PREMIER *medical group*

INSTRUCTIONS

Page 1 - *Patient Registration Form* - fill out entire page and sign at bottom of page.

Page 2 - Complete *Records Release Form* as required for your upcoming office visit.

Page 3 – Complete the *Health History Questionnaire* (per specialty).

Bring all paperwork, filled out, to your scheduled appointment along with:

- Medical insurance and prescription cards
- Any recent labs or radiology workups
- Picture ID
- List of medications

If your insurance requires a referral, you must bring it with you at the time of service or you will be required to sign a waiver holding you responsible.

NO SHOW POLICY

A FEE MAY BE CHARGED TO ANY PATIENT WHO DOES NOT CANCEL THEIR OFFICE VISIT WITHIN 24 HOURS AND WILL BE CHARGED FOR ANY NO SHOW FOR AN OFFICE PROCEDURE.

CO-PAYS ARE EXPECTED AT THE TIME OF SERVICE

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PATIENT REGISTRATION FORM

PATIENT ACCOUNT NUMBER: _____

PATIENT INFORMATION

PATIENT NAME (LAST, FIRST, MIDDLE INITIAL) SEX ❑ MALE ❑ FEMALE	PRIMARY PHYSICIAN
PATIENT'S ADDRESS	EMERGENCY CONTACT AND TELEPHONE #
CITY STATE ZIP	STUDENT STATUS: If 18 years or older: (Circle one) Full Time Part Time Not a Student
TELEPHONE ( ) CELL PHONE ( ) DATE OF BIRTH ___/___/___ MO DAY YEAR	MARITAL STATUS: (Circle one) Single Married Separated Divorced Widowed
RACE: **ETHNICITY:**	**PRIMARY LANGUAGE:** / **EMAIL ADDRESS:**

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME COPAY _____	SECONDARY INSURANCE COPAY _____
INSURANCE ADDRESS	INSURANCE ADDRESS
CITY STATE ZIP	CITY STATE ZIP
INSURED'S ID NUMBER GROUP PLAN NUMBER	INSURED'S ID NUMBER GROUP PLAN NUMBER
PATIENT'S EMPLOYER NAME TELEPHONE ( )	**PHARMACY NAME** **TELEPHONE** ( )
EMPLOYER'S ADDRESS	**PHARMACY ADDRESS**
CITY STATE ZIP	CITY STATE ZIP

RESPONSIBLE PARTY INFORMATION

RESPONSIBLE PARTY'S NAME (LAST, FIRST, MIDDLE)	SEX ❑ MALE ❑ FEMALE	LEGAL REPRESENTATIVE ❑ YES ❑ NO
RESPONSIBLE PARTY'S ADDRESS	EMPLOYER'S NAME	
CITY STATE ZIP	EMPLOYER'S ADDRESS	
TELEPHONE ( )	RELATIONSHIP TO PATIENT SPOUSE PARENT GUARDIAN OTHER _____	

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance.

If your insurance requires a written referral from your physician and you do not obtain one prior to your visit or procedure, you will be responsible for payment for Services rendered.

COPAYMENTS ARE EXPECTED AT THE TIME SERVICES ARE RENDERED.

If this account is assigned to an attorney of collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.
I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.
I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to the practice named on this form.
This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I AGREE TO THE ASSIGNMENTS AND FINANCIAL RESPONSIBILITIES SHOWN ON THIS PAGE. **YOU SHOULD READ THESE TERMS CAREFULLY.** THANK YOU FOR YOUR COOPERATION.

X _____ DATE _____
SIGNED (Patient, or parent if under 18 years of age)

PREMIER medical group

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE: _____

I hereby authorize _____to disclose the following Protected Health Information (PHI) to _____.

PHYSICIAN PHONE: _____FAX: _____

The following information is to be disclosed: (please check off those that apply)

Physician notes _____ Dates _____
Lab results _____ Dates _____
X-Ray reports _____ Dates _____
Operative reports _____Dates _____
COMPLETE RECORD _____
Other: _____

The PHI to be used or disclosed for the following purposes:

I understand that the information in my record may include information relating to sexually transmitted diseases (STD), Acquired Immunodeficiency Syndrome (AIDS), or infection of the Human Immunodeficiency Virus (HIV). It may also include information about behavioral or mental health services or treatment for alcohol or drug abuse.

PREMIER MEDICAL GROUP will not determine my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide an authorization. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal or State laws.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed). DATE: _____

Signature of patient or patient representative

_____

Date

_____

Revised 4/29/15

PREMIER *medical group*

AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____

ADDRESS: _____

_____

TELEPHONE: _____

I hereby authorize _____ to disclose the following Protected Health Information (PHI) to _____.

PHYSICIAN PHONE: _____FAX: _____

The following information is to be disclosed: (please check off those that apply)

Physician notes _____ Dates _____
Lab results _____ Dates _____
X-Ray reports _____ Dates _____
Operative reports _____Dates _____
COMPLETE RECORD _____
Other: _____

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Unless otherwise revoked, this authorization will expire on the following date, event or condition: (if I do not specify an expiration date, event or condition, this authorization will expire in one year from the date signed). DATE: _____

Signature of patient or patient representative

_____

Date

_____

Revised 4/29/15

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Patient name_____ Date of Birth_____

Primary Care Physician_____

Past Medical History:

Please check all conditions that apply to you:

- ☐ Arthritis
- ☐ Atrial fibrillation
- ☐ Bone marrow transplant
- ☐ Breast cancer
- ☐ Colon cancer
- ☐ COPD
- ☐ Coronary artery disease
- ☐ Depression
- ☐ Diabetes
- ☐ End stage renal failure
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ HIV/AIDS
- ☐ Leukemia
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Prostate cancer
- ☐ Radiation treatment
- ☐ Seizure disorder
- ☐ Stroke
- ☐ Other_____

Please list any medications you are currently taking:

_____**Dose**_____
_____**Dose**_____
_____**Dose**_____
_____**Dose**_____
_____**Dose**_____
_____**Dose**_____
_____**Dose**_____
_____**Dose**_____
_____**Dose**_____

Please list any medications you are allergic to and your reaction:

_____
_____
_____
_____
_____

Check each skin condition that applies to you:

- ☐ Acne
- ☐ Actinic keratosis
- ☐ Asthma
- ☐ Blistering sunburn
- ☐ Dry Skin
- ☐ Eczema
- ☐ Flaking or itchy scalp
- ☐ Poison ivy
- ☐ Precancerous moles
- ☐ Psoriasis
- ☐ Poor healing
- ☐ Basal cell carcinoma
- ☐ Squamous cell carcinoma
- ☐ Melanoma
- ☐ Bleeding disorder
- ☐ Hay fever/Allergies
- ☐ Other_____

Family Health:

Have any of these member of your family been diagnosed with melanoma?

☐ Mother ☐ Father ☐ Sister
☐ Brother ☐ Unknown ☐ No

Social History:

Do you or did you smoke?

☐ Current every day ☐ Current some day
☐ Former smoker ☐ Never smoker

Do you drink alcohol?

☐ Regularly ☐ Occasionally
☐ Rarely/Socially ☐ No, I don't drink

Please list any major surgeries you've had:

_____
_____
_____
_____
_____

Signature_____ Date_____
(Parent or guardian if patient is a minor)

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PATIENT CONSENT FOR MEDICAL PHOTOGRAPHY

During your visit (s) to Premier Medical Group of the Hudson Valley, PC, your dermatologist may find it necessary to photo-document the specific location and appearance of your symptoms in order to best diagnose and treat your condition.

By signing below, I consent for medical photographs to be taken of me (or my child or person for whom I am legal guardian) and stored in our HIPAA compliant Electronic Medical Records system. I understand that the information may be used for my medical record and for third party diagnostics and treatments.

Patient
Name:_____

Signature: _____
Date:_____

(If minor, signature of parent or guardian):

_____