Advanced Dermatology Center
Belmina N. Michael, M.D.
Advanced Urology Center
Alan Y. Sadah, M.D., FACS

Registration (please print)

Date_____Home Phone_____Cell Phone_____

Patient Information

Last Name_____First Name_____Mid Initial_____

Email_____

Address_____

City_____State_____Zip Code_____

Sex M F Age_____Birthdate_____

Employer? / School_____Occupation_____

Employer / School Address_____Employer/School Phone_____

Whom May We Thank For Referring You?_____

In Case Of Emergency Who Should We Notify?_____

Phone#_____

Assignment and Release

I Certify that I and/or my dependent(s) have insurance coverage with _____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. The above-named Doctor may use my health care information and may disclose such information to the above-named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

*signature of patient, parent, guardian or personal representative *Date

Name: _____ Age:_____
Refeered by: Dr. _____ Familiy (name): _____ Friend (name): _____
Other(please specify): _____
Medical History:
In your own words please state the reason for your visit: _____
_____
How long have you had this problem: _____
Symptoms (how does it bother you):
_____
Please list all prior treatments you have received for this problem: _____
_____
Please list all medications you are currently taking:
_____
Please list all drug and enviromental allergies: _____
_____
Rash? (Yes/No) Swelling? (Yes/No) Wheezing? (Yes/No) upset stomach? (Yes/No)
Have you ever seen a doctor for skin problems? _____
Have you had any skin, mucous membrane, hair or nail symptoms not listed above_____
_____
Have you had any of the following?

	Yes	No		Yes	No
Pacemake	___	___	Psychiatric illness	___	___
Heart disease	___	___	Epilepsy/Seizures	___	___
Heart Murmur	___	___	Tuberculosis	___	___
Mitral valve prolapse	___	___	Cancer (diagnostico)	___	___
Mitral valve insufficiency	___	___	(Year diagnosed)	___	___
Heart valve replacement	___	___	High Blood Pressure	___	___
Joint replacement	___	___	Thyroid disease	___	___
Lung disease	___	___	Anemia	___	___
Liver disease	___	___	Eye disease (diagnosis)	___	___
X-Ray therapy	___	___	Immune Deficiency (AIDS)	___	___
Gastrointestinal disease	___	___	Hepatitis B	___	___
(diagnosis)			Hepatitis C	___	___
Diabetes	___	___			

Comments on the above: _____
Women: Are you pregnant or do you plan to become pregnant soon? _____
Any history of Drug, Alcohol, Tobacco use? (if yes please circle all that apply)
How long? _____ Quit? Yes/No)
Personal History: (education)/ (current employment) (married) (single):_____
Past Family Medical History and Family Social history: _____
Please list all past major illnesses and operations and dates: _____
_____
Is there a family history of (please circle): melanoma, skin cancer, asthma, hay fever, eczema, psoriasis, hair loss, diabetes, adult acne, genetic disease? Other _____
When you are exposed to sunlight, do you:

__ Always burn __often burn, tan slowly __rarely burn, always tan
__usually burn, rarely tan __sometimes burn, tan well __ never burn, deeply

Rev ( ) Date: _____/_____/_____

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Treatment Consent And Assignment Form

Consent for Diagnosis and Treatment

I hereby authorize Dr. Michael / Dr. Sadah, to administer such medications and to perform such procedures as may be deemed necessary.

Payment for Guarantee / Assignment of Insurance Benefits

I understand that clinical care, physician services, which may include medical supplies, (the "Health-care Services") have been or will be provided to me or my dependent, (patient whose name appears above).

I represent that I presently maintain insurance coverage which will reimburse the charges for the Health-Care Services being provided; if my insurance coverage is not sufficient to satisfy the charges in full, I acknowledge that if the resulting balances are not covered by this assignment, I will be fully responsible for payment of incurred charges, and I agree to pay the established rates for all Health-Care Services.

In consideration of the services rendered, I hereby assign to Dr. Michael / Dr. Sadah all of my rights to medical reimbursement, including, but not limited to, the right to designate a beneficiary, add dependent eligibility and to have an individual policy continued or issued in accordance with the terms and benefits under any insurance policy, subscription certificate or other health benefit indemnification agreement otherwise payable to me for those services rendered.

Consent For Release of Information / Patient Notification Statement

I hereby authorize the physician who bill for my services, to release to employer groups, insurance companies, government agencies, or other third party payers and their agents information concerning medical care, advice, treatment, or supplies or other information that may be necessary for the purpose of determining eligibility and available benefits and obtaining payment on my behalf for the health care service provided to me. This authorization for my release of information may be revoked in writing at any time except as to those actions, which may have already occurred.

I understand the information contained in this Treatment Consent and Assignment Form.

Signature of Patient or Guarantor / Guardian if Patient is a Child **Date**

I acknowledge receipt of a copy of the Notice of Privace Practices; the physician has reserved the right to change his or her privacy Practices described in the notice. A copy of any revised Notice will provide or made available on a follow up appointment.

Signature of Patient or Guarantor / Guardian if Patient is a Child **Date**

Witness **Date**

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Financial Policy

Thank you for choosing us as your healthcare provider. We at Dr. Michael and Dr. Sadah's Office are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive health care available today. The following is a statement of our financial policy, which we invite you to read and sign prior to any treatment.

1. Payment: Co-pays are due at the time of check-in. We accept cash, check, or credit cards. Please check with your insurance company if a co-payment amount is not listed on the front of your insurance card. There will be a $25.00 service charge for any checks returned for insufficient funds.
2. Identification, insurance, address and phone number information is verified each visit: be prepared to present your insurance card at each office visit. In addition, federal privacy guidelines require each patient to present photo identification at the initial visit.
3. Insurance: Prior to your visit you should confirm with your insurance company, or HMO managed Care Company, that we are participating providers. On your behalf, we will bill your insurance company or other verified third party carrier for services rendered. The insurance contract is an agreement between the patient and the insurance company. Any unpaid balances will remain the responsibility of the patient. By law, you are liable for the bill if the insurance company does not reimburse within 60 days. You may also inquire about our other bill payment options with Care Credit for any balances owed by you.
4. Release of Medical Records: A notice of 14 days is required for the copying and release of medical records. Records are copied by an independent service that comes bi-weekly to our office.
5. Missed Appointment: There will be a $35.00 charge for missed appointments. A missed appointment is an appointment that is not cancelled at least 48 hours prior to the scheduled appointment time. We request that you call 48 hours in advance if you cannot make your scheduled appointment. Patients with frequent missed appointments will unfortunately be dismissed from the practice.
6. Referrals: It is the responsibility of HMO patients to obtain a referral for all services in our office. Please call for the referral at least 14days prior to your appointment time to secure it. If you have PPO insurance, you may still require pre-authorization for certain services or surgical procedures. If you fail to obtain a referral and the insurance company pays for services rendered, you will be refunded.
7. Past Due Accounts over 60 days past due will be referred to a collection agency. Unless other arrangements are made. We allow forty-five days from the date of billing for insurance companies to pay their portion of your account. Any remaining balance afterwards will be your responsibility.
8. Self-Pay Patients: Full payment is due at the time of service for office visits.
9. Medicare patients: As participating physicians with Medicare, we accept assignment for services provided to you. However, you are responsible for the 20% unpaid by Medicare and the annual deductible amount. Please provide us with any secondary insurance information for claim submission. Any remaining balance will be your responsibility.
10. Medicaid (IDPA) patients: Patients are responsible for bringing their card, which determines their eligibility. Your co-pay is due at the time of service. Federal Law requires that we collect it at the time of your visit.

By signing Below I acknowledge that I have received and read Dr. Michael's, Advanced Dermatology Center, and Dr. Sadah's, Advanced Urology Center financial policy.

_____ _____

Print Name Date

_____

Patients Signature