Rejuvenate Yourself

Fine Skin Dermatology

Dr. Renuka H.Bhatt, M.D.

General, Cosmetic and Surgical Dermatology, Mohs Skin Cancer Surgery, Laser Center and Medical Spa

REGISTRATION INFORMATION

PATIENT INFORMATION

Date			D.O.B.	
LAST NAME	FIRST NAME	MI	SOCIAL SECURITY# – –	
HOME ADDRESS	CITY	STATE	ZIP	SEX: ◯ MALE ◯ FEMALE
SPOUSE'S NAME	HOME #	WORK #		
EMAIL ADDRESS	MOBILE #	MARITAL STATUS: ◯ MARRIED ◯ SINGLE ◯ DIVORCED ◯ SEPARATED ◯ WIDOWED		

RESPONSIBLE PARTY INFORMATION (if other than Guarantor)

D.O.B.				
LAST NAME	FIRST NAME	MI	HOME#	
ADDRESS	CITY	STATE	ZIP	SOCIAL SECURITY
EMPLOYER	OCCUPATION	WORK#		
EMPLOYER'S ADDRESS	CITY	STATE	ZIP	RELATIONSHIP TO RESPONSIBLE PARTY ◯ SPOUSE ◯ SON ◯ DAUGHTER
MOTHER'S NAME (if patient is minor)	MOTHER'S BIRTH DATE	FATHER'S NAME (if patient is minor)	FATHER'S BIRTH DATE	

EMPLOYMENT INFORMATION

PATIENT'S EMPLOYER OR SCHOOL NAME IF STUDENT:	OCCUPATION	EMPLOYMENT OR STUDENT STATUS: ◯ FULL-TIME ◯ NOT EMPLOYED ◯ SELF EMPLOYED ◯ PART-TIME ◯ RETIRED ◯ ACTIVE MILITARY	
PATIENT'S EMPLOYER'S OR SCHOOL ADDRESS			
CITY	STATE	ZIP	

EMERGENCY INFORMATION

NAME	RELATIONSHIP		HOME#
ADDRESS	CITY	STATE	ZIP / WORK#

INSURANCE INFORMATION ◯ PPO ◯ POS ◯ MEDICARE ◯ HMO CO-PAY $

PRIMARY INSURANCE	SOCIAL SECURITY# – –	SUBSCRIBER NAME	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY / STATE / ZIP		PHONE#
SECONDARY INSURANCE	SOCIAL SECURITY# – –	SUBSCRIBER NAME	DATE OF BIRTH
GROUP NUMBER	IDENTIFICATION NUMBER		EFFECTIVE DATE
ADDRESS	CITY / STATE / ZIP		PHONE#

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MEDICARE PATIENTS ONLY

MEDICARE PATIENTS ONLY - Lifetime Signature on File and Lifetime Consent I request that payment of authorized Medicare benefits be made on my behalf to Renuka H. Bhatt, MDSC. I authorize any holder of medical information regarding me to be released to the Health Care Financing Administration and its agents any information needed to determine those benefits or the benefits payable for related service. I request that payment of authorized Medigap or secondary insurance benefits be made on behalf to Renuka H. Bhatt, MDSC.

X

Signature of Beneficiary | Medigap Insurer | Medigap# | Date

ASSIGNMENT OF BENEFITS AND RECORDS RELEASE

I hereby authorize direct payment of all medical and/or surgical benefits, including major medical, private insurance, and other health plans to Renuka H. Bhatt, MDSC of any medical benefits payable to me for the services provided at Fine Skin Dermatology. I also authorize the release of all medical information necessary to process insurance claims. This authorization shall remain in effect as long as charges are being submitted for insurance claim processing or as long as dictated by payor. I understand it is my responsibility to pay all deductible amounts, co-insurance, or any other balance deemed patient responsibility by the insurance company. I understand it is my responsibility to pay the balance in full if the insurance information provided proves false or ineffective. I also understand that if my insurance requires a referral or prior-authorization for my appointments it is my responsibility to obtain a referral prior to the appointment and I will be responsible for the unpaid balance due any bills if this referral is not done. If this account is assigned to an attorney for collection/or suit, the prevailing party shall be responsible for any reasonable attorney fees and cost of collection.

X

Patient Signature or Signature of Guardian or Parent | Date

PATIENT FINANCIAL AGREEMENT

I hereby authorize the release of pertinent medical information to my insurance carriers, I am aware that I signed up for this health insurance coverage and I am aware that insurances vary, also that insurance carriers may use terms such as customary, reasonable prevailing, deductible and out-of-pocket etc. to limit their coverage. I am ultimately responsible, for payment of all charges for services rendered by the providers of Fine Skin Dermatology, as well as other charges for laboratory fees, pathology fees, and any other fees incurred as a result of the treatment rendered to myself or my immediate family. If I have insurance which the doctors are contracted with, I understand that I will be responsible for any co-payments (due at time of office visit) deductibles, co-insurances or any procedure that is not considered medically necessary by my insurance carrier.

I also understand and agree that if I fail to keep my scheduled appointment and I do not give 48 hours notice of cancellation I will be charged a no-show fee. The no-show fee is $50.00 for regular office visits and $100.00 no-show fee for surgical appointments, cosmetic and Saturday appointments. No-show charges are not billable to your insurance, this is your responsibility.

In the event I fail to pay the balance of my account to Renuka H. Bhatt, MDSC, DBA: Fine Skin Dermatology, I hereby agree that if Fine Skin Dermatology sends my account to a collection agency, I will pay the fee charged by the collection agency to Fine Skin Dermatology. In addition if my account is forwarded to an attorney to undertake legal action to collect the debt, I hereby agree to pay all of the reasonable attorney fees incurred by Renuka H. Bhatt, DBA: Fine Skin Dermatology, in regards to the collection of the unpaid balance.I have also been given a copy of the Office Policy and understand that the Office Policy is incorporated by reference and made a part of this agreement.

X **X**

Patient Name | Signature of Patient / Responsible Party | Date

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Welcome to our practice and thank you for giving us the opportunity to take care of your skin care needs.

Our office policies are as follows:

- Your insurance requires that co-payment be paid at the time of your service.
- Your insurance company has applied your service charges to your deductable please pay within 30 days
- It is the patients responsibility to call their insurance company for prior authorization of all services.
- All HMO patients are responsible for obtaining and presenting their referral at the date of service.
- We require 48 hours notice for all appointment cancellations; we reserve the right to charge $50 for a missed appointment and $100 for Surgical appointments, cosmetic and Saturday appointments. No show charges are not billable to the insurance and it is your responsibility.
- We require 48 hours notice for an office visit appointment cancellation; we reserve the right to charge $50 for a missed appointment.
- We reserve the right to charge $15.00 for a refill on a prescription and charge $15.00 for a lost prescription.
- Regarding any pathology and / or lab work, if office has not contacted you within 2 weeks, it is your responsibility to call the office to inquire about your results.
- I consent further to photograph of my or said patient's body or portions.
- Nursing Staff Direct Line: 708.226-0044 (Orland Park Office) 815.676.5310 (Joliet Office) Prompt Press
- Our records release policy requires a 2 week advance notice in order to prepare your records and has a $15 fee. An emergency record release of less than 48 hours is a $50 fee.
- I hereby authorize the physician or their representative to leave laboratory or pathology results with ( ) Home answering machine ( ) Work voicemail ( ) Cell Phone ( ) E-mail ( ) Patient only Initials____
- Any information, including the diagnosis and records of any examination, laboratory studies or treatment, rendered to me can be released to the person mentioned below

NAME: _____ Relationship: _____

The above information is accurate and complete to the best of my knowledge. I understand that it is my obligation and responsibility to notify Fine Skin Dermatology of any changes in my medical condition or medications during the course of my medical treatment.

Referred By:_____ Primary Care Physician _____

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM
I have had the opportunity to review the above listed office policies, in addition to the Notice of Privacy Procedure (HIPPA) information.

PRINTED NAME: _____

SIGNATURE:_____ DATE: _____

www.fineskin.com
10743 W 159th Street • Orland Park, IL 60467 • 708.226.0044 • f:708.226.0066
2202 Essington Road • Suite 101 • Joliet, IL 60435 • 815.676.5310 • f: 815.725.1321
570 Village Center Dr., Suite 201 • Burr Ridge, IL 60527 • 630.789.9900 • f: 630.734.8274
120 Batson Court, Unit 201 • New Lenox, IL 60451 • 815.717.8606 • f: 815.717.8607

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MEDICAL HISTORY INTAKE FORM

Last Name: _____ First Name: _____ MI:_____

Referred By:_____

Primary MD: _____ City/State: _____

PLEASE CIRCLE WHERE APPLICABLE IN THE FOLLOWING SECTIONS:

Dermatologic Related Allergies:

- ☐ Adhesive Tape
- ☐ Latex
- ☐ Local anesthetic
- ☐ Epinepherine
- ☐ Bacitracin
- ☐ Neosporin
- ☐ Polysporin

Chronic Conditions:

- ☐ Anticoagulant treatment (Coumadin, Warfarin, Pradaxa, Aspirin)
- ☐ Bleeding disorders
- ☐ Artificial joint / year of surgery _____
- ☐ Memory problems
- ☐ CLL Chronic leukemia
- ☐ Artificial heart valve
- ☐ Fainting / Syncope
- ☐ Pacemaker / Defibrillator
- ☐ Hepatitis
- ☐ Mitral valve prolapse
- ☐ HIV+
- ☐ Immunosuppressed
- ☐ MRSA
- ☐ Organ transplant
- ☐ Hypertension

Need to pre-medicate before procedures

- ☐ Diabetes
- ☐ Kidney disease
- ☐ HSV–cold sores
- ☐ Thyroid disease
- ☐ Eczema
- ☐ Lupus
- ☐ Asthma
- ☐ Arthritis
- ☐ Hay fever
- ☐ Psoriasis
- ☐ Heart disease
- ☐ Abnormal scars / Keloid scars
- ☐ Poor wound healing

Do you have history of Melanoma? ☐ Yes ☐ No

Do you have history of non-melanoma skin cancer? ☐ Yes (year_____) ☐ No

Do you have history of other cancers? ☐ Yes ☐ No

Current Medications with dose if known:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Drug Allergies: None known or List here:_____

FOR WOMEN ONLY:

ARE YOU PREGNANT	☐ Yes	☐ No	☐ Unsure
ARE YOU BREASTFEEDING	☐ Yes	☐ No	
ARE YOU ON BIRTH CONTROL	☐ Yes	☐ No	
DO YOU HAVE REGULAR MENSTRUAL CYCLES	☐ Yes	☐ No	

First day of your last period:_____

Primary Language:
English /Arabic / French / German /Mandarin / Spanish / Russian / Other / Decline to answer

Race:
American Indian / Asian / African American / Black / Native Hawaiian / Other Pacific / White / Unknown/ Other / Decline to answer

Ethnicity: Hispanic or Latino / Non-Hispanic or Latino / Decline to answer

Pharmacy Name: _____

Pharmacy Street and City:_____

Do you have a family history of melanoma?
Yes, family member(s) affected: _____ / No / Uncertain

Do you have a family history of non-melanoma skin cancer?
Yes, family member(s) affected:_____/ No / Uncertain

Occupation:_____ Retired?	☐ Yes	☐ No		
Do you use tobacco?	☐ Yes	☐ No		
Do you drink alcohol?	☐ No	☐ Socially	☐ Moderately	☐ Heavily
Do you use sunscreen?	☐ No	☐ Occasionally	☐ Daily	
Do you use tanning beds?	☐ Yes	☐ No	☐ In the past	
Do you have a history of blistering sunburns?	☐ Yes	☐ No		

Review of Systems (circle if you are reporting that you have related symptoms)

Constitutional	**Eyes/Ears**	**Respiratory**	**GI**	**Hematology**
Chills	Irritation	Cough	Nausea	Clotting
Fever	Glaucoma	Short of breath	Vomiting	Bleeding
Fatigue	Hearing aid	Emphysema	Abdominal pain	Bruising
Weight loss			Liver Disease	Anemia
Weight gain			Stomach ulcer	

Endocrine	**Musculoskeletal**	**Skin**	**Neuro**	**Psychiatric**
Swollen lymph nodes	Joint pain	Rash	Dizziness	Depression
		Itching	Headache	Anxiety
		Acne	Seizures	
		Keloid		

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❖ Please fill out information to access *InteliChart Patient Portal*.

Note: (*) fields are mandatory.

1) Patient Name * : Last Name: _____ First Name: _____ MI: _____

2) Patient Date of Birth * : ___/___/_____

3) Address * : _____

City: _____ State: _____ Zip code: _____

4) Email * (Upper-Case Only) : _____

5) Phone Number : Cell Phone * : (___) - ___ - _____

Carrier * : _____ (Ex.: T-mobile, AT&T, etc.)

Home Phone : (___) - ___ - _____

❖ Would you like to sign up to Our InteliChart Patient Portal?

☐ Yes ☐ No

Patient Signature _____

Date ___/___/_____

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Patient Acknowledgement of Financial Responsibility

Please read carefully before signing.

Due to the rising cost of medical insurance coverage, patients are seeing a rise in their deductibles and out of pocket expense. Please be aware that you are financially responsible for this portion of your bill and may receive a call to ask for a deposit for any type of procedure. When the office calls you for a deposit we cannot quote an exact price because all insurances vary with co-pays and deductibles or the percent which you are liable. If your deductible and out of pocket has not been met for the fiscal insurance year a portion or all of your bill may be applied to the deductible which you are liable. We will file a claim on your behalf to your insurance company through our billing office. You are given the insurance discount at the time the payment is received from your insurance company. If insurance does not pay within the allotted time for reimbursement which is normally 180 days the patient is financially responsible at that time.

HMO patients are responsible for obtaining a referral from their PCP (Primary Care Physician) and also for prior-authorization for any procedures. The patient may call the office for an appointment after they have the referral in hand or faxed to the respected office. (Numbers listed below)

Several cosmetic procedures may require a deposit, the balance or total is due at the time of the service.

Please do not call our billing office or the doctor office for a discount to write off a balance, the patient is responsible for all co-pays, deductibles, out of pocket and non-covered expenses. If you are not sure what your liability is please call the number on the back of your insurance card prior to having any procedures or visits.

We do understand that health issues can cause financial hardship and we are more than willing to work with our patients and set up a monthly payment plan. Below is a list of the office phone numbers where you can ask to speak to someone in billing to set up a payment plan or to pay a bill.

Thank you for your understanding in this matter.

PATIENT NAME: _____**SIGNATURE**:_____

Date: _____Phone:_____

Minor Patient Guarantor

Name: _____SIGNATURE:_____

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