PATIENT REGISTRATION

PATIENT'SNAME:_____

LAST FIRST

GENDER: **M** **F** **DOB:** _____

Check one MM/DD/YYYY

ADDRESS: _____

_____

CITY STATE ZIP CODE

CHECK BOX FOR PREFERRED NUMBER

HOME PHONE _____

CELL PHONE _____

EMPLOYER _____

OCCUPATION _____

EMAIL _____

(PLEASE PRINT CLEARLY)

MARITAL STATUS _____

SOCIAL SECURITY _____

EMERGENCY CONTACT OR GUARDIAN

NAME _____

PHONE NUMBER _____

Please hand over completed forms to the front desk. Thank you.

History and Intake Form

Patient's Name: _____

Birthday**:**_____
MM DD YYYY

Preferred PHARMACY NAME: _____

PHARMACY Phone #: _____

Pharmacy city or Zip code: _____

REASON FOR VISIT: _____

PRIMARY CARE DOCTOR: _____.MD **Tel #:**_____

ADDRESS:_____ZIP_____

**Have you had your flu shot this season? [ ] yes [ ] no
Have you had your pneumonia vaccine? [ ] yes [ ] no [ ] N/A

Past Medical History: (please CHECK all that applies)

Anxiety	Coronary Artery Disease	Thyroid Problems
Arthritis	Depression	Leukemia
Asthma	Diabetes	Lung Cancer
Atrial fibrillation	End Stage Renal Disease	Lymphoma
Bone Marrow	GERD	Prostate Cancer
Transplantation	Hearing Loss	Radiation Treatment
Breast Cancer	Hepatitis	Seizures
Colon Cancer	High Blood Pressure	Stroke
COPD	HIV/AIDS	
	High Cholesterol	NONE

Other_____

Past Surgical History: (please CHECK all that applies)

Appendix Removed	Joint Replacement within 2 years
Bladder Removed	Kidney Biopsy (Nephrectomy)
Mastectomy (Right, Left, Bilateral)	Kidney Removed (Right, Left)
Lumpectomy (Right, Left, Bilateral)	Kidney Stone Removal
Breast Biopsy (Right, Left, Bilateral)	Kidney Transplant
Breast Reduction	Ovaries Removed: Endometriosis
Breast Implants	Ovaries Removed: Cyst
Colectomy: Colon Cancer Resection	Ovaries Removed: Ovarian Cancer
Colectomy: Diverticulitis	Prostate Removed: Prostate Cancer
Colectomy:IBD	Prostate Biopsy
Gallbladder Removed	TURP (Prostate Removal)
Coronary Artery Bypass	Spleen Removed
Mechanical Valve Replacement	Testicles Removed (Right, Left, Bilateral)
Biological Valve Replacement	Hysterectomy: Fibroids
Heart Transplant	Hysterectomy: Uterine Cancer
Joint Replacement, Knee (Right, Left, Bilateral)	
Joint Replacement, Hip (Right, Left, Bilateral)	NONE

Other: _____

Skin Disease History: (please CHECK all that applies)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	
		NONE

Other_____

Do you wear Sunscreen? Yes No If yes, what SPF?_____
Do you tan in the tanning salon? Yes No

Do you have a family history of Melanoma? Yes No

If yes, which relative(s)_____

Medications: (Please enter all current medications)

_____
_____
_____

Allergies: (Please enter all allergies)

_____
_____

Social History: (Please CHECK all that apply)

Cigarette Smoking:	**Alcohol Use:**
Currently Smokes	EtOH-None
Has smoked in the past	EtOH- less than 1 drink a day
Never smoked	EtOH-1-2 drinks per day
Former Smoker	EtOH-3 or more drinks per day

Preferred Language: _____ Race:_____

ALERTS: (please CHECK all that applies)

Allergy to Adhesive	Allergy to lidocaine	Allergy to topical antibiotics
Artificial heart valve	Artificial joint replacement	Blood thinners
Defibrillator	MRSA	Pacemaker
Require antibiotics prior to surgical procedure		
Rapid heart beat with epinephrine		
Pregnant or currently trying to get pregnant		NONE

_____ _____
Patient/Patient's Guardian Date

POBLETE DERMATOLOGY

Financial Policies & Payment

Your health coverage is a contract between you and your insurer, not the physician. Third party payers (commercial and government insurers) reimburse the physician according to a negotiated fee schedule. However, if issues arise, the patient is ultimately responsible for payment. As a courtesy to our patients, we will submit your claim to the insurer. You will then receive an EOB (explanation of benefits) in the mail/by email directly from your insurer detailing the amount you are required to pay, if any. We are now in the era of managed care. Insurance companies are concerned about the rising costs of healthcare. In an attempt to control their costs, they share the burden of paying for your healthcare with you. Please understand that we did not select your insurance plan. You will be responsible for any co-payments and/or deductibles or non-covered services specified by your insurer at the time of service. A deductible is the amount of money your insurance company requires you to pay before your plan "kicks in" and covers the rest. You should assume every procedure done in a dermatology office will be applied to your deductible. We reserve the right to collect deductibles and coinsurance up-front PRIOR to certain procedures. We are contractually obligated with your insurer to collect these charges. There are no exceptions.

If your insurance requires a REFERRAL to see a specialist, it is your responsibility to ensure our office has that referral PRIOR to your visit. If we do not have a referral, your insurance will not cover the visit and you will be responsible for the cost of the visit. You will also be financially responsible if your health plan is not a plan our office participates in.

We accept payment in the form of cash, personal check, Visa, Mastercard, Discover, American Express, and CareCredit. There is a $25 returned check policy.

Patients with Out of Network Coverage

If we are not a provider with your insurance plan, you are expected to pay 100% of the charges at the time service is rendered. A claim form will be given at the end of the visit to submit to your insurance company.

Patients with No Insurance Coverage

Self pay patients are required to pay the office visit fee before seeing the physician. If procedures are deemed necessary, the patient will be responsible for these costs as well. We will discuss the estimated charges before the procedure is performed. For larger procedures, such as surgical removal of skin cancer, full payment is required the day the procedure is performed. An estimate of the cost will be provided prior to your surgery.

Pathology and Lab Fees

Diagnostic fees for skin biopsies or excisions are the patient's responsibility. Facilities our practice uses include D-Path, DermPath, and Inform Diagnostics to name a few. If you have questions about a bill received from one of these entities, you should call the phone number listed on the statement. We do not have the authority to discuss charges or your account balance with these laboratories.

Financial & Collections Policy

As a courtesy, we will file an insurance claim to any carrier we participate in for our services. In order to properly file or appeal a claim, we must have each patients' current valid insurance card. We will ask for this item when scheduling your first appointment. This ensures we have the most pertinent information on file and we can verify insurance eligibility prior to or on the date of service, thus helping make your visit more efficient.

In order to continue to provide outstanding medical care, we make every effort to collect money owed to our practice for previous treatment. All patient balances are due 30 days from receipt of the statement from our office, or at any follow up visits. If, after several attempts, we fail to collect the outstanding balance, you may be unable to schedule future appointments until that balance is paid in full.

_____ _____

Patient Signature Date

1601 Whitehorse-Mercerville Rd. Suite 2
Hamilton NJ 08619
Tel:609-838-9040
pobletedermatology@gmail.com

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH DESIGNATED PARTIES

PATIENT'S NAME:_____DATE OF BIRTH: _____

I VOLUNTARILY REQUEST AND AUTHORIZED DR. MARIA ABELLO-POBLETE AND THE STAFF OF POBLETE DERMATOLOGY, TO DISCUSS AND RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO THE FOLLOWING:

PLEASE DESIGNATE FAMILY AND FRIENDS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

DESIGNATED PARTY:_____RELATIONSHIP TO PATIENT_____

DESIGNATED PARTY:_____RELATIONSHIP TO PATIENT_____

DESIGNATED PARTY:_____RELATIONSHIP TO PATIENT_____

_____ INITIAL: I understand that I may revoke this authorization at any time through a written request.

_____ INITIAL: I understand that my treatment cannot be contingent upon my signing of this authorization.

_____ _____

PRINT PATIENT REPRESENTATIVE'S NAME DATE

_____ _____

SIGNATURE OF PATIENT OR PATIENT'S REPRESENTATIVE DATE

Maria Veronica Abello-Poblete, MD, FAAD
Board Certified Dermatologist

POBLETE DERMATOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA rules, to safeguard general health related information about you. We have a **Notice of Privacy Practices** that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and /or their authorized representatives) when they first become our patient and a copy of its available on our website: www.pobletedermatology.com.

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. Personal copies can be requested from our staff. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You may refuse to sign this acknowledgement if you wish. You are not making any statements about the content of the Notice of Privacy Practices and about your agreement or disagreement with any portion of it.

Acknowledgement
I acknowledge that Poblete Dermatology LLC has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed, and how I can access this information.

I understand if I have any questions or complaints I may contact: Privacy Officer **Claudia VanSaders RN**, or **DR. Maria Abello-Poblete**, at 609-838-9040. I also understand that I am entitled to receive updates if Poblete Dermatology LLC amends or changes its Notice of Privacy Practices in a material way.

_____
Signature of patient/Patient's representative

_____ _____
Printed name of patient/Patient's representative Date

1601 Whitehorse-Mercerville Road, Suite 2, Hamilton NJ 08619. TEL:609-838-9040 frontdeskpobletederm@gmail.com

POBLETE DERMATOLOGY

NO SHOW/CANCELLATION POLICY

We understand that there are times when you must miss an appointment due emergencies or work and family obligations. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule. As of March 1, 2019, our policy has been changed & will be valid for 1 year from the last appointment date:

- Appointment Policy:
  - 24 hour notice is needed to cancel/change an appointment. If 24 hour notice is not given, the following will apply:
    - Appointments for **examinations, consultations, evaluations, and checkups** will incur a $25 fee.
    - Appointments for **surgical procedures** will incur a $50 fee due to the large block of time set aside for the procedure.
    - Appointments for **cosmetic procedures** will incur a $100 fee due to the block of time and ordering of specific materials.
  - No Show appointments. If you fail to show for a scheduled appointment, you will be considered a "no show". No shows are subject to the fees described above.
  - 8-8:30am and 4:30-5:30pm appointments. Due to the high demand for these time slots, the following will apply:
    - Once scheduled for your appointment, if you fail to show for the appointment without notification, you **may not** be able to schedule another appointment for those time slots.

Any fees are charged to the patient and are **NOT** covered by insurance. Any fees are **due at the time of the patient's next office visit**.

By signing this form, the patient acknowledges that they have been informed of, and consent to the Poblete Dermatology, LLC cancellation policy.

_____ _____

Print Patient Name Date

_____

Patient/Guardian Signature