CLINIC 5Ĉ

REGISTRATION FORM

(Please Print)

Primary Care Provider:	**Today's Date:**
Referring Physician:	**Preferred Pharmacy:**

DEMOGRAPHIC PATIENT INFORMATION

Patient's last name:	**First:**	**Middle**:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	**Marital status (circle one)** Single / Mar / Div / Sep / Wid
Street Address:	**PO Box:**	**City:**	**State:**	**ZIP Code:**	
SSN:	**Birth Date:** / /		**Age:**	**Gender:** ❑ M ❑ F	
Occupation:	**Employer:**		**Work phone :** ( )		
Primary Phone:	**Cell:**				
Primary Language:	**Email:**				
Preferred Communication: ☐ Phone ☐ Text ☐ Email	Would you like to be opted out of our promotional email list? ☐ Yes ☐ No				
Race: ❑ American Indian/Alaska Native ❑ Asian ❑ Black/African American ❑ Native Hawaiian/Pacific Islander ❑ Other Race ❑ Unknown ❑ White ❑ Declined	**Ethnicity:** ❑ Hispanic ❑ Non-Hispanic ❑Declined				

Do we have your permission to:

Leave a detailed message (including biopsy results) on your primary phone?	❑Yes	❑No	If no, alternate #:_____
Send a detailed text message to your cell phone (including biopsy results)	❑Yes	❑No	If yes, cell #:_____
Discuss your medical condition with any member of your household?	❑Yes	❑No	If yes, whom: _____

INSURANCE INFORMATION

Person responsible for bill:	Birth Date: / /	Address (if different):		Home phone number: ( )	
Is this person a patient here? ❑ Yes ❑ No					
Occupation:	Employer:	Employer address:		Work phone number: ( )	
Is this patient covered by insurance? ❑ Yes ❑ No					
Primary Insurance:					
Subscriber's name:	Subscriber's SSN:	Birth date: / /	Policy number:	Group number:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Secondary Insurance (if applicable):	Subscriber's name:	Birth date: / /	Policy number:	Group number:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY

Name:	Relationship to patient:	Phone number: ( )	

I hereby authorize my insurance carrier to pay medical and/or surgical benefits directly to Clinic 5C and associated providers. I am financially responsible for any balance due and I have read and understand Clinic 5C's Financial Agreement. I authorize the doctor or insurance company to release any information required for this medical claim. I understand that Clinic 5 C's Notice of Privacy Practices is posted in the office and on the website for my information and is available to me upon request.

_____ _____

Signature of Patient or Legal Guardian **Date**

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Date: ____/____/____ **Name: _____** **DOB: ____/____/____**

We take your privacy <u>extremely seriously</u>, your information facilitates contact from us only

Best contact number : _____ Ok to text: Y / N Prefer voicemail Y / N

Email: _____

How did you find us? _____

Preferred Pharmacy: (Name/Phone) _____

Reason for today's visit: _____

Any particular procedures or areas of interest: _____

Describe your history of sun exposure: _____

Have you had any prior cosmetic treatments? _____

Fillers/Botox? Location and date: _____

Lasers or other devices? Location and date: _____

Surgery? Location and date: _____

For females: Having periods? Y N Are periods regular? Y N Are you pregnant? Y N

Personal Past Medical History or Current Diseases:

Skin Cancer	Y N	HIV/ AIDS	Y N
Eye problems/dry eye/contacts	Y N	Hepatitis C / Liver Disease	Y N
Melanoma	Y N	Thyroid Disorders	Y N
Any type of cancer	Y N	Diabetes	Y N
Asthma/COPD/Sleep apnea	Y N	Bleeding Problems	Y N
Seasonal allergies / hay fever	Y N	High Blood Pressure	Y N
Keloids	Y N	Pacemaker / Defibrillator	Y N
Autoimmune Disease	Y N	Arthritis / Artificial joints	Y N
Anxiety/Depression.	Y N		

If you answered **YES** to any of the above, please explain: _____

Other major medical illnesses / surgeries: _____

Social History:

Tobacco use: Current Former Never

Alcohol Use: Current Former Never

Vaping: Current Former Never

Ethnicity: (optional) _____

Relationship Status: (optional) Single Married Other

Occupation: _____

Marijuana use: Current Former Never

Allergies (Medications, latex, food): _____

Current Medications: _____

Review of systems: *Are you having any of these symptoms today? ( ) YES ( ) NO <u>If YES, please circle:</u>*

Fevers, Chills, Nausea, Vomiting, diarrhea, constipation, chest pain, shortness of breath, cough, headaches, numbness, Joint pain, vision changes, unintended weight loss, anxiety, depression, easy bruising / bleeding

CLINIC 5Ĉ

Billing Notice

Welcome to our office! Your Mohs/surgical procedure is a two-part process. The first step is the removal and/or microscopic pathology. The second step is the closure and/or reconstruction. We are fortunate to be able to offer both steps, on site in a state-of-the-art surgical facility. You may see this reflected once your insurance has been billed. This means you may get two separate bills, one from Clinic 5C as a reduced professional fee and the second from Chesnut Institute of Cosmetic and Reconstructive Surgery as a facility fee. Please contact your insurance company regarding any out of pocket costs. If you have any further questions or concerns don't hesitate to call. Thank you for trusting us with your care.

Depending on several factors related to your surgery/procedure, you may receive services for which you will get additional bills. Some of these may include but not limited to: The surgery center, your Physician/Surgeon, Pathology services or Anesthesia provider.

Clinic 5C NPI#: 1437798568
Surgery Center CICRS NPI#: 1063935286

I have read and understand:_____
Signature/Date

Financial Policy

If you do not have insurance, you must pay at the front desk prior to the time of service or make other arrangements with our billing staff. We accept cash, personal checks, and all credit cards including CareCredit.

If you have insurance, we will file claims for you. We will need your current insurance and policy holder information. You will need to authorize payment directly to Clinic 5C and Chesnut Institute of Cosmetic and Reconstructive Surgery (CICRS). If your insurance requires co-payments, you **must** pay that amount at the time of service. Co-pays *not* paid at the time of service will be subject to a $10 statement fee. You are responsible for paying Chesnut MD/CICRS for any services not covered by insurance.

We will send you a monthly statement so you will know your insurance company has made a payment and the remaining balance. Payment is due upon receipt of the monthly billing statement. Even if you have insurance**, payment to Clinic 5C/CICRS is your responsibility.** You should know the details of your insurance plan, including which doctor your plan requires you to see. Many insurance plans require you to use certain doctors and may require pre-certification or referrals to another facility. We are not responsible if you are sent to the wrong facility.

Clinic 5C/CICRS may bill you these additional charges:

- $25 for late cancellations and no-shows for office visits (24 hour notice required)
- $100 for a surgical visit no show (We require at least a 48 hour notice to avoid charges.)
- $20 NSF fee for returned checks
- $10 statement fee for nonpayment of co-pay at time of service

Accounts not paid in full within 90 days may be turned over to an outside collection agency. If you cannot make regular monthly payments and pay in full within the 90 days, please contact us. If you have any questions about this information, please call (509) 252-1299.

***I have read and understand Clinic 5C/CICRS Financial Policy:**

_____/_____

Thank you, **Signature & Date** **Printed Name**

Clinic 5C/Chesnut Institute of Cosmetic and Reconstructive Surgery PLLC (509-252-1299)