DAVID KAPLAN, MD

Adult and Pediatric Dermatology
4601 W. 109th St., Suite 116
Overland Park, Kansas 66211
913-469-1115

NEW PATIENT REGISTRATION FORM

Patient Name: _____

Address:_____ **City, State, Zip:** _____

Sex: Male Female **Birth Date:**_____/_____/_____ **Age:** _____ **Marital:** S / M /D / W

Cell Phone:_____ **Home Phone:** _____ **Email:** _____

Employer & Phone: _____

Pharmacy & Phone:_____ **Primary Physician:** _____

How were you referred (Please check one and include the physician or person(s) name):

___Physician_____Friend/Patient_____Website_____Google ___Facebook_____Other, specify _____

Referral Physician or Referral Person(s) Name: _____

Who is financially responsible for payment for these services?

____Self ____Spouse _____Parent/Guardian _____Other _____

Responsible Party (Bill To) Information (if different from patient)**:**

Full Name:_____ **Relationship:** _____

Address:_____ **City, State, Zip:** _____

Primary Phone:_____ **Alt Phone:**_____ **DOB:** _____

Employer:_____

May we leave personal medical/cosmetic/billing information/appointment reminders on your

Home Phone? _____ Cell Phone? _____ PICK ONE

Do you give our office permission to discuss your personal/medical/cosmetic/billing information with family members?_____YES_____NO, if yes, please provide their names and phone numbers below. **(If yes is marked and the names are left blank, the approval is invalid).**

1. **Name and Phone Number(s):**_____ Relationship: _____
2. **Name and Phone Number(s):**_____ Relationship: _____

Emergency Contact:_____ Relationship: _____

Phone Number(s): _____

Please present your photo ID, the receptionist will make a copy and return it to you promptly. I hereby acknowledge receipt of Adult and Pediatric Dermatology's Notice of Privacy Practices, Welcome Packet, and Patient Consent for Use of Disclosure of Protected Health Information.

_____Initials

I/we have read and understand the Financial Policies and Cancellation/No Show Policies.

_____Initials

(If this form is completed prior to your appointment, please do not initial or sign until you arrive at our office) Digital signatures/initials are not accepted.

_____ _____

Patient or Parent or Guardian Signature **Date**

ADULT AND PEDIATRIC DERMATOLOGY
FINANCIAL POLICY

1. **Direct Pay Practice** We are a direct pay practice and do NOT participate with ANY insurance or government healthcare program. Patients pay for their care at the time of service.

2. **Payment** Payment in full is required for all services before you leave our office. Cash, checks, and all major credit cards are accepted. For your convenience, we offer the option to keep a credit card on file. If you are interested, please inquire at your visit.

3. **Fees** All office visits are based on time spent with the provider. Patients will be given an estimate of charges and be notified of any additional charges prior to extending the visit or procedures.

4. **Out of Network** Adult and Pediatric Dermatology and/or providers are considered as OUT OF NETWORK for ALL insurance plans. The practice and providers are not contracted with any government or commercial insurance plan. This includes Medicare, Medicaid, Medigap, Tricare, and all commercial primary, secondary and/or tertiary insurance plans.

5. **Out of Network Coverage** Your Insurance company may reimburse you for out-of-network coverage, depending on your specific insurance. If you would like to file for reimbursement, you will receive a statement of services. Please note that it is your responsibility to understand your plan's out of network coverage. We cannot make any guarantees regarding whether you will be reimbursed by your insurance plan. If you have questions, you should speak directly with your insurance company or benefits manager.

6. **FSA/HSA** Services provided to you at our office are eligible for payment via Flexible Spending Accounts (FSAs) or Health Savings Accounts (HSAs). You will need to check with your plan prior to your appointment. If your FSA/HSA balance does not pay for all charges, another form of payment is required.

7. **Labs** If you need any biopsy tests or lab work done, it will be done by an outside lab and you will receive a separate bill from that lab. If you have insurance, you may choose to have these services billed to your insurance. We have negotiated discounted pathology fees with preferred labs for our self-pay patients.

8. **Medicare** If you are enrolled in Medicare, Medicare requires that you sign a one-page private contract with your provider indicating that you have been informed that medical services will not be covered. This applies both to traditional Medicare as well as Medicare Advantage plans. Please note that any prescriptions or tests ordered will still be covered by Medicare.

9. **Legal** Any legal documents for Guardianship or Power of Attorney must be presented at the time of service. All legal documents must be original copies. If these documents cannot be provided, you will be asked to reschedule the appointment. This office is NOT a party to any divorce decree.

10. **Children** All children under 18 years of age must be accompanied by a parent or legal guardian on the first visit and any visit that requires consent for treatment. Payment in full is still required at the time of service.

11. **Appointment Cancellations/Reschedules/No-Shows** Our business days are Monday through Thursday. Your appointment date and time are reserved exclusively for you. If you need to cancel/ reschedule an appointment, please provide us with advance notice of at least one full business day. Cancellations/reschedules less than one full business day or "no-shows" will be charged a $50.00 fee.

If you or a dependent are scheduled for a procedure and fail to provide at least one full business day notice of cancellation/reschedule, or if you or a dependent fail to appear (no-show) for the procedure, you **will** be assessed a minimum cancellation fee of $50.00. **We will be unable to schedule any new appointments until all fee(s) are paid.**

12. **Returned Check/Credit Card Fees** We will assess a $35.00 fee for any check returned to our bank due to insufficient funds or for any other reason. We will assess a $35.00 charge-back fee for any credit card transaction that is returned by our merchant banker. We will assess a *15%* or *$10.00*, *whichever is* greater, collection fee if your account is sent to a collection agency. We reserve the right to discharge from the practice any patient who does not pay in full at the time of service.

13. **Products Refunds** Product purchases will be refunded if the return is within 30 days and if the product is less than 75% used. We reserve the right to refuse a refund if the product has been used more than 75% or if there is a pattern of returns.

I/we understand that ultimately the services rendered are my responsibility. I/we agree to permit Adult and Pediatric Dermatology and their business associates to contact me, and all other responsible parties on my account, with an automated dialing device on our cell phone or other mobile device concerning all aspects of my financial account.

I/we agree that if this account is not paid when due, and Adult and Pediatric Dermatology should retain an attorney or collection agency for collection. **I/we** agree to pay all costs of collection including reasonable interest, reasonable attorney's fees (even if suit is filed), and reasonable collection agency fees.

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DERMATOLOGY HISTORY/REVIEW OF SYSTEMS

Patient Name: _____ **Birth Date:**____/____/_____ **Age:** _____

Reason for today's visit: _____

Are you allergic to any medications/anesthesia? ☐ NO ☐ YES, please list: _____

List all medications you are currently taking (include prescriptions, over-the-counter medications, vitamins, herbals):

_____

_____

DO YOU CURRENTLY HAVE OR HAVE HAD ANY OF THE FOLLOWING:

YES	NO	
☐	☐	Skin cancer (type) _____
☐	☐	Personal history of other cancer _____
☐	☐	Family history of melanoma (siblings, parents, or children only)
☐	☐	History of blistering sunburns and/or tanning bed exposure
☐	☐	Keloids or excessive scarring
☐	☐	Lupus erythematosus
☐	☐	Eczema
☐	☐	HIV or AIDS
☐	☐	Chronic Pain
☐	☐	Bleeding tendency, anemia
☐	☐	Nervous or mental problems
☐	☐	Depression or anxiety
☐	☐	Arthritis including any artificial joints (which one)_____
☐	☐	Inflammatory bowel disease (Crohn's or Ulcerative Colitis)
☐	☐	Asthma
☐	☐	Diabetes

YES	NO	
☐	☐	Heart Disease or murmurs
☐	☐	Pacemaker or Defibrillator
☐	☐	Hypertension (high blood pressure)
☐	☐	Thyroid disease
☐	☐	Hepatitis or liver disease
☐	☐	Tuberculosis
☐	☐	Seizures or epilepsy

WOMEN:
☐ ☐ Are you pregnant? Due date:____/____/_____
☐ ☐ Are you breastfeeding?

List any other conditions not noted above: _____

_____

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS?

YES	NO	
☐	☐	Cough
☐	☐	Shortness of breath
☐	☐	Fever or chills
☐	☐	Night sweats
☐	☐	Weight loss that is unexplained or unexpected
☐	☐	Nausea, vomiting or diarrhea
☐	☐	Pain (out of 1/10) _____
☐	☐	Fatigue, lethargy or malaise
☐	☐	Mood changes

SKIN TYPE (PLEASE CIRCLE)

- **I** Always burns, never tans
- **II** Always burns, tans less than average
- **III** Sometimes burns, tans average
- **IV** Rarely burns, tans with ease
- **V** Moderately pigmented, always tans
- **VI** Deeply pigmented, never burns

SOCIAL HISTORY:

Do you drink? ☐ NO ☐ YES, drinks per day _____

Do you smoke? ☐ NO ☐ YES, what?_____How often? _____

Do you use IV or illicit drugs? ☐ NO ☐ YES, what? _____

What is your occupation?_____Hobbies? _____

_____ Date:_____

Patient or Guardian Signature **(Digital signatures are not accepted)**

I have reviewed and discussed the above information with the patient:

_____

Signature Nurse/MA Date Provider Initials: _____