REGISTRATION FORM

PATIENT INFORMATION

Patient's Last name: **First:** **Middle:**

Date of Birth:

Sex Assigned at Birth:
□ M □ F

Marital Status:
□ M □ D □ S □ W □Partner

Preferred Pronouns:
□ He/Him
□ She/Her
□ They/Them

Gender Identity:
□ Identifies as Male □ Transgender Male
□ Identifies as Female □ Transgender Female
□ Gender Non-conforming
□ Other _____
□ Choose not to disclose

Legal Sex:
Same as sex assigned at birth:
□ Yes □ No

Sexual Orientation:
□ Lesbian, gay, or homosexual
□ Straight or heterosexual
□ Bisexual
□ Something else, please describe_____
□ Don't know
□ Choose not to disclose

Street Address:

City/State: **Zip Code:** **Country:** □ U.S. □ Other_____

Home Phone: **Work Phone** **Cell Phone:**

Email: **Contact Preference**: □ Home □ Work □ Cell

Authorization to Text: ☐ Yes ☐ No Text is used to send communications such as appointment reminders, weather cancellations, and online check-in. You can unsubscribe at any time.

Race:
□ American Indian or Alaska Native
□ Asian □ Black or African American
□ Native Hawaiian or Pacific Islander
□ White □ Decline
□ Other _____

Ethnicity:
□ Hispanic or Latino
□ Not Hispanic or Latino
□ Unknown
□ Decline

Language:
□ English □ Spanish
□ French □ Russian
□ Portuguese □ Chinese
□ Other _____

Interpreter requested for visit. □ YES □ NO

Primary Care Physician Name: **Physician Address:**

How did you hear about us? (Please check one box): □ My Primary Care Physician □ Dr.
□ Family □ Friend □ Close to home/work □ Insurance Plan □ Hospital □ Other

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Cell/Home phone no.: ( )	Work phone no.: ( )

INSURANCE INFORMATION (Please give your insurance card to the receptionist)

Primary Insurance Name:		Secondary Insurance Name:	
Policy#:	Group #	Policy#:	Group #
Subscriber's Name:		Subscriber's Name:	
Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other	Subscriber's Date of Birth:	Patient's relationship to subscriber: □ Self □ Spouse □ Child □ Other	Subscriber's Date of Birth:
Subscriber's Address (if different than patient):		Subscriber's Address (if different than patient)	

The above information is true to the best of my knowledge. I have received, understand, and agree to the financial policy. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any non-covered services, or any balances I am contractually obligated to pay as determined by my insurance plan. I also authorize Dermatology Associates, LLC. Or the insurance company, to release any information required to process my claims.

Patient/Guardian signature: ***Date:***

Relationship to patient if signature is not patient:

Consent to Treatment

Initial: ____ I authorize and request care by Dermatology Associates, LLC, and its affiliated practice's (Dermatology Associates) physician, physician assistant, and/or nurse practitioner (Provider) and their care team. My Provider will recommend the necessary care to treat my condition. This care may include medical, surgical, or diagnostic treatment such as laboratory tests. Recommended care will not be performed until the treatment or service is explained to me and I consent. I understand I may choose another provider at any time to deliver care or to render a second opinion. I understand my care team may include medical students and other clinical trainees. I am aware that I have the option to decline a trainee's involvement in my care at any time by notifying the practice staff or Provider.

Notice of Privacy Practices

Initial: ____ I acknowledge the receipt of the Notice of Privacy Practices. The Notice of Privacy Practices provides detailed information about how my protected health information may be used and disclosed by Dermatology Associates. I understand that Dermatology Associates may change its privacy practices at any time. I also understand that the current version of the Notice of Privacy Practices is available on Dermatology Associates' website https://www.apderm.com/notice-of-privacy-practices-apderm/ at each office, or upon my request.

Dermatology Associates, LLC *Affiliated Practices*

- Adult & Pediatric Dermatology, PC
- Advanced Dermatology and Aesthetic Center
- Associates In Dermatology
- Boston Center For Plastic Surgery
- Boston Dermatology & Laser Center
- Coastal Dermatology
- Dermatology Associates
- Dermatology Professionals
- DermCare Physicians & Surgeons
- Lexington-Waltham Dermatology Group
- Marla C. Angermeier, MD
- Mystic Valley Dermatology Associates
- Stuart J. Arbesfeld, MD

Cancellation & No-Show Policy

Initial: ____ As a courtesy to our providers and other patients, if you need to cancel or reschedule your appointment, we ask that you notify us at least 48 hours in advance and 72 hours in advance for cosmetic appointments for 60 minutes or longer. *No-Show* appointments are considered appointments that are canceled the same day as the appointment, not showing for an appointment, or when a patient arrives 15 minutes after their scheduled appointment time. A *Late Cancellation* is considered less than 72 hours prior to a 60-minute cosmetic appointment. We reserve the right to charge a non-refundable cancellation or no-show fee of $50-$100 for a general dermatology appointment. If a scheduling fee is required when scheduling a cosmetic appointment, that fee is forfeited if a patient is considered a no-show or has given a late cancellation notice. Three no-show appointments within a 12-month period will put you in jeopardy of scheduling with the clinician and possible dismissal from the practice.

Dermatology Associates

Financial & Office Policies

If you have questions about our financial policy, or to pay your bill, please contact our billing department at (978) 371-7010, press 5, press 2. We accept cash, check, Visa, MasterCard, American Express, and Discover.

Insurance: We accept most insurance plans. At each visit we verify your current insurance. If we are unable to verify insurance coverage, you will be expected to pay at the time of service. It is your responsibility to know your plan's benefits and coverage. Please contact your insurance company directly with any questions you may have regarding your plan.

Co-Payments and Deductibles: Co-payment and co-insurance are determined by your insurance. All co-payments must be paid at the time of service. A deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance begins to pay.

Referrals: If your insurance policy requires a referral from your Primary Care Physician, it is your responsibility to obtain one. If the referral is not sent to us prior to your appointment, you will be responsible for the cost of services rendered.

Non-Covered Services: Some services you receive may not be covered by your insurance. If you and your provider agree that non-covered services are needed or if you request a non-covered service, you will be responsible for full payment of the non-covered service. Aesthetic services are always payable at the time of the visit.

Treatment of Minors: Patients under the age of 18 must be accompanied by a parent or guardian to their first appointment. To provide treatment to a minor without the presence of a parent or guardian during subsequent visits, a signed consent form must be on file. All copays or monies due are expected to be paid at the time of each service.

Non-Payment and Returned Checks: We understand that temporary financial problems may affect the timely payment of your balance. Please communicate your situation with the billing department so that we can assist you in the management of your account. If your account is 90 days past due, your account will be referred to a collection agency. This agency may report your delinquency to a credit bureau. You also may be dismissed from our practice for non-payment. There will be a $25 charge for checks returned for insufficient funds.

By signing below, I acknowledge I have read, understand, and agree with the above policies and statements, and that all my questions have been answered in a language that I understand.

Print Patient's Name: _____ Date: _____

Patient/Guardian Signature: _____

Relationship to Patient (if signature is not patient): _____

PERMISSION FOR VERBAL COMMUNICATION

Dermatology Associates and its affiliated practices recognize that patients may prefer family members or friends to be involved in their care. For example, a patient may want their spouse or adult child to assist with billing questions, to be informed about appointments on their behalf or to be updated on their health status. This form serves as a record of your wishes. Please complete this form if you would like to allow our healthcare team members to discuss your health information with a specific individual. This document does not permit release of any written health information to the individuals named.

_____ _____

(Print name of patient or place patient label) (Date of birth)

Please list the individual(s) that you allow us to speak with about your care:

Family or Friend's Name	Phone Number	Relationship

I acknowledge and understand that:

- *I am allowing* Dermatology Associates and its affiliated practices *to share information with the above-named individual(s) only by verbal discussions and that my permission does not give the above-named individual(s) access to my hard-copy or electronic medical record.*
- *The information I allow to share is not limited unless specified:* _____ _____.
- *My permission will remain in effect for an unlimited amount of time unless a date is listed, or I cancel my permission:* _____.
- *I can change my permission at any time by contacting the dermatology office where I receive care, but my cancellation will not have an effect on information shared prior to my cancellation.*
- *Information shared with the above-named individual(s) may be further shared by them and not protected under confidentiality and privacy laws.*
- *My permission is voluntary, and my treatment, payment or eligibility for services is not conditioned on my signature.*
- *If at any time I do not want my healthcare team members to discuss my healthcare information with the above-named individual(s), I must provide written notice to the dermatology office where I receive care or contact the privacy officer at (978) 849-7582 or 526 Main Street, Suite 302, Acton, Massachusetts 01720.*

By signing below, I acknowledge I have read, understand, and agree with the information on this form and that all my questions have been answered in a language that I understand.

Patient/Guardian Signature:_____ Date:_____

Representative's Name: _____ Relationship to Patient: _____

Name: **Date of Birth:**

MEDICATIONS
Please list the name of the medication, the dosage (e.g., 5mg, 10mg), and the frequency you take it.

ALLERGIES
Please list all allergies.

PHARMACY INFORMATION
Any prescription we provide to you today will be sent electronically to your pharmacy of choice. Please list the pharmacy below. If there is more than one pharmacy in your town, please be sure we have the correct street name.
PHARMACY NAME:
PHARMACY TELEPHONE: (if you know it)
TOWN OF THE PHARMACY and STREET NAME:

Do you use a mail away pharmacy? □NO □YES If Yes, what is the name of it?

Dermatology Associates, LLC
Medical Questionnaire
(Please print legibly)

Today's Date: _____

Patient Name: _____ **Date of Birth**: _____

□ New Patient □ Return Patient

Chief Concern: _____

Location: _____

Duration of Symptoms: (enter #) _____ (check one) □ Hours □ Days ☐ Weeks ☐ Months ☐ Years

Severity: (check one) □ Same □ Worse ☐ Better

What have you tried to help the problem? (e.g., topicals, antibiotics, creams, over the counter product, prescriptions)
_____
_____
_____

Current Non-Dermatological Problems: (check all that apply)

□ Anxiety □ CHF □ Depression □ Diabetes □ Dizziness □ Hepatitis □ HIV
□ Irregular Heart Rhythm □ Liver Disease □ Lymphoma □ Other_____

Surgical History: (check all that apply)

□ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Keloids Removed □ Melanoma
□ Benign Moles Removed □ Other Skin Cancer Treatment □ Aortic Valve Replacement □ Cancer Treatment
□ Mitral Valve Replacement □ Pacemaker □ Other_____

Family History: (check all that apply)

□ Acne □ Basal Cell Carcinoma □ Squamous Cell Carcinoma □ Eczema □ Hair Loss
□ Melanoma □ Psoriasis

Social History: (check all that apply)

Occupation_____ Smoker? □ Current □ Previous □ Never Packs Per Day_____
Alcohol use: □ Yes □ No Sunscreen use: □ Yes □ No □ Sometimes SPF? _____

Cosmetic Skincare: Do you have any cosmetic skincare questions today? Yes or No

Please circle or (other):_____

Skin Tone and Texture	Wrinkles	Brown Spots	Red Spots
Skin Tightening	Hair Removal	Body Contouring	Tattoo Removal