returned the following business day.

Minor Policy: All minor patients must be seen on the first visit with their Parent or Guardian. Written authorization must be obtained for future appointments unaccompanied by a Parent/Guardian.

Billing Questions: When calling with a billing question, you will be directed to a voicemail. We will do our best to return calls within 48 hours.

After Hours: If you need to reach us for urgent medical matters, call the office and follow the instructions to reach the provider on call. DO NOT leave prescription requests or appointment cancellation information in the providers voicemail.

I understand and agree to abide by Farmington Valley Dermatology’s financial and office polices.

____
Patient Name (Print)

____ ____________________
Patient/Parent/Legal Guardian Signature Date