WASHINGTON DC DERMATOLOGY

1140 Connecticut Ave., NW, Suite 675, Washington DC 20036
(One block from Farragut North, Two blocks from Farragut West Metro)

Patient Registration

First Name _____ Last Name _____

Address _____ Apt.# _____ City _____ State _____ Zip Code _____

Home Telephone _____ Cell _____ Work _____

Employer _____ Full Time Student ☐ Yes ☐ No

Email Address _____

Sex: ☐ Male ☐ Female Date of Birth _____ Marital Status S M D W

Race _____ Ethnicity _____ Language _____

Primary Care MD _____ Phone _____

Emergency Contact _____ Telephone _____

Insurance Information

Primary Insurance _____ Policy # / Member ID _____ Group # _____

Policy Holder _____ Relationship To Patient _____

SSN _____ Address Of Policy Holder (Address if different from above) _____

City _____ State _____ Zip Code _____ Home Phone _____

DOB _____

Secondary Insurance

Name _____ Policy # / Member ID _____ Group # _____

Address Of Policy Holder _____ Subscriber's Name/DOB _____

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Financial Policy Agreement
Waiver for payment of services

Your insurance company may deny any procedure and/or visit. If my insurance company does not pay for these services, I agree to pay in full what my insurance deems my responsibility. Washington DC Dermatology has no input into the insurance companies classification of procedures.

I *understand my insurance policy and my benefits, I am aware that copayment for each office visit is due at the time of my visit. I also understand this office may bill me for my deductible, coinsurance and/or any other out-of-pocket charges as per my insurance plan.
Insurance companies classify some dermatological procedures as cosmetic, your provider will let you know before any treatment or procedure is performed.

It is also my responsibility to keep referrals up to date if required by my insurance provider.
_____ (Initials)

Collections and outstanding balances

Washington DC Dermatology reserves the right to add a $15 monthly statement processing fee on any account that has an unpaid balance.

Any outstanding balance after 90 days of the date of service may be referred to an outside collection agency. Accounts referred to an outside collection agency or attorney may be subject to a collection fee of 25%, which will be added to the account at the time of write off.

Patients with unpaid delinquent accounts or accounts which have been sent to collections may be discharged from the practice.

I understand that I will be responsible for any cost(s) associated with the collection of my account if I default on this agreement. I understand that the terms of this financial agreement may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

By signing below, I have read and fully understand the contents of this financial policy.

Signature _____ Date _____

Print _____

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HIPAA Statement

Your health information is personal and confidential. We have policies in place to protect your information against unlawful use and disclosure. Personal health information is any information that relates to the physical or mental condition of a patient. Our office may collect information such as your name, address, telephone number, social security number, date of birth, medical history, diagnosis, treatment, family and emergency contacts. We take all precautions to protect against unauthorized use and disclosure of this information. You have the right to ask in writing to restrict use of your personal health information related to treatment, payment or routine health care facility operations. You may request disclosure restrictions to family members. Our practice will honor your request except in the case of emergency. If you believe your privacy rights have been violated, contact us immediately. Please include your name, address, telephone number and a brief description of you concerns. You may also register an anonymous complaint. Contact the Secretary of the Department of Health and Human Services at:

US Department of Health and Human Services
200 Independence Ave. SW
Washington, DC 20001

I have read the above statement which will be filed in my medical records and I can receive a copy of this statement per my request.

_____ _____

Name Date

_____

Relationship (If not the patient)

If you would like to authorize someone else access to your medical records (Spouse, Parent, Son/Daughter, other family member) please list name, telephone number and relationship to the person being authorized.

_____ _____

Name Telephone Number

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No Show / Cancellation Policy

If you fail to notify us before 48 hours of your scheduled appointment, a $75 No Show Fee will be billed to your account. You must call and leave a message or speak to someone in our office.
Email cancellation send 48 hours prior to scheduled appointment – admin@washingtondcdermatology.com

I have read and agree to the above statements.

_____

Signature

_____

Print Name

_____

Date

Please Read Carefully

1. Patient will be responsible for all amounts not covered by insurance. We accept Visa, Mastercard, American Express and Discover. etc.
2. I acknowledge that I am fully responsible for all charges incurred for services rendered to me. Any payments received from an insurance company will be credited to my account and I will be liable for any unpaid balance. I understand that if I don't pay, I may be transferred to a collection agency.
3. I hereby authorize the release of all information relating to any claim for benefits on behalf of myself and/or my dependents. My signature on this document authorizes Yolanda C. Holmes, M.D., F.A.A.D. to submit claims for benefits arising from services rendered.

Signature _____ **Date** _____

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Medical History

Patient _____ Date of Birth _____ Today's Date _____

Reason for todays visit _____

Do you have or have you had any of the conditions and/or diseases listed (please check Yes/No)

Lungs:	Yes	No
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐
Cardiovascular:	☐	☐
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heart Beat	☐	☐
Phlebitis	☐	☐
Inflammation of Vein	☐	☐
Blood Clots	☐	☐
Pacemaker	☐	☐
Cancer:	☐	☐
Type: _____		

	Yes	No
Diabetes	☐	☐
Excessive Thirst/Hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/Burning	☐	☐
Gastrointestinal	☐	☐
Stomach Absorptive Disorder	☐	☐
Nausea, Vomiting, Diarrhea when taking Antibiotics	☐	☐
Yeast Infection when taking Antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited Motion	☐	☐
Artificial Joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other conditions and/or diseases _____

List any surgical procedures you have had in the last 10 years _____

Skin: Have you ever had skin cancer?

Do you have problems with healing?

Do you develop keloids (scars) after surgery?

Do you bleed easily?

Do you develop skin rashes in reaction to: ☐ Medication ☐ Food ☐ Environment ☐ Bandages

☐ Topical Neosporin Other _____

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Social History:

Do you drink alcohol? ☐ Yes ☐ No If YES _____ drinks per day

Do you use Recreational Drugs? ☐ Yes ☐ No If YES, What _____ How often? _____

Have you ever smoked? ☐ ☐ Yes No If YES, How often? _____

Have you had or have you been exposed to HIV (AIDS)? ☐ Yes ☐ No

Please answer the following questions:

(Women) Are you pregnant? ☐ Yes ☐ No Due Date _____

What is your occupation? _____ Hobbies? _____

Family History: ☐ Hypertension ☐ Cancer ☐ Diabetes ☐ Heart Disease ☐ Skin Disease

List all medications you are currently taking (including prescriptions, over-the-counter meds, vitamins and herbals):

1. _____ 2. _____ 3. _____ 4. _____

5. _____ 6. _____ 7. _____ 8. _____

Are you allergic to any medications? ☐ Yes ☐ No If Yes, list below:

1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ☐ Yes ☐ No Any bad reactions? ☐ Yes ☐ No

Completed by: ☐ Patient

_____ _____
Signature of Patient Date

☐ Medical Staff _____

_____ _____
Signature of Staff Date

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Payment Policy For Cosmetic Procedures

All payments for Cosmetic procedures are due in full at the time of your scheduled procedure/treatment and it's non-refundable.

Procedure and/or treatments such as:

- Chemical Peels
- Microdermabrasion
- Botox, Cosmetic Fillers
- Complexion Blending
- Body Contouring
- Cosmetic Consultation
- Skin Tightening
- Laser Hair Removal
- IPL
- Laser Genesis
- Spider Veins

These treatments are considered cosmetic and Washington DC Dermatology will not bill your insurance company. Should you decide you want to file a claim with your insurance company and get reimbursed for the above procedures, our office will be happy to provide you with a copy of the itemized bill.

All FSA and /or prior authorization for cosmetic procedures requiring letters of medical necessity will be charged a $25.00 administrative fee.

_____

By signing, I understand the terms of this payment policy

_____ _____

Signature Date

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Pharmacy Information
For Electronic Prescribing

Patient Name _____ Date Of Birth _____

Pharmacy Name _____

Pharmacy Address _____

City _____ State _____ Zipcode _____

Telephone _____ Fax _____