MacInnis Dermatology – New Patient Registration Form

27950 US Hwy 27
Leesburg, FL 34748

17521 US Hwy 441 Ste 21
Mt Dora, FL 32757

1950 Laurel Manor Drive, Ste 124
The Villages, FL 32162

Phone (352) 350-5230 ***Fax (866) 539-7193***

www.macinnisdermatology.com

(please complete using your name as listed on your insurance card) **DATE**_____

Patient First Name: _____MI: _____ Last Name: _____

Mailing Address:_____

City: _____ State: _____ Zip: _____

Date of Birth: _____/_____/_____ SS#: _____-_____-_____

Primary Contact Number: _____-_____-_____ 2ndary Contact Number: _____-_____-_____

Do we have your permission to leave a voice message regarding your appointment? YES NO

Email Address: _____

Occupation: _____ Employer:_____

If Patient is a Minor, Please Complete

Person Responsible or Guardian: _____Date of Birth: _____

SS #: _____-_____-_____ Phone # (if different) _____-_____-_____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Please Circle

Marital Status: Single Married Significant Other/Domestic Partner Divorced Widowed

Birth Sex: M or F **Do you identify as anything other than your Birth Sex?** Y or N
If yes what do you identify as?_____

Language: English Spanish Other: _____

Race: White Black/African American Asian American Indian Other Race_____

Ethnic Group: Hispanic/Latino Not Hispanic/Latino Unknown _____

Seasonal Mailing Address

_____

City: _____ State: _____ Zip: _____

Start & End Dates: _____ to _____

continue on back

HIPAA and Emergency Contact

****HIPAA POLICY**** - Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of MacInnis Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA form.

Emergency Contact - Individual(s) to be contacted in case of an emergency.

If no one will be added, please write NONE
(We will speak with **you** and **ONLY you**.)

HIPAA	Emergency Contact	NAME	Contact number	Relationship
•	•			

Primary Insurance: _____

Policy # / Member ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____/_____/_____

Relationship:_____

Insurance Address:_____ -------

Secondary Insurance: _____

Policy # / Member ID #: _____ Group #: _____

Policy Holder: _____ DOB: _____/_____/_____

Relationship:_____

Insurance Address:_____

How did you hear about us: (Please select one)

Primary Care/Referring Physician: _____Phone#: _____

Patient/Friend/Family Insurance Newspaper:_____ Other:_____

Patient Signature: _____ Date: _____

MacInnis Dermatology – Consent Form

Please initial and sign at the bottom

_____ **Initials**	**Consent for treatment –** I voluntarily consent to receive medical and health care services by Dr. Colleen MacInnis and/or her assistants that may include examinations, routine office procedures, diagnostic procedures, and other treatments deemed necessary by Dr. MacInnis. I agree to communicate any questions or concerns about my treatment to Dr. MacInnis prior to being treated. I agree to inform Dr. MacInnis before services are rendered about any health problems I may have, possible drug allergies, current medications I am taking, or any other information that may be pertinent to my treatment.

_____ **Initials**	**Team Approach to Treatment – I understand that at MacInnis Dermatology we have a Certified Physician's Assistant (PA-C) on staff. The relationship between a PA-C and the supervising physician is one of mutual trust and respect. The Physician Assistant is a representative of the physician, treating the patient in the style and manner developed and directed by the supervising physician. The physician and PA practice as members of a medical team in the delivery of medical care.**

_____ **Initials**	**No Guarantees –** I understand that the practice of medicine is not an exact science and results vary among patients. I understand there is no contract, warranty, guarantee or promise concerning the results of medical services provided by Dr. MacInnis and/or her assistants.

_____ **Initials**	**Limited Release of Information –** I authorize the release of medical information to my primary care or referring physician, to consult if needed and as necessary to process insurance claims, insurance applications and prescriptions.

_____ **Initials**	**Assignment of Benefits –** I authorize MacInnis Dermatology to accept assignment/payment from my insurance carrier(s) for services rendered. I authorize use of my signature below on all my insurance submissions.

_____ **Initials**	**Pathology Services for non-Medicare patients –** I authorize Dr. MacInnis and/or her assistants at MacInnis Dermatology to send my tissue or other specimens to CarePath DX or other laboratories for microscopic slide processing and interpretation. I authorize representatives of MacInnis Dermatology to bill my insurance carrier for all pathology services performed by outside laboratories.

I acknowledge having received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

Patient Signature: _____ Date :_____/_____/_____

continue on back

MacInnis Dermatology - Financial Policy

I understand and agree to the following terms of MacInnis Dermatology's financial policy:

- Payment is due in full at the time of service for self-pay patients and for cosmetic procedures.
- We bill insurance as a courtesy, and balances are ultimately the patient's responsibility. If we cannot collect insurance payment within 90 days, the balance will be assigned to the patient.
- Co-payments and co-insurance (where a percentage of charges is assigned to the patient) are due at the time of visit.
- Patients must provide proof of insurance at the time of visit. If the patient's insurance card is not presented when there is a change in coverage, the patient will be responsible for full payment at the time of service.
- Patients are responsible for knowing their insurance coverage and benefits. Although we make every attempt to accurately confirm our participation in various plans, it is ultimately the patient's responsibility to verify coverage. We recommend calling your insurance carrier prior to your visit to verify coverage. Rejection of all or part of your medical insurance claim by your insurance company does not relieve your financial obligation to MacInnis Dermatology.
- Payment for patient bills is due upon receipt. After we receive insurance payment, there may be a remaining patient balance for deductibles, additional co-payments, non-covered services or any other charge the insurance carrier may assign to the patient. Payment is due immediately upon receiving a bill from MacInnis Dermatology.
- Prior balances are due at the time of visit. Returning patients must pay their bill if they arrive for an appointment and have an outstanding balance on their account.
- Accounts not paid within 120 days will be sent to a collection agency, and may subject to an additional fees.
- Missed appointments are subject to a $50.00 cancellation fee. Please provide at least 24-hours advance notice if you need to reschedule or cancel your appointment.
- Missed surgery appointments are subject to a $150.00 cancellation fee. Please provide at least 24-hours advance notice if you need to reschedule or cancel your appointment.
- MacInnis Dermatology accepts cash, checks and all major credit cards. If a check payment is returned by the bank, a $25.00 fee will be applied to the patient's account. Patients who have a returned check must use cash or credit card only for all future payments.
- If you are a cash pay patient or are insured and choose not to bill insurance, we will provide you with a good faith estimate of charges. If the bill is at least $400 more than your estimate you may dispute the charges. You have 120 days from the date of the bill. For more information see www.cms.gov/nosurprises.

_____ _____ _____/_____/____

Patient or Responsible Party Signature **Print Name** **Date**

Patient Intake Form

Name: _____ Date of Birth _____ Date: _____

Preferred Pharmacy

Name: _____ Phone: _____ City _____

Preferred Laboratory to Send Specimens

Name: _____ Please note: We use CarePath for our specimens. Results may take 2-3 weeks to come back. All benign results will be posted to the patient portal. You will be contacted **ONLY** if you need to schedule treatment

Past Medical History

Select any of the following medical conditions you currently have:

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Enlargement of prostate
- ☐ 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
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ NONE
- ☐ Other

_____
_____
_____
_____

Please turn page over

Past Surgical History

Have you had any surgeries on the following organs?

- ☐ Heart: Pacemaker
- ☐ Heart: Mechanical Valve Replacement
- ☐ Breast: Lumpectomy (Right | Left | Bilateral)
- ☐ Breast: Mastectomy (Right | Left | Bilateral)
- ☐ Gallbladder: _____
- ☐ Joint Replacement: Knee (Right | Left | Bilateral)
- ☐ Joint Replacement: Hip (Right | Left | Bilateral)
- ☐ Other: _____
- ☐ Colon: _____
- ☐ Liver: _____
- ☐ Kidney: _____
- ☐ Ovaries: _____
- ☐ Prostate: _____
- ☐ Uterus: _____
- ☐ NONE

Skin Disease History

Have you had any of the following?

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ 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
- ☐ NONE
- ☐ Other

_____

_____

If any skin cancers please list location and date skin cancer._____

_____

Do you wear Sunscreen?

◯ Yes ◯ No

If yes, what SPF? _____

Do you tan in a tanning salon?

◯ Yes ◯ No

Do you have a family history of Melanoma?

◯ Yes ◯ No

If yes, which relative?

- ☐ Mother
- ☐ Father
- ☐ Sister
- ☐ Brother
- ☐ Daughter
- ☐ Son
- ☐ Other:

_____

_____

Medications

List all current medications within the chart below;

Name of medication	Unit	Route (Oral, Injection etc.)	Dosage	Form (Pill, Cream, etc)	Frequency (How often)
1.					
2.					
3.					
4.					
5.					
6.					

Can we import medications from your pharmacy? **Yes No**

Any Known Drug Allergies

List all drug allergies if known:

_____

_____

_____

_____

Social History

Smoking Status (please choose one):

- ☐ Current everyday smoker
- ☐ Current someday smoker
- ☐ Former smoker
- ☐ Never smoker
- ☐ Unknown if ever smoked

Number of days in the past year you had Alcohol (please choose):

- ☐ None
- ☐ 1-3 per day, on _____ occasions in a year
- ☐ 4+ per day, on _____ occasions in a year
- ☐ 5+ per day, on _____ occasions in a year

Please turn page over

Family History of Skin Cancer

Please include only first-degree relatives:

_____

_____

_____

Other Medical

Have you had the Pneumonia vaccine?

☐ Yes ☐ No

Do you have advanced care planning in place?

☐ Yes ☐ No

Do you have a healthcare surrogate?

☐ Yes ☐ No

If yes, Provide the name of your surrogate.

_____

Have you had the Influenza vaccine?

☐ Yes ☐ No

If no, please explain: Allergy or Other_____