PATIENT REGISTRATION

PATIENT NAME:

_____

LAST FIRST

GENDER: M F DOB:_____

Circle One MM/DD/YYYY

ADDRESS: _____

_____

CITY STATE ZIP CODE

HOME PHONE _____ ▢ **THIS IS MY PRIMARY NUMBER**

CELL PHONE _____ ▢ **THIS IS MY PRIMARY NUMBER**

EMAIL _____**@**_____

(PLEASE PRINT CLEARLY)

EMERGENCY CONTACT OR GUARDIAN

NAME _____

RELATIONSHIP _____

PHONE NUMBER _____

INSURANCE_____

ID# _____

SUBSCRIBER _____

SUBSCRIBER'S DATE OF BIRTH _____

RELATIONSHIP TO SUBSCRIBER _____

HISTORY AND INTAKE FORM

PATIENT NAME: _____**DOB**: _____

REASON FOR VISIT: _____

PHARMACY NAME:_____

PHARMACY ADDRESS: _____

PHARMACY PHONE #: _____

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

ADDRESS:_____

Have you had your flu shot this season? ▢ YES ▢ NO
Have you had your pneumonia vaccine? ▢ YES ▢ NO ▢ N/A
Do you have an advanced care plan with a healthcare proxy? ▢ YES ▢ NO

PAST MEDICAL HISTORY: (please CHECK all that applies or NONE)

▢ **NONE**

□ Anxiety
□ Arthritis
□ Asthma
□ Atrial fibrillation
□ Bone Marrow
□ Transplantation
□ Breast Cancer
□ Colon Cancer
□ COPD
□ Coronary Artery Disease
□ Depression
□ Diabetes
□ End Stage Renal Disease
□ GERD
□ Hearing Loss
□ Hepatitis
□ High Blood Pressure
□ HIV/AIDS
□ High Cholesterol
□ Thyroid Problems
□ Leukemia
□ Lung Cancer
□ Lymphoma
□ Prostate Cancer
□ Radiation Treatment
□ Seizures
□ Stroke

Other_____

PAST SURGICAL HISTORY: (please CHECK all that applies or NONE)

▢ **NONE**

□ Appendix Removed
□ Bladder Removed
□ Mastectomy (Right, Left, Bilateral)
□ Lumpectomy (Right, Left, Bilateral)
□ Breast Biopsy (Right, Left, Bilateral)
□ Breast Reduction
□ Breast Implants
□ Colectomy: Colon Cancer Resection
□ Colectomy: Diverticulitis
□ Colectomy:IBD
□ Gallbladder Removed
□ Coronary Artery Bypass
□ Mechanical Valve Replacement
□ Biological Valve Replacement
□ Heart Transplant
□Joint Replacement, Knee (Right, Left, Bilateral)
□ Joint Replacement within 2 years
□ Kidney Biopsy (Nephrectomy)
□ Kidney Removed (Right, Left)
□ Kidney Stone Removal
□ Kidney Transplant
□ Ovaries Removed: Endometriosis
□ Ovaries Removed: Cyst
□ Ovaries Removed: Ovarian Cancer
□ Prostate Removed: Prostate Cancer
□ Prostate Biopsy
□ TURP (Prostate Removal)
□ Spleen Removed
□ Testicles Removed (Right, Left, Bilateral)
□ Hysterectomy: Fibroids
□ Hysterectomy: Uterine Cancer
□ Joint Replacement, Hip (Right, Left, Bilateral)

Other: _____

Skin Disease History: (please CHECK all that applies or NONE)

▢ NONE

□ Acne
□ Actinic Keratoses
□ Asthma
□ Basal Cell Skin Cancer
□ Blistering Sunburns
□ Dry Skin
□ Eczema
□ Flaking or Itchy Scalp
□ Hay Fever/Allergies
□ Melanoma
□ Poison Ivy
□ Precancerous Moles
□ Psoriasis
□ Squamous Cell Skin Cancer

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)_____

MEDICATION: (Please enter all current medications or check NONE)

▢ NONE

_____
_____
_____

ALLERGIES: (Please enter all allergies or check NONE)

▢ NONE

_____
_____

Social History: (Please CHECK all that apply)

Cigarette Smoking:

□ Currently Smokes
□ Has smoked in the past
□ Never smoked
□ Former Smoker

Alcohol Use:

□ EtOH-None
□ EtOH- less than 1 drink a day
□ EtOH-1-2 drinks per day
□ EtOH-3 or more drinks per day

Preferred Language: _____ Race:_____

ALERTS: (please CHECK all that applies or check NONE)

▢ NONE

□ Allergy to Adhesive
□ Artificial heart valve
□ Defibrillator
□ Require antibiotics prior to surgical procedure
□ Rapid heart beat with epinephrine
□ Pregnant or currently trying to get pregnant
□ Allergy to lidocaine
□ Artificial joint replacement
□ MRSA
□ Allergy to topical antibiotics
□ Blood thinners
□ Pacemaker

_____ _____
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

POBLETE DERMATOLOGY

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