

PATIENT REGISTRATION

Date: _____ **Date of Birth:** ____/____/____ **Sex:** Male / Female
Name: _____ **Primary Number:** _____
 Home / Cell / Work
Street: _____ **Secondary Phone:** _____
 Home / Cell / Work
City: _____ **State:** _____ **Zip:** _____
Patient SSN: _____ - _____ - _____ **Email:** _____
Occupation: _____ **Spouse/Parent Name:** _____
Employer: _____ **Spouse/Parent Employer:** _____

Emergency Contact
Name: _____ Relationship: _____
Phone Number: _____

Primary Care Provider: _____
Referred By Physician: Yes / No
Physician Name: _____

BILLING INFORMATION

Payment of insurance copay or for any cosmetic services is expected the day of services are rendered.
 We accept MasterCard, Visa, Discover, American Express, Checks, and Cash.

Responsible Party (person responsible for any remaining balance due)
Name: _____ Relationship: _____ Date of Birth: ____/____/____
Street Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ - _____ - _____ Phone Number: _____ Home / Cell

Primary Insurance Name: _____
Name: _____ Relationship: _____ Date of Birth: ____/____/____
Home Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ - _____ - _____ Phone Number: _____ Home / Cell

Secondary Insurance Name: _____
Name: _____ Relationship: _____ Date of Birth: ____/____/____
Home Address: _____ City: _____ State: _____ Zip: _____
SSN: _____ - _____ - _____ Phone Number: _____ Home / Cell

PAYMENT POLICY

Payment of all co-pays is due at the time of service. As a service to you, our office will bill your insurance company. Being a participating provider with most insurance companies, the insurance companies require that we collect these fees, as they are terms of your health care contract. Additionally, patients are ultimately responsible for all balances, if you should have any. Our mission is to provide you with the highest quality dermatological care possible. With this in mind, we are constantly trying to control our costs while conforming to the standard fee schedules approved by most major insurance companies. Our receptionist will need to verify your insurance coverage prior to your visit.

1. Any outstanding balances should be paid before your office visit or procedure, unless prior payment arrangements have been made.
2. Your insurance is a contract between you and the insurance company. While we accept the reimbursement rates of many insurance companies, we are not a party to your contract and do not determine which are medically necessary services that they cover and which they do not.
3. We require payment in full on the date of service for co-pay and offices charges defined under your policy as your responsibility.
4. A \$40 administrative fee for delayed payment will be added to your balance if you choose not to pay at the time services are rendered. This \$40 fee is not billable to your insurance company; it is your responsibility. To avoid this fee, you must pay at the time of service.
5. We expect you to call us if you are not able to make it your appointment. For your convenience, we may make an attempt to remind you of your appointment. Your appointment is a reservation of the office' staff and provider's time and resources.

We realize that on occasion, temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact the billing department in our office for assistance.

I hereby authorize direct payment of surgical/medical benefits to Musick Dermatology & Advanced Clinical Spa, LLC for services rendered by the physician or under the physician's supervision. I understand that I am financially responsible for any balance not covered by my insurance and if necessary reasonable attorney and court fees incurred to collect said professional fees due to Musick Dermatology & Advanced Clinical Spa, LLC for medical services rendered to me.

Patient Signature/Parent of Legal Guardian: _____ **Date:** _____

PROTECTED HEALTH INFORMATION

This acknowledgement of notice and consent authorizes Musick Dermatology & Advanced Clinical Spa, LLC to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices: Musick Dermatology & Advanced Clinical Spa, LLC has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgement and consent.

Amendment: We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

I have received the Notice of Privacy Practices for Musick Dermatology & Advanced Clinical Spa, LLC and authorize Musick Dermatology & Advanced Clinical Spa, LLC to release and obtain health information about me from other physicians and medical facilities for continued care.

I hereby authorize Musick Dermatology & Advanced Clinical Spa, LLC to discuss any medical information for the treatment of my care. Person(s) to whom information may be disclosed below: spouse, parent(s), legal guardian, or other.

Name of person/Relationship

Name of person/Relationship

Patient Signature/Parent of Legal Guardian: _____ **Date:** _____

MEDICAL HISTORY

Drug Allergies: _____

Latex Allergy: Yes / No

Local Anesthetic (Xylocaine) Allergy: Yes / No

Chronic Illness: _____

Past Surgeries: _____

Do you have any artificial joints: Yes / No

Mitral valve prolapse or artificial heart valve: Yes / No

Alcohol Intake: _____

Smoking History: _____

Family Diseases: _____

SKIN DISEASE HISTORY

Check All That Apply:

- | | | |
|---|---|--|
| <input type="checkbox"/> Acne | <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Actinic Keratosis | <input type="checkbox"/> Flaking or Itchy Scalp | <input type="checkbox"/> Squamous Cell Carcinoma |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hay Fever/Allergies | <input type="checkbox"/> NONE |
| <input type="checkbox"/> Basal Cell Skin Cancer | <input type="checkbox"/> Melanoma | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> Blistering Sunburns | <input type="checkbox"/> Poison Ivy | _____ |
| <input type="checkbox"/> Dry Skin | <input type="checkbox"/> Precancerous Moles | |

Do you wear sunscreen? Yes / No

Do you tan in a tanning salon? Yes / No

Do you have a family history of Skin Cancer? Yes / No If yes, which relative(s)? _____

REVIEW OF SYSTEMS

Do you have any recent problems with the following? If yes, please describe in this space.

- Fevers/Chills/Weight loss? Yes / No
Sore eyes/Dry eyes? Yes / No
Sores in mouth or nose? Yes / No
Chest pains/Leg swelling? Yes / No
Burning urination/Frequent urination? Yes / No
Muscle or joint pains? Yes / No
Numbness of feet/Dizziness? Yes / No
Depressed/Anxious mood? Yes / No
Fatigue/Cold intolerance? Yes / No
Swollen lymph glands? Yes / No
Runny nose/Stuffiness/Asthma? Yes / No

MEDICATION LIST

Patient Name: _____

Date of Birth: ____/____/____

Name of Medication	Dosage	Frequency

PHARMACY INFORMATION

Preferred Pharmacy

Name: _____

City: _____ State: _____ Zip Code: _____

Phone Number: _____

HIPAA PATIENT CONSENT FORM

Musick Dermatology & Advanced Clinical Spa, LLC, Notice of Privacy Practices provides information about how we may use and disclose protected health information about you in accordance to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Notice contains a Patient Rights section describing your rights under the law. You have the right to review out Notice before signing this consent. The terms of our Notice are subject to change. If we change our Notice, a new Notice will be available at the reception desk or you may obtain a revised copy by contacting our office located at 4948 Benchmark Centre Drive, Swansea, IL 62226 or by calling (618) 628-2588.

You have the right to request that Musick Dermatology & Advanced Clinical Spa, LLC restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. Musick Dermatology & Advanced Clinical Spa, LLC is not required to agree to this restriction, but if we do, Musick Dermatology & Advanced Clinical Spa, LLC shall honor that agreement.

By signing this form, you consent to Musick Dermatology & Advanced Clinical Spa, LLC's use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. Musick Dermatology & Advanced Clinical Spa, LLC provides this form to comply with the HIPAA guidelines.

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations
- Musick Dermatology & Advanced Clinical Spa, LLC has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- Musick Dermatology & Advanced Clinical Spa, LLC reserves the right to change the Notice of Privacy Practices
- The patient has the right to restrict the uses of their information but Musick Dermatology & Advanced Clinical Spa, LLC does not have to agree to those restrictions
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease
- Musick Dermatology & Advanced Clinical Spa, LLC may condition receipt of treatment upon the execution of this Consent.

Name of Patient: _____

**Signature of Patient or
Legal Representative:** _____

Date: ___/___/___

If signed by someone other than the patient:

Print Name: _____

**Relationship to Patient
(if other than patient):** _____

Date: ___/___/___