The Trokhan Group

## NEW PATIENT REGISTRATION

LAST NAME:_____ SSN:___-___-____ DOB:___/___/____

FIRST NAME:_____ HOME ADDRESS: _____

MIDDLE:_____ CITY, STATE, ZIP _____

GENDER: ☐ FEMALE ☐ MALE

HOME PHONE: (___) _____

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

*CELL PHONE: (___) _____

RACE:_____ LANGUAGE:_____

WORK PHONE: (___) _____

*EMAIL ADDRESS:_____

***APPOINTMENT REMINDERS AND BALANCES WILL ONLY BE SENT ELECTRONICALLY**

REFERRED HERE BY:_____

DRUGSTORE NAME:_____ PRIMARY CARE PHYSICIAN:_____

PHONE OR TOWN:_____ PHONE OR TOWN:_____

### PRIMARY INSURANCE INFORMATION

INSURANCE COMPANY:_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB:_____

RELATIONSHIP TO PATIENT:_____

### SECONDARY INSURANCE INFORMATION (IF APPLICABLE)

INSURANCE COMPANY:_____

POLICY HOLDER'S NAME:_____

POLICY HOLDER'S DOB:_____

RELATIONSHIP TO PATIENT:_____

### EMERGENCY CONTACT INFORMATION

IN CASE OF EMERGENCY, WHOM SHOULD WE NOTIFY:_____

RELATIONSHIP TO PATIENT:_____ PHONE NUMBER:(___) _____

PLEASE PRESENT YOUR INSURANCE CARD(S) AND PHOTO ID TO THE RECEPTIONIST. THE RECEPTIONIST WILL SCAN AND RETURN THEM TO YOU AT THE END OF YOUR VISIT.

SIGNATURE OF RESPONSIBLE PARTY:_____ DATE:_____
(MUST BE 18 YEARS OF AGE OR OLDER)

**PLEASE TURN THIS PAGE OVER. SIGNATURE IS NEEDED ON BACK**

**DERMATOLOGY** **ORTHOPAEDIC SURGERY**

# Office Policy Regarding Patient Financial Responsibility

Providing quality medical care for our patients is our primary concern. The following is a summary of our financial policy. We would be happy to provide further clarification if necessary. We ask that you read and sign the following to acknowledge that you have been advised of your financial responsibility for medical services provided here.

## *Please initial each numbered item and sign below*

1._____ Prior to seeing a medical professional at this office I can request that a staff member discuss the likely costs involved in my procedure(s) and review my financial responsibility.

2._____ This office participates with some insurance plans. It is my responsibility to provide this office with an up-to-date insurance card, and to notify this office of any changes to my insurance plan.

3._____ I understand that insurance may not cover all fees. I am responsible for understanding my specific insurance plan and for payment of all co-pays and/or deductible charges at the time of service. (A billing form can be supplied to you for out of network insurance submission if requested.) Any returned checks will incur a $35.00 fee that will be added to the balance due.

4._____ I understand that some procedures performed at Trokhan Dermatology, LLC are considered cosmetic and will not be covered by insurance. (You will be notified before any procedure is performed if this is the case.)

5._____ Any laboratory analysis that is required can be sent to an external laboratory of my choice and/or as required by my insurance.

6._____ For patients seeing Orthopaedic surgeons, a **$50.00** fee or a copayment, whichever is higher, will be collected at each visit. This is used towards insurance deductibles.

7._____ I understand that any reimbursement sent by the insurance company directly to the patient/insured for services rendered by our doctors will be remitted to this office within 2 weeks of receipt or extra fees will be incurred.

8._____ I understand that I have financial responsibility for payment of medical services provided by this office, and hereby assume and guarantee payment of all expenses incurred during my office visit. Should legal action be required to secure payment of this account, I agree to pay the legal expenses incurred by this office.

**I have read and understand this financial policy and agree to accept responsibility as described.**

Signature of responsible party:_____ Date:_____
(Must be 18 years of age or older)

## NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. You have the right to review our Notice before signing this Consent. The terms of our notice may change. If we change our Notice, you may obtain a revised copy at any time by contacting our office.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations. We may also create and distribute "de-identified" health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to our office:

*The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to your immediate family members, other relatives, close personal friends or other individuals you identify. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
*The right to inspect and copy your protected health information.
*The right to amend your protected health information.
*The right to receive an accounting of disclosures of protected health information.
*The right to obtain a paper copy of this notice from us upon request.

I have been notified of the updated Notice of Privacy rights and understand I can request of copy of them.

**Signature of responsible party**:_____Date:_____
(Must be 18 years of age or older)

## ALL PATIENTS:

I hereby authorize any physician, health care practitioner, hospital, clinic, or other medical or medically related facility to furnish any and all records, medical history, services rendered or treatment given to me or any dependent for purposes of review, investigation, or evaluation of any claim submitted to my insurer. I also authorize my insurer to disclose to a hospital or health care service plan, self-insurer, or any insurer, any medical information obtained if such disclosure is necessary to allow the processing of any claim.

If my coverage is under a Group Contract held by an employer, an association, trust fund, union, or similar entity, this authorization also permits disclosure to them for purposes of utilization review or audit.

**Signature of responsible party**:_____Date:_____
(Must be 18 years of age or older)

## DERMATOLOGY PATIENTS ONLY:

I understand that Dermatologists often perform biopsies, liquid nitrogen treatments or minor skin surgeries.

I understand that any time my skin is cut (for a biopsy or minor skin surgery) there is a risk of scarring, bleeding, infection, allergic reactions, swelling, recurrence and if the biopsy or surgery is near the eyes or forehead, bruising around my eyes. I also understand that any time liquid nitrogen is used to treat my skin, a blister may form and the treatment may result in a lighter or darker discoloration of the area treated.

By my signature below, I hereby give the physicians at Trokhan Dermatology, LLC authorization to treat my skin with a biopsy, liquid nitrogen or minor skin surgery. Our physicians will always discuss the procedure with you and be given consent by you before any procedure is performed.

**Signature of responsible party:**_____**Date:** _____
**(Must be 18 years of age or older)**

## AUTHORIZATION FOR RELEASE OF INFORMATION

Patient name:_____ Date of Birth:_____

Trokhan Dermatology, Trokhan Orthopaedics, and Parron Orthopaedics is authorized to release protected health information, both medical and financial, or leave messages about lab/test/X-ray results regarding the above patient to the entities below:

VOICEMAIL (please mark yes or no): [ YES ] [ NO ]

SPOUSE (PROVIDE NAME):_____

PARENT (PROVIDE NAME):_____

OTHER (PROVIDE NAME): _____

## CANCELLATION/ NO-SHOW/APPOINTMENT POLICY

1. For doctor appointments: We understand there are times when you must miss an appointment due to emergencies or family obligations for work or family. 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 when another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" schedule. **If an appointment is not cancelled at least 24 hours in advance you will be charged a $50.00 fee; this will not be covered by your insurance company**

2. For surgery or cosmetic appointments: Due to the larger block of time allotted for these type of visits, last minute cancellations can cause scheduling problems and added expenses for the offices. **If these appointments are not cancelled at least 24 hours in advance, you will be charged a $100.00 fee; this fee will not be covered by your insurance company.**

3. We will require that patients with balances pay their account balances to zero prior to receiving any further services by our practice. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to our office manager with whom they can review their account and concerns. Patients with balances over $100 must make payment arrangements prior to future appointments being made.

I acknowledge that I have read the above.

**Signature of responsible party**:_____Date:_____
(Must be 18 years of age or older)

## CREDIT CARD ON FILE PATIENT POLICY FORM

WE HAVE IMPLEMENTED A POLICY A CREDIT CARD HELD ON FILE POLICY. AS YOU MAY BE AWARE, THE CURRENT HEALTHCARE MARKET HAS RESULTED IN INSURANCE POLICIES INCREASINGLY TRANSFERRING COSTS TO YOU, THE INSURED. SOME INSURANCE PLANS REQUIRE DEDUCTIBLES AND COPAYMENTS IN AMOUNTS NOT KNOWN TO YOU OR US AT THE TIME OF YOUR VISIT. TO MAKE MANAGING PAYMENTS EASIER FOR BOTH OUR PATIENTS AND OUR STAFF, WE WILL NOW ASK YOU FOR A CREDIT CARD AT THE TIME OF CHECK-IN, SIMILAR TO HOTELS OR CAR RENTAL AGENCIES, AS WELL AS MANY OTHER PHYSICIAN OFFICES. YOUR CARD INFORMATION WILL BE HELD SECURELY UNTIL YOUR INSURANCES HAVE PAID THEIR PORTION AND NOTIFIED US OF THE AMOUNT YOU OWE. ANY REMAINING BALANCE OWED BY YOU WILL BE CHARGED TO YOUR CARD ON FILE IF IT REMAINS UNPAID FOR MORE THAN 30 DAYS. A RECEIPT SUBSEQUENTLY WILL BE EMAILED TO YOU.

CARDS ON FILE CAN BE USED FOR THE FOLLOWING REASONS:

1) COPAYMENTS
2) NO SHOW OR LATE CANCELLATION FEES
3) OUTSTANDING BALANCES GREATER THAN 30 DAYS PAST DUE
4) CREDITS DUE TO YOU, THE PATIENT

THIS WILL NOT COMPROMISE YOUR ABILITY TO DISPUTE A CHARGE OR QUESTION YOUR INSURANCE COMPANY'S DETERMINATION OF PAYMENT

**FREQUENTLY ASKED QUESTIONS**:

1) **WHY THE CHANGE?**

   Nothing is changing about how much you pay. When you come to our office and receive a service, you do so with the understanding that you are ultimately responsible for the cost of care. With the changing environment in healthcare, more responsibility of payment falls on the patient. While we have wonderful patients and we know most of you pay your balances, not everyone does.

   We are also trying to help the environment. By being able to issue credits due to you via your credit card, or charge any balances due on a saved credit card, we can save a lot of paper, which will save our trees!

2) **WHAT IF I DO NOT HAVE A CREDIT CARD?**

   A valid debit card, health savings account (HSA) card or flexible spending account (FSA) card will be accepted

3) **WHAT ABOUT IDENTITY THEFT AND PRIVACY?**

   Under HIPAA, we are under strict state and federal guidelines to protect patient privacy. Your card on file is considered protected health information. Our credit card processing vendor, Square, will store your information on a secure site which will enable us to run card transactions through our computer system. The full credit card is not available to us once entered, only the last 4 digits.

4) **WHAT IF I NEED TO DISPUTE MY BILL?**

   We will always work with you to understand if there has been a mistake. Should your card be mistakenly run, we will refund your card. We will only charge the amount that we are instructed to by your insurance plan in the EOB they send to us or for any balances on cosmetic procedures.

☐ VISA ☐ Mastercard ☐ American Express ☐ Discover ☐ Other_____

Patient's Name_____ Date of Birth_____

Cardholder name (print): _____

Last 4 of Credit/Debit Card Number: _____

Card billing address:_____ EXP. Date:_____

Debit/Credit card holder signature:_____ Date:_____

☐ I decline to have my credit card saved on file. **I understand that a $10 fee will be added to any delinquent bill sent on paper by mail. Overdue accounts will be sent to collections after 90 days.**

**Signature of responsible party**:_____Date:_____
(Must be 18 years of age or older)

Visit www.TROKHAN.com for more information about our doctors

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