New Patient Registration

Patient Information

Date:

Full Name:

Date of Birth:

Street Address: City: State: Zip:

Home Phone: Cell Phone: Work Phone:

Email: Patient Gender: ☐ M ☐ F

SSN: Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Race: ☐ African-American ☐ American Indian/Alaskan Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ White

Ethnicity: ☐Hispanic/ Latino ☐ Not Hispanic/Latino Language: ☐ English ☐ Spanish ☐ ASL ☐ Other

Interpreter Needed? ☐ Yes☐ No

Employment Status: ☐ Full Time ☐ Part Time ☐Retired ☐Unemployed

Employer:

Emergency Contact Information

Name: Relationship to Patient:

Primary Phone: Secondary Phone: I give Harmonie Medical Dermatology permission to speak with this person in detail about my healthcare.

☐Yes ☐ No **Signature:**

Name, Phone Number, and Relationship to Patient of other individuals that Harmonie Medical Dermatology may speak to about my healthcare

1.

2.

Signature:

Insurance Information

PLEASE HAVE YOUR INSURANCE CARD(S) AVAILABLE WITH YOUR NEW PATIENT REGISTRATION FORM

Primary Insurance:	ID #:	Group #:
Secondary Insurance:	ID #:	Group #:

Guarantor Information	Name:	Relationship to Patient:	
Phone:	Address:		Date of Birth:

By signing below, I am acknowledging the following:

- I have reviewed the information above for correctness and have made all changes necessary.
- I hereby authorize and consent to examinations, treatments, and release of medical information to insurance companies, claim representatives, adjusters, and other physicians necessary to process claims and assign to the physician payment for services.
- A copy of the Notice of Privacy Practices for Family Physicians of Evans has been made available to me on the website and in the office. I have been provided with an opportunity to ask questions regarding the Notice and its contents.

Signature: **Date:**

If you have Medicare, please circle Yes or No:

Are you receiving Black Lung Benefits? *YES or NO* If yes, Date benefits began: _____

Are the services to be paid by a government research program? *YES or NO*

Are you entitled to benefits through the Department of Veterans Affairs? *YES or NO*

Was the illness/injury due to a work-related accident? *YES or NO*

Was the illness/injury due to a non-work-related accident? *YES or NO*

Are you entitled to Medicare based on Age? *YES or NO*

Are you entitled to Medicare based on disability? *YES or NO*

Are you entitled to Medicare based on End-Stage Renal Disease? *YES or NO*

Are you currently employed? *YES or NO* If applicable, date of retirement?_____

Do you have a spouse who is currently employed? *YES or NO* If applicable, date of retirement? _____

Patient Health History Questionnaire

Allergies and Sensitivites

Type	Reaction
i.e. Latex	*Rash*
1.	
2.	
3.	
4.	
5.	

Past Hospitalizations/Surgeries

Description	Date
i.e. Knee Replacement	*Oct. 2019*
1.	
2.	
3.	
4.	
5.	

Current Medications

Name	Dosage	Frequency	Reason
i.e. Advil	*200mg*	*2x daily*	*Back Pain*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Preferred Pharmacy: **Location:** **Phone:**

I acknowledge that I do not have any known drug allergies: Initials: _____

Medical History

Do you or have you had any of the following?

☐ Tendency to Bleed ☐ Hay Fever ☐ Bleeding Problem after Dental Work or Surgery

☐ Glaucoma ☐Heart Murmur ☐ Radiation Therapy

☐ Mitral Valve Prolapse ☐ Bacterial Endocarditic ☐ Cancer (where)_____

☐ Diabetes ☐ Heart Disease ☐Low Thyroid ☐ High Thyroid

☐ Kidney Disease ☐ Seizures ☐ Rheumatic Fever

☐ Fainting ☐ High Blood Pressure ☐ Hepatitis
☐ Rheumatoid Arthritis ☐ Lupus ☐ Depression
☐ Blood Clot in Leg ☐ HIV/Aids ☐ Sexually Transmitted Infection
☐ Pacemaker ☐ Blood Clot in Lung ☐ Phlebitis
☐ Tuberculosis ☐ Heart Valve Replacement ☐ Internal Defibrillator
☐ Stroke ☐ Heart Bypass Surgery ☐ Asthma
☐ Heart Attack ☐ Blood Transfusion ☐ Joint Replacement: What Joint? _____

Any other health conditions?

Please list any known diseases or disorders in your family: (i.e., Heart disease, Cancer, High Blood Pressure, Diabetes, etc.)

_____ Relationship: _____ _____ Relationship: _____

_____ Relationship: _____ _____ Relationship: _____

Have you ever had skin cancer? Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Unknown Type
☐No ☐ Yes; which type?

Where was the skin cancer located? **What year were you diagnosed?**_____

Were you treated? ☐ No ☐ Yes

If yes, what type of treatment? (please circle one) Excision MOHS Surgery Medication Scraping
Freezing Chemotherapy Radiation Therapy

Have you ever had pre-skin cancer? ☐ No ☐ Yes; Type:_____
Location:_____

Have you ever had abnormally pigmented lesions or moles? ☐ Yes ☐No

FOR FEMALES ONLY:

Are you pregnant? ☐ No ☐ Yes; if so what is your due date?_____

Are you breastfeeding? ☐ No ☐ Yes

Social History

Do you currently use tobacco, smokeless tobacco, E-Cig/Vape or nicotine?	☐ Yes How Often?_____	☐ No, Former Smoker •How Many Years?_____ •Year Quit:_____	☐No, Never
Do you currently drink alcohol?	☐ Yes How Often?_____	☐ No, Former Drinker •How Many Years?_____ •Year Quit:_____	☐No, Never
Do you currently use recreational or illegal drugs?	☐Yes •How Often?_____ •What do you use/abuse?_____	☐No, Former User •How Many Years?_____ •Year Quit:_____ •What did you use/abuse?_____	☐No, Never

Please tell us about the problem(s) you are having today. Some of the things we want to know are the size, color, shape, and any type of lesion. We also want to know where it is, how long you've had it and has it changed. When and what was the change? Is it tender? Does it drain or bleed? Has it previously been treated? What was the treatment?

Problem #1:

Problem #2:

TEST RESULTS POLICY

If unable to reach me by phone, I give permission to the physicians or staff of Harmonie Medical to release my test results to my (initial all that apply):

Spouse_____Parent_____Child_____Answering Machine_____ Other_____

Lab services

It is your responsibility to inform our staff which lab is preferred by you and/or your insurance company at the time services are rendered that require lab services. *We typically use the following labs: LabCorp, DermPath Diagnostics, Clinical Pathology, SkinPath, or Cutaneous Pathology.* If your insurance requires a different or a particular laboratory, please let us know. **If you do not specify which laboratory during the time services are rendered that require lab services and Harmonie sends the specimen to a nonpreferred lab by your insurance company, you will be responsible for any bills you receive from that lab. Harmonie Medical will not be financially responsible or held liable for any bills you receive from a nonpreferred lab.**

Initial:_____

MISSED APPOINTMENT POLICY

Your appointment time has been reserved especially for you. If you cannot keep your appointment, please call at least 24 hours in advance to cancel or reschedule. We also reserve the right to reschedule your appointment if you are more than 15 minutes late; however, we will do our best to work you back in your provider's schedule; however, you may have an extended wait time. You may also be given an option to see another provider that may be able to see you quicker. **Initial:**_____

MEDICAL RECORDS POLICY

You may request your medical records to be released to any physician/medical practice by signing a release in our office or you may sign a release at the physician's office you want your medical records sent and they will send the release to our office at no cost to you. However, there will be a charge for any other request for medical records as allowed by Georgia Law. Pursuant to O.C.G.A §31-33-3, effective July 1, of each year, the costs related to medical record retrieval, certification and copy may be adjusted in accordance with the medical component of the consumer price index. Effective July 1, 2015, the Department of Community Health (DCH) became the state entity responsible for calculating the annual inflation adjustment and publishing the revised rates for medical records retrieval. Accordingly, the rates effective July 1, 2023, are as follows:

Initial:_____

		Effective July 1, 2023
Search, Retrieval and Other	Up to:	$25.88
Certification Fee	Up to Per Record:	$9.70
Copying Costs for Records in Paper Form	Per page for pages 1-20:	$0.97
	Per page for pages 21-100:	$0.83
	Per page for pages over 100:	$0.66

Billing Practices

- Harmonie Medical will file a claim with your insurance for any appointments or services rendered. If there is an outstanding balance, our local third-party billing company, Physician Technologies/Phy-Tech, will mail a statement to the address provided in your paperwork. Please note that it is your responsibility to update your mailing address with us if you move. Payment is due as stated on the Phy-Tech statement.
- If you overpay for any service(s), the credit will be applied to your account for future visits. If you do not have any upcoming visits, a refund check will be issued to you. You may request a refund at any time provided that you do not have any outstanding balances. If you owe any unpaid balances for service(s) rendered by Harmonie Medical, any credit will be applied towards unpaid balances.
- Failure to make pay amount(s) due at check-in, will result in rescheduling of appointments until a payment can be made. Unfortunately, we cannot make exceptions based on insurance or billing history.
- Please note that your insurance policy is a contract between you and your insurance company, and you are responsible for payment of your medical bills. It is your responsibility to understand your medical benefits, and we can only assist you in obtaining an estimation of costs from your insurance company. This estimation is not a guarantee of payment or coverage. Harmonie Medical is required to bill your active insurance and has no control over services covered or not covered by your plan. If your insurance is not an insurance company we hold an active contract with, we will still prepare and file a claim for services rendered; however, you are still responsible for balances unpaid by your insurance company.
- Statements and an Explanation of Benefits (EOB) will be delivered by mail. Statements will arrive in a "Phy-Tech" envelope. It is your responsibility to monitor your incoming mail and ensure that we have your correct address on file. If the EOB indicates a balance as your responsibility and you have not received a statement, contact Harmonie Medical or Physician Technologies (Phy-Tech) to confirm the correct mailing address and inquire about an outstanding balance.
- We accept cash, check, debit or credit cards, and Care Credit. Any declined cards or checks will incur a $35 returned payment fee. Please note that we are not responsible for payments lost in the mail.
- Any outstanding balances must be cleared before future appointments. You may make payment arrangements with our in-office billing specialist, but it is your responsibility to maintain these arrangements. We will not call to remind you of a payment due.
- Failure to pay may result in the following:
  - Harmonie Medical has the right to refuse seeing you as a patient until balances are paid
  - Dismissal from the practice. We will be happy to resume care once outstanding balances are paid.
  - Your account may be turned over to an outside collection agency. If we turn your account into the collection agency for delinquency, your account balance will incur an additional 25% charge for collection costs.
  - Refusal to pay may result in legal action being taken by Harmonie Medical to collect any unpaid debt.

Signature: _____ **Date:** _____

Financial Liability Form

Patient Name:_____ Date:_____

Our staff is required to check/verify your insurance card(s) at every visit, so please have it/them ready at the time of check-in. If we cannot verify your insurance coverage you will be asked to **reschedule** your appointment, or you will be considered a self-pay patient and will be required to pay for your visit in full before services are rendered. We reserve the right to file your self-pay visits to your insurance. If your insurance changes or is no longer in effect, you should advise the staff immediately at check-in.

Co-Pays: Co-Pays are part of the agreement in your insurance contract and must be paid at the time of service. Every time you come to our office for a medical visit, you will be expected to pay a co-pay. **No exceptions** will be made. If you **cannot pay** your co-pay, you will be asked to reschedule your appointment. If you have a condition requiring frequent visits to our office, expect to pay a co-pay for each visit. Your co-pay may or may not cover the entire cost of your office visit and/or procedure that you may have done. Office visit charges do not include procedure charges (injections, freezing, biopsies, excision, etc.), you may be billed separately for each. We will submit all charges for your office visit and procedures to your valid insurance company. Your insurance company determines what portion of your office visit and/or procedure cost, exceeding your co-pay/co-insurance that you are responsible for.

Deductibles: Most insurance plans have a deductible. A deductible is an amount of money your insurance company wants you to pay for your healthcare before they will pay the rest. Almost every procedure (major or minor) that a doctor performs will be applied to your deductible. This means that if you have a yearly $1000.00 deductible, any non-cosmetic procedure we do such as removing a cancer, treating a wart, etc., will go towards your deductible. You will receive a statement from our office for these charges and you are expected to pay the balance in full unless prior arrangements have been made. We reserve the right to collect all or a portion of your deductible at the point of service.

Non-Payment: We participate with **most (not all)** major insurance carriers and will file a claim with those plans with which we have an agreement. In the event your health plan determines a service to be "non-covered", or a plan exclusion, you will be responsible for the charges.

Referral/Prior Authorizations: If your insurance requires a referral/prior authorization for a service deemed "cosmetic", lacking medical necessity, or non-payable, it is your responsibility to ensure that the authorization/referral has been obtained prior to being seen in our office. In the event that an authorization is not acquired, or is deemed invalid, you may be responsible for a portion or all of the visit.

Insurance Adjudication Errors: In the event that your insurance makes a mistake while adjudicating your claim/s, we will explore all possible options in terms of getting their mistake resolved on our end. However, if your insurance does not correct their adjudication error, you will be responsible for paying the balance, or working with your insurance to get the mistake corrected.

Self-Pay: A **New Patient** self-pay office visit charge is $113.00. An **Established Patient** self-pay office visit charge is $91.00. This amount may be collected prior to your encounter. Office visit charges do not include any procedures that you may have done. You will be charged a separate procedure fee (injections, freezing, biopsies, excisions, etc.) which will be collected at check out. **You may inquire about procedure fees prior to having procedures performed, as many procedures have different costs.** In addition, many procedures require multiple treatments, for which you may be charged for each treatment. You are expected to pay the entire cost at the time of your visit.

Bad Debt Account: Patients with accounts in bad debt status will not be allowed to schedule further appointments at our office until balances are paid in full. Patients with an account having a history of nonpayment are subject to being dismissed from the practice. You will receive a bad debt letter (a Dunning Letter), before being turned over to collections.

*If you have questions about your insurance, cost of procedures, statements or payments, please speak with the Billing Department as our providers do not handle these questions.

*If you have a deductible/coinsurance, you will be required to pay the full price for your visit

*By signing this document, you agree that you have read and understand all its contents in its entirety.

_____
Patient/Legal Guardian Signature:

_____
Witness Initials: