The Clinical Skin Center of Northern Virginia, PLLC

MINOR PATIENT REGISTRATION FORM

Child's Name: (Last, First, Middle): **Today's Date:**

Date of Birth: **Sex:**

○ Male ○ Female ○ Other _____

Mailing Address Line 1: **Mailing Address Line 2:**

City: **State:** **Zipcode:**

Legal Guardian or Parent Name: **Parent Birth Date:**

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

Email:

Referring Physician: **City:**

Primary Physician: **City:**

In case of Emergency, who should be notified? **Phone:**

I give my permission and consent for private medical information to be released to:

Full Name: **Relationship to patient:**

Primary Insurance-Policy Holder's name: **Secondary Insurance-Policy Holder's name:**

Relationship to Policy Holder (Primary Ins.):
○ Self ○ Spouse ○ Child/parent

Relationship to Policy Holder (Secondary Ins.):
○ Self ○ Spouse ○ Child/parent

In order to establish optimal relations with our patients and avoid misunderstandings regarding out payment policies, please note: IT IS THE POLICY OF THIS OFFICE THAT THE ADULT PRESENTING THE CHILD FOR TREATMENT IS RESPONSIBLE FOR PAYMENT OF "THE PATIENT PORTION" AT THE TIME OF SERVICE. Your signature below indicates that you understand and accept this policy.

Signature of Parent / Legal Guardian (signed electronically): **Date:**

Please present insurance cards and photo ID to the receptionist so copies can be made

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MEDICAL HISTORY

Patient Name: _____ DOB: _____ Date: _____

What skin issue are you here for: **(issues separated by commas)**

Are you ALLERGIC to LATEX?:
○ YES ○ NO

If Yes, explain reaction: _____

Have you ever had a SKIN CANCER?:
○ YES ○ NO ○ UNSURE

If YES, Select Type:
☐ MELANOMA ☐ BASAL CELL CARCINOMA ☐ SQUAMOUS CELL CARCINOMA

FAMILY HISTORY of MELANOMA?:
○ YES ○ NO ○ UNSURE

Who?: _____

FAMILY HISTORY of Other SKIN CANCER?:
○ YES ○ NO ○ UNSURE

Who?: _____

Have you ever been diagnosed with either HIGH BLOOD PRESSURE or DIABETES?:
○ YES ○ NO

Are you taking ASPIRIN, MULTI-VITAMINS, FISH OIL or HERBAL SUPPLEMENTS?:
○ YES ○ NO

Do you currently use Nicotine?:
○ YES ○ NO

If yes, check type:
☐ Tobacco ☐ Vaping electronic pen

How many yrs? _____

Do you have any MEDICAL PROBLEMS / SURGICAL HISTORY? (Not Skin)
○ YES ○ NO

If yes, please list: (problems separated by commas; if list is extensive, please bring it to the office)

History of SKIN PROBLEMS?
○ YES ○ NO

If yes, please list:

_____

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MEDICAL HISTORY CONTINUED

Patient Name: DOB: Date:

Are you ALLERGIC to any medicines?: ○ YES ○ NO
If Yes, please list:

Medication you are allergic to:	Reaction:

MEDICATIONS and SUPPLEMENTS/HERBALS you are currently taking:
MUST include dose. Please indicate route of administration if not taken orally
○ YES ○ NO
If any, please list:

CURRENT OCCUPATION:

EXTRA INFORMATION:

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PATIENT FINANCIAL POLICY AND SIGNATURES ON FILE

Patient Name: **Date of Birth:**

RELEASE OF INFORMATION: I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payments of medical benefits to the physician.

PAYMENT POLICIES: MEDICARE: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible, paying for the co-payment and charges for non-covered /cosmetic services. If we participate with your secondary/supplemental carriers we will file a claim for you. However, in the event that the secondary does not pay within 60 days, patients will be billed for the balance.

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. I authorize any holder of medical or other information about me to be released to the Social Security Administration, Center for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

PPO, HMO, TRICARE, OR OTHER MANAGED CARE PATIENTS: If **we participate (are contracted)** with an **insurance plan** under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible for paying your annual deductible, copayment and charges for any non-covered, cosmetic service. In the event that we are not aware that a particular service is not covered by your plan, you will be billed for the balance after we obtain a denial from your insurance carrier.

NON-MEDICARE PATIENTS WHO HAVE INSURANCE COVERAGE WITH A CARRIER THAT WE DO NOT HAVE A CONTRACT (PARTICIPATE) WITH: Patients covered by private, commercial plans in which our physicians are not members will be responsible for payment in full at the time of service, regardless of the benefits and payment policies of your carrier. We will NOT file claims directly with your insurance company. Patients may elect to independently seek reimbursement from their carrier, if so we can provide you documentation of the services performed.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient or Responsible Party Signature (signed electronically): **Date:**

If you have a **SUPPLEMENTAL POLICY** to which your **MEDICARE** carrier automatically “crosses over”: I request authorized benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above supplemental carrier any information needed to determine these benefits or the benefits payable for related service.

Patient or Responsible Party Signature (signed electronically): **Date:**

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HIPAA ACKNOWLEDGMENT & NOTICE OF PRIVACY PRACTICES

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) permits health care providers to use and disclose protected health information (PHI) for purposes of treatment, payment, and health care operations (TPO) without obtaining patient authorization.

The Clinical Skin Center of Northern Virginia, PLLC is required by law to provide you with a Notice of Privacy Practices that explains how your PHI may be used and disclosed and describes your rights regarding your health information, including additional protections provided under Virginia law.

A copy of the Notice of Privacy Practices is available at the front desk, on the practice's website and upon request.

Acknowledgment

I acknowledge that I have been offered an opportunity to review the Practice's Notice of Privacy Practices. I understand that my protected health information may be used and disclosed for purposes of treatment, payment, and health care operations, as described in the Notice and as permitted by federal and Virginia law. I understand that certain uses and disclosures of my PHI require my written authorization and that I may revoke such authorization in writing, as provided in the Notice.

Printed Name: _____

Signature: _____

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PATIENT AUTHORIZATION AND INFORMED CONSENT FOR TELEMEDICINE (FOR VIRTUAL VISITS WITHIN THE STATE OF VIRGINIA)

Patient Name: Date of Birth:

1. I understand that my health care provider will engage with me in a telemedicine consultation.
2. My health care provider has explained to me how the video, audio and still photographic conferencing technology will be used to affect such a consultation. I understand that this will not be the same as a direct patient/healthcare provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to provide medical support and/or technical assistance. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. During the public health crisis, by order of Department of Health Human Services HHS, a limited waiver on HIPAA Privacy rules is in effect. This allows medical practices to facilitate easier and better communication with patients and enable widespread use of telemedicine consultation. The information contained in this transmission may contain privileged and confidential information, including patient information protected by federal and state privacy laws. This health information may not be protected under the Health Insurance Portability and Accountability Act (HIPAA) and may not be 100 percent secure.
6. I understand the alternatives to a telemedicine consultation. In choosing to participate in a telemedicine consultation, I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
7. I understand that the practice of Dermatology often involves physical tests which may only be conducted during in-person visits in our office. I agree that is my responsibility to follow-up in a timely manner for any tests or biopsies as ordered or directed by my provider. I understand that any remaining medical concerns, persistent or worsening lesions, rashes or symptoms require further prompt evaluation in-person.
8. I understand that billing will occur from my practitioner just as it would for an in-office visit and I will be responsible for any applicable copays and/or deductibles as determined by my insurance carrier.
9. I have had the opportunity to ask questions in regard to this form and this procedure. My questions have been answered to my satisfaction and I understand the risks, benefits and any practical alternatives to a Telemedicine Consultation
10. Telemedicine services are only offered and available for patients who are physically located in VA at the time of the virtual visit. By signing below, I agree that I will only participate in a telemedicine visit within the state of Virginia. (Rev. 2-15-2022)

Patient's/Guardian Signature: Date:

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CONSENT FOR OFFICE VISITS AND IN-OFFICE PROCEDURES PERFORMED DURING COVID-19 / PANDEMIC SITUATIONS

Patient Name: **Date of Birth:**

On March 11, 2020, the World Health Organization declared the COVID-19 disease a pandemic. There are risks to patients who visit a healthcare provider and/or undergo medical procedures during the COVID-19 pandemic. These risks include but are not limited to exposure to other patients, healthcare staff, and healthcare facilities.

I understand that COVID-19 is very contagious. It is most likely spread by person-to-person contact. I understand that my doctor and his or her staff will follow all laws and recommendations from local, state, and national health officials.

Some patients have a higher risk of complications from COVID-19, including those with:

- asthma,
- chronic lung disease,
- serious heart disease or problems,
- chronic kidney disease,
- extreme obesity,
- a compromised or suppressed immune system,
- liver disease,
- pregnant,
- age 65 or older, or
- nursing home or long-term care facility residents.

Some risks are not yet known. I understand that if I have one or more of these conditions, I may have a higher chance for 1) getting COVID-19 and 2) health problems if I get COVID-19. I understand that these problems may be serious.

I understand that possible exposure to COVID-19 before, during, or after my visit, procedure or surgery may result in: a COVID-19 diagnosis, a long quarantine or self-isolation, more tests, being in the hospital, intensive care treatment, intubation/ventilator support, short-term or long-term intubation, other complications, and the risk of death. Also, after office visit, procedure or surgery, I may need to go to an emergency room or a hospital for care. I have been given the option to wait until a later date to have my office visit and/ or procedure/surgery.

There may be other ways to meet with your doctor/provider and be treated. You could have a phone evaluation or a telehealth evaluation. These other options may or may not be right for you. This depends on your health problem and overall health. If remote assessment and treatment are not appropriate, your doctor will explain why you need an in-person visit.

This consent form provided information about COVID-related risks. By signing this form, I acknowledge that I understand the facts provided to me, the risks and choices. I give my consent for in-office evaluation, treatment and/or any elective procedures and surgeries. I agree that no one has given me any guarantees, that I have had the opportunity to ask questions, and that all of my questions have been answered.

Patient signature /Guardian (signed electronically): **Date:**