



New Patient Registration Form

Name Last First Today's date M.I.

Mailing Address Number, Street, Apartment Number Age

City State Zip

Home Phone Cell Phone Work Phone

E-Mail Address

Date of Birth SS # Marital Status Sex

Employer Full Time Part Time Retired Student

Spouse's Name: Employer Work #

Person to notify in case of emergency Relationship

Phone Number (H/W/C) Phone Number (H/W/ C) (Please list a person not living in your home)

Referring Doctor Primary Care Doctor

May we leave a message on your home answering machine or cell phone? Y N

May we leave a message for you at work to call us? Y N

May we discuss your medical condition with another person? Y N

If yes, whom Relationship

How did you hear about our practice?

Policy Holder (if different from patient or responsible party)

Policy Holder's Date of Birth SS#

Employer of Policy Holder Work Phone

Patient's Relationship to Policy Holder

If patient is a minor please enter responsible party information. (Note: We do not bill absent parents, the adult presenting the minor for care is the responsible party.)

Name Last First SS# M.I.

Address Number, Street, Apartment Number DOB

City State Zip

Home Phone Work Phone Cell Phone

PLEASE PRESENT THESE FORMS WITH YOUR INSURANCE CARD AND DRIVER'S LICENSE TO THE RECEPTIONIST



Assignment of Benefits

MEDICARE

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card Date

MEDIGAP (Supplemental Insurance) Policies

If you have a supplemental policy and it is a MEDIGAP policy or other policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP Card Date

ALL INSURANCE EXCEPT MEDICARE

I authorize my insurance company to pay benefits on my behalf directly to Premier Dermatologic Surgery. I authorize Premier Dermatologic Surgery to provide to my insurance company, any information necessary to process claims for services rendered to me.

Signature as it appears on your insurance card Date

Y N Do you or your spouse work in a company which has more than 20 employees and have coverage through insurance at that job?

Y N Are you covered by any other insurance that makes Medicare secondary?

Acknowledgment of Receipt of Notice of Privacy Policies

We are required by law to provide you with a copy of our Notice of Privacy Practices. To ensure that our records are accurate, we ask that you please sign this form and return it to our receptionist to acknowledge that you have been provided with a copy of our Notice. I have been given the option of signing a separate Patient Consent Form.

Signature of Patient Date

Signature of Staff Member Title Date



Patient Financial Policy

This office has contracts with Medicare and many other health insurance plans. Please check with our reception staff to determine whether your plan is one of these.

You are expected to present your insurance card at each visit. If we have a contract with your plan, we will file a claim with your insurance company. **All copays, deductibles, coinsurance percentages or fees for non-covered services are required at the time of service. Any past due balances are also due and payable at the time of service.**

If your insurance has designated a primary care physician (PCP), **you are required to have prior authorization from your PCP prior to your office visit.** If this authorization is not provided, you will be asked to either reschedule your appointment or pay for your visit at the time of service.

Payment is required at the time of service for all **SELF-PAY ACCOUNTS.** Self-pay accounts include:

- 1) Patients without an insurance card on file;
- 2) Patients who are covered by carriers (i.e. insurance companies) with which Premier Dermatologic Surgery, P.A. does not participate; or
- 3) Patients who have not met their deductible.

If at any time you are concerned about the cost of a procedure proposed by the provider, you may ask for someone from the business office who will be happy to discuss the cost with you.

For your convenience, this office accepts Master Card, Visa, Discover, and American Express, in addition to cash and checks. **All balances must be paid in full when billed.** It is the policy of the practice not to accept checks marked "Paid in Full", as statements do not reflect charges pending with insurance companies.

For Cosmetic or Self Pay Procedures: 50% is due when the procedure is scheduled and the balance is due at the time of service. Cancellations made within three business days of scheduled service are subject to forfeiture of the deposit.

Please note that even if a procedure is medically necessary and "covered" by a given insurance, **there may be deductibles or coinsurance amounts that are your responsibility and required at the time of service.**

If you do not pay your account balance in full, when due, you may be sent to the credit bureau for collection. All collection fees and court costs will be added to your balance due.

If a patient is due a refund, the practice will issue a check once the following criteria are met: You have not been seen in the office for 30 days; there are no outstanding insurance claims on your account; there are no outstanding patient balances on your account.

It is our hope that the above financial policy will serve as notification to you, our patient, of your responsibilities in order for us to provide you the best quality of care. **If you have any questions or need clarification of any of the above policies, please do not hesitate to contact our business office at (913) 327-1117 or speak to a staff member.**

I certify that I have read the financial policy of Premier Dermatologic Surgery, P.A., and agree to abide by the policy.

Signature \_\_\_\_\_ Date \_\_\_\_\_



New Patient Medical History Form

Patient: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

Referred by:  Self  Relative/Friend  Dr. \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

Body site(s) involved: \_\_\_\_\_

When did it begin? \_\_\_\_\_

What symptoms are associated?  None  Bleeding  Scabbing  Crusting  Never seems to heal
 Tenderness  Irritation  Other: \_\_\_\_\_

Was this ever treated before?  No  Yes:  Surgery  Freezing/Burning  Medication: \_\_\_\_\_

Please list your current medications: \_\_\_\_\_

Do you take aspirin, Plavix, or Coumadin/warfarin? Yes  No

Do you have any allergies to medications? Yes  No  Pharmacy Name / Phone: \_\_\_\_\_

If yes, list medication and reaction type: \_\_\_\_\_

Please check appropriate box(es) of any of your past or current medical conditions:

General

- Unexplained fever
 Unexplained weight change
 Night sweats
 Anorexia
 Other:

Skin

- Abnormal scarring
 Poor wound healing
 Sensitive skin
 Cold sores/fever blisters
 Other:

Infectious Disease

- HIV/AIDS
 Tuberculosis
 Hepatitis B
 Hepatitis C
 Other:

Cardiac

- PACEMAKER
 DEFIBRILLATOR
 Bypass surgery
 High blood pressure
 Heart murmur
 Chest pain
 Other:

Pulmonary

- Shortness of breath
 Cough
 Asthma
 Other:

Endocrine

- Diabetes
 Thyroid disease
 Other:

Gastrointestinal

- Nausea/vomiting/diarrhea
 Colon polyp or cancer
 Irritable bowel disease
 Other:

Renal/Urology

- Dialysis
 Prostate disease
 Other:

Orthopedic

- Artificial joint
 Prosthesis
 Other:

Hematologic:

- Bleeding disorder
 Easy bruising
 Blood clots
 Other:

Immune system

- Organ transplant
Type: \_\_\_\_\_
 Previous or current cancer
Type: \_\_\_\_\_
 Current or past chemotherapy
 Other:

Neurologic

- Stroke
 Dizziness
 Weakness or arms/legs
 Decreased sensation
 Other:

Ob/gyn

- Currently pregnant
 Trying to conceive
 Hysterectomy
 Frequent yeast infections
 Other:

Please list any other medical conditions: \_\_\_\_\_

Please list any previous surgeries with dates: \_\_\_\_\_

Skin Cancer and Surgery Related Questions:

Have you ever had a skin cancer? Yes  No  List: \_\_\_\_\_

Have you ever had a sunburn? Yes  No

Do you have a family history of skin cancer? Yes  No  Was it a melanoma? Yes  No  Uncertain

Have you previously used a tanning booth? Yes  No  Do you currently or periodically use a tanning booth? Yes  No

Do you take sun protective measures?  No  Yes: Sunscreen  Sunglasses  Hat  Avoiding midday sun

How often do you monitor your skin for sun damage/cancer?  Not regularly  Monthly self check  Routine check-up w/ Dr.

Occupation: \_\_\_\_\_ Hobbies: \_\_\_\_\_

Do you smoke? Yes  No  If yes, how many packs per day? \_\_\_\_\_

Do you drink alcohol? Yes  No  If yes, how many drinks per week? \_\_\_\_\_

This form was completed by:  Patient  Family or friend  Medical Staff \_\_\_\_\_
Initials

Patient accompanied by:  Spouse  Other family member:  Parent  Friend

I hereby acknowledge that the completed information is accurate.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_



Notice of Health Information Privacy Practices

Effective Date: April 14, 2003

*This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.*

We are required by law to provide you with this notice that explains our privacy practices with regard to your medical information and how we may use and disclose your protected health information for treatment, payment and for health care operations, as well as for other purposes that are permitted or required by law. You have certain rights regarding the privacy of your protected health information, and we also describe them in this notice.

**Ways in Which We May Use and Disclose Your Protected Health Information:**

The following paragraphs describe different ways that we use and disclose your protected health information. We have provided an example for each category, but these examples are not meant to be exhaustive. We assure that all of the ways we are permitted to use and disclose your health information fall within one of these categories.

**Treatment.** We will use and disclose your protected health information to provide, coordinate or manage your health care and any related services. We will also disclose your health information to other physicians who may be treating you. Additionally we may, from time to time, disclose your health information to another physician whom we have requested to be involved in your care. For example, we would disclose your health information to a specialist to whom we have referred you for a diagnosis to help in your treatment.

**Payment.** We will use and disclose your protected health information to obtain payment for the health care services we provide you. For example, we may include information with a bill to a third-party payer that identifies you, your diagnosis, procedures performed and supplies used in rendering the service.

**Health Care Operations.** We will use and disclose your protected health information to support the business activities of our practice. For example, we may use medical information about you to review and evaluate our staff's performance while caring for you. In addition, we may disclose your health information to third party business associates who perform billing, consulting or transcription services for our practice.

**Other Ways We May Use and Disclose Your Protected Health Information:**

**Appointment Reminders.** We will use your protected health information to contact you or mail you a reminder about scheduled appointments or treatments.

**Treatment Alternatives.** We will use and disclose your protected health information to provide you with information about or to recommend possible alternative treatments or options that may be of interest to you.

**Others Involved in Your Care.** When necessary, we will use and disclose your protected health information to a family member, a relative, a close friend or any other person you identify who is involved in your medical care or payment for care.

**Research.** We will use and disclose your protected health information to researchers provided the research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

**As Required by Law.** We will use and disclose your protected health information when required to by federal, state or local law. You may request an accounting of such disclosures at any time. There may be a small charge associated with a second or subsequent request within any twelve month period.

**To Avert a Serious Threat to Public Health or Safety.** We will use and disclose your protected health information to a public health authority that is permitted to collect or receive the information for the purpose of controlling disease, injury or disability. If directed by that health authority, we will also disclose your health information to a foreign government agency that is collaborating with the public health authority.

**Worker's Compensation.** We will use and disclose your protected health information for worker's compensation or similar programs that provide benefits for work-related injuries or illness in accordance with state law.

**Inmates.** We will use and disclose your protected health information to a correctional institution or law enforcement official if you are an inmate of that correctional institution or under the custody of the law enforcement official. This information would be necessary for the institution to provide you with health care to protect the health and safety of others; or for the safety and security of the correctional institution.

**Your Health Information Rights**

Although your health record is the physical property of the health care practitioner or facility that compiled it, the information belongs to you. You have the right to:

**A Paper copy of This Notice.** You have the right to receive a paper copy of this notice. If we have not already provided you with a copy, you may obtain a copy by asking our receptionist at your next visit or by calling and asking us to mail you a copy.

**Inspect and Copy.** You have the right to inspect and copy the protected health information that we maintain about you in our designated record set for as long as we maintain that information. The designated record set includes your medical and billing records, as well as any other records we use in making medical decisions about you. Any psychotherapy notes about you that may have been included in records we received from other sources are not available for your inspection or copying by law. We may charge you a fee for the costs of copying, mailing or other supplies used in fulfilling your request as allowed by law.

If you wish to inspect or copy your medical information, you must submit your request in writing, bearing your signature, to our Privacy Officer at Premier Dermatologic Surgery, 12200 W 106<sup>th</sup> St., Ste. 210, Overland Park, KS 66215; fax 913-327-1119. Your may mail or fax in your request, or bring it to our office. We will have 30 days to respond to your request regarding information that we maintain at our practice site. If the information is stored off-site, we are allowed up to 60 days to respond, but we must inform you of this delay.



**Notice of Health Information Privacy Practices (continued)**

**Request Amendment.** You have the right to request that we amend your medical information if you feel that it is incomplete or inaccurate. You must make this request in writing to our practice manager, stating exactly what information is incomplete or inaccurate, and the reasoning that supports your request.

We are permitted to deny your request if it is not in writing or if it does not include a reason to support the request. By law, we may also deny your request if:

- the information was not created by us, or the person who created it is no longer available to address the requested amendment;
- the information is not part of the records which you are permitted to inspect and copy;
- the information is not part of the designated record set kept by this practice;
- or if it is the opinion of the health care provider the information is accurate and complete.

**Request Restrictions.** You have the right to request a restriction or limitation of how we use or disclose your medical information for treatment, payment or health care operations. For example, you could request that we not disclose information about a prior treatment to a family member or friend who may be involved in your care or payment for that care. Your request must be made in writing to our practice manager.

We are not required to agree to your request if we feel it is in your best interest to use or disclose that information. However, if we do agree, we will comply with your request unless that information is needed for emergency treatment.

**An Accounting of Disclosures.** You have the right to request a list of the disclosures of your health information we have made outside of our practice that were not for the treatment, payment or health care operations (e.g. as required by law). Your request must be made in writing and must state the specific time period for the requested information. You may not request information for any dates prior to April 14, 2003 (the compliance date for the federal regulation) nor for a period of time greater than six years (our legal obligation to retain information).

Your first request for a list of disclosures within a 12-month period will be free. If you request an additional list within 12-months of the first request, we may charge you a fee for the cost of providing the subsequent list as allowed by state law. We will notify you of such cost and afford you the opportunity to withdraw your request before any costs are incurred.

**Request Confidential Communications.** You have the right to request how we communicate with you to preserve your privacy. For example, you may request that we call you only at your work number, or by mail at a special address or postal box. Your request must be made in writing and must specify how or where we are to contact you. We will accommodate all reasonable requests.

**File a Complaint.** If you believe we have violated your medical information privacy rights, you have the right to file a complaint with our Privacy Officer or directly to the Secretary of Health and Human Services.

To file a complaint with our Privacy Officer, you must make it in writing within 180 day of the suspected violation. Provide as much detail as you can about the suspected violation and send it to the attention of our Privacy Officer at Premier Dermatologic Surgery, P.A., 12200 W 106<sup>th</sup> St., Ste. 210, Overland Park, KS 66215; fax 913-327-1119. You should know that there can be no retaliation for your filing a privacy complaint.

**Uses or Disclosures Not Covered**

Uses or disclosures of your health information not covered by this notice, or the laws that apply to us, may only be made with your written authorization. For example, if you request that we transfer your medical records to another provider, we will ask you to sign an authorization to do so. You may revoke such authorizations in writing at any time and we will no longer disclose health information about you for the reasons stated in your written authorization. Disclosures made in reliance on the authorization prior to the revocation are not affected by the revocation.

**For More Information**

If you have questions or would like additional information regarding our privacy practices, you may contact our Privacy Officer at 913-327-1117.  
Effective Date: April 14, 2003

Rev. 4/7/2010

Map and Directions to Our Office

Premier Dermatologic Surgery is located in the **Medical Plaza West Building on the west side of the Overland Park Regional Medical Center Campus**. We are located on the 2<sup>nd</sup> floor in Suite 210. We are easily accessible from I-435, I-35 and Highway 69. Convenient, free patient parking is available directly across from the entrance to the building.

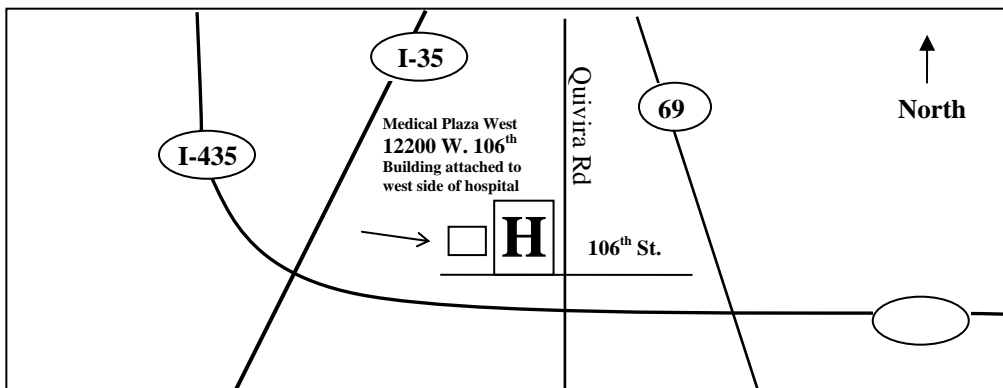
**From the West:** Take I-435 South/East to Quivira Road. Turn left (North) on Quivira and proceed to 106<sup>th</sup> Street (the exit to Overland Park Regional Medical Center). Turn left (West) and proceed past the Doctor's Medical Building and the Hospital entrance. Just west of the Hospital is the parking lot of the Medical Plaza West Building. Reserved patient parking is found directly across from the entrance to the building.

**From Olathe/South I-35:** Take I-35 North to I-435 East. Exit at Quivira Road. Turn left (North) on Quivira and proceed to 106<sup>th</sup> Street (the exit to Overland Park Regional Medical Center). Turn left (West) and proceed past the Doctor's Medical Building and the Hospital entrance. Just west of the Hospital is the parking lot of the Medical Plaza West Building. Reserved patient parking is found directly across from the entrance to the building.

**From South/Highway 69:** Take Highway 69 North to I-435 West. Exit at Quivira Road. Turn right (North) on Quivira, remaining in the lane designated as the hospital exit. The 1<sup>st</sup> stoplight is 106<sup>th</sup> Street (the exit to Overland Park Regional Medical Center). Turn left (West) and proceed past the Doctor's Medical Building and the Hospital entrance. Just west of the Hospital is the parking lot of the Medical Plaza West Building. Reserved patient parking is found directly across from the entrance to the building.

**From the East:** Take I-435 West to Quivira Road. Turn right (North) on Quivira, remaining in the lane designated as the hospital exit. The 1<sup>st</sup> stoplight is 106<sup>th</sup> Street (the exit to Overland Park Regional Medical Center). Turn left (West) and proceed past the Doctor's Medical Building and the Hospital entrance. Just west of the Hospital is the parking lot of the Medical Plaza West Building. Reserved patient parking is found directly across from the entrance to the building.

**From the North:** Take I-35 South to I-435 East. Exit at Quivira Road. Turn left (North) on Quivira and proceed to 106<sup>th</sup> Street (the exit to Overland Park Regional Medical Center). Turn left (West) and proceed past the Doctor's Medical Building and the Hospital entrance. Just west of the Hospital is the parking lot of the Medical Plaza West Building. Reserved patient parking is found directly across from the entrance to the building.



**Phone: (913) 327-1117**