CLEAVER MEDICAL GROUP
THE CENTER FOR DERMATOLOGY
& SKIN CANCER SURGERY

PATIENT REGISTRATION FORM

Please present your insurance cards and your photo ID to the receptionist so copies may be made.

Name: ____ ☐Jr. ☐Sr. Sex: ☐Male ☐Female

First Middle Last

Marital status: ☐Married ☐Single ☐Wid. ☐Div. ☐Other _____ Social Security #: ____________________

Address: ____

Street Name City State Zip Code

Home Phone: ________________________________ Date of Birth: ____________________________

Month/Day/Year

Cell Phone: ________________________________ E-mail: ________________________________

*Please circle preferred contact number above.

How did you hear about us? ☐Specialist ☐Primary Care Physician ______________________________

☐Family/Friend ☐Internet ☐Patient in Practice ☐Yellow Pages ☐Newspaper ☐Magazine ☐Skin Screening

☐Insurance Directory ☐Other ______________________________

Spouse Name and Phone #: _______________________________ Spouse's Date of Birth: ________________

Month/Day/Year

Insurance Policy Name: ____________________ Policy Holder Name: ____________________________

Policy Holder Date of Birth: _______________ Policy Holder SSN: ______________________________

Month/Day/Year

Policy Holder Relationship to Patient: ____________________________

Emergency Information (Please list someone who does not live in your household):

Name and Phone #: _____________________________________ Relationship: _________________

Address: ____

Street Name City State Zip Code

If Patient is a Minor: It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service. Minors must be accompanied by parent or legal guardian.

__________________________ ____________________________ __________ __________

Signature of Parent or Legal Guardian | Printed Name of Parent or Legal Guardian | Date of Birth | Date

Race:	**Language**	**Ethnicity:**
White	English	Hispanic/Latino
Black/African American	Spanish	Non-Hispanic/Latino
Asian	Other: ____________________	
American Indian or Native American		
Native Hawaiian/Pacific Islander		

In order to establish optimal relations with our patients and avoid misunderstandings regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to the doctor when assigned claim is filed.

____ ___________________________

Signature of Patient, Parent, Legal Guardian or POA Date

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HISTORY & INTAKE FORM
(Please Print)

Patient: ________________________________ Medical Record #:__________________________

How do you prefer that we address you (nickname, etc)? ______________________________________

Primary Care Physician: _______________________ Referring Physician: ____________________

Past Medical History/Alerts: (Please circle all that apply)

Alerts:
Blood Thinners
Defibrillator
Pre-meds Prior to Procedure
HIV/Hepatitis
Pregnant/Nursing

Allergic to:
Latex
Lidocaine
Epinephrine

Past Medical History:

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH (prostate)
Bone Marrow Transplant
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease

Depression
Diabetes
End Stage Renal Disease
GERD (reflux)
Hearing Loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyper **OR** Hypothyroidism

Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Radiation Treatment
Seizures
Stroke
NONE
Other: ___________
____

Past Surgical History: (Please circle all that apply)

Appendix Removed
Bladder Removed

Breast:
Breast Biopsy
Lumpectomy (Right, Left, Bilateral)
Mastectomy (Right, Left Bilateral)

Colon:
Colectomy (Colon Cancer Resection)
Colectomy (Diverticulitis)
Colectomy (IBD)
Colostomy

Gallbladder Removed

Heart:
Biological Valve Replacement
Coronary Artery Bypass
Heart Transplant
Mechanical Valve Replacement
PTCA (Angioplasty)

Other: ____________________

Joint Replacement:
Hip (Right, Left, Bilateral)
Knee (Right, Left, Bilateral)

Kidney:
Kidney Biopsy
Kidney Stone Removal
Kidney Transplant
Nephrectomy (Kidney Removal)

Liver:
Hepatectomy (Liver Removal)
Liver Transplant
Shunt

Ovaries:
Oophorectomy (Endometriosis)
Oophorectomy (Ovarian Cancer)
Oophorectomy (Ovarian Cyst)
Tubal Ligation

Pancreas Removed

Other: ___________________

Prostate:
Prostatectomy (Biopsy)
Prostatectomy (Prostate Cancer)
Prostatectomy (TURP)

Rectum:
APR/Abdominoperineal Resection
Lower Anterior Resection

Skin:
Biopsy
Basal Cell Carcinoma
Squamous Cell Carcinoma
Melanoma

Spleen Removed
Testicles Removed

Uterus:
Hysterectomy (Fibroids)
Hysterectomy (Uterine Cancer)
Hysterectomy (Cervical Cancer)

NONE

Skin Disease History: (Please circle all that apply)

Acne
Actinic Keratosis
Basal Cell Carcinoma
Blistering Sunburns

Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever/Allergies

Melanoma
Poison Ivy
Precancerous Moles
Psoriasis

Rosacea
Squamous Cell Carcinoma
Other: __________

Do you wear sunscreen? YES NO What SPF? ___________ Do you tan in a tanning salon? YES NO

Do you have a family history of non-melanoma skin cancer? YES NO If yes, what relative(s)? __________________

Do you have a family history of melanoma? YES NO If yes, what relative(s)? ______________________________

Medications: (Please list all current medications)

1. ________________________ 4. ________________________ 7. ________________________

2. ________________________ 5. ________________________ 8. ________________________

3. ________________________ 6. ________________________ 9. ________________________

Immunizations: ***Flu Immunization*** - YES NO ***Pneumonia Vaccination*** - YES NO

ALLERGIES: (Please list all allergies and drug allergies as well as type of reaction)

____

____

Pharmacy:

____

Name Phone Street City State Zip Code

Height/Weight: ___________________

Do you have **health care proxy** in the event you are unable to make your own medical decisions? YES NO

Designee: _____________________ Designee Best Phone Number: __________________________

Do you have a **living will**? YES NO

Which statement best reflects your wishes on advanced care recommendations?

☐**Do Not Intubate**: I do not wish to have a breathing tube, even if it is necessary to save my life.

☐**Do Not Resuscitate**: If my heart were to stop, I do not wish to have chest compressions or an automated external defibrillator to restart my heart, even if its necessary to save my life.

☐**Full Cardiopulmonary Resuscitation**: I want full cardiopulmonary resuscitation efforts to be made.

Social History: (Please circle all that apply)

Tobacco: Current / Past / Never **Alcohol Consumption**: YES NO

How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 years) or more drinks in a setting? __________________

Do we have your permission to:

Leave a message on your answering machine at home? ☐YES ☐NO Cell phone? ☐YES ☐NO

Discuss your medical condition with any member of your household? ☐YES ☐NO

If yes, with whom: ____ Relationship: __________________

All patients please sign:

- I authorize the release of any medical information needed to process Medicare and/or other insurance.
- I authorize Cleaver Medical Group Dermatology to treat the above named patient (including minors) as necessary.
- I authorize the release or acquisition of any medical information to/from any physician or physician's office, laboratory, pharmacy, hospital or surgical facility involved in my care. I have read the HIPAA privacy policy of Cleaver Medical Group Dermatology.

Signature: ____ Date: ________________________________

Signature of Patient, Parent/Guardian or POA

Rev. 12/30/2021

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Patient Financial Responsibility

Thank you for choosing Cleaver Medical Group for your medical care. We appreciate that you have entrusted us with your healthcare, and we are committed to providing you with the best patient care possible.

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Patients or their legal representatives are ultimately responsible for all charges for services rendered. All services rendered to minor patients will be the responsibility of the accompanying adult, custodial parent or legal guardian.

Your insurance is a contract between you and your insurer. It is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer. Cleaver Medical Group is contractually obligated to collect applicable co-payments at the time of services are rendered. We are also obligated to collect any deductible and/or co-insurance amounts deemed patient responsibility by your insurance company.

Medicare & Contracted Insurance Plans
If you are on traditional Medicare or are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co-payment, co-insurance and/or deductible at the time services are rendered as required by your insurance company. You will be billed in full for any services that your health plan deems as "not a benefit" or a "non-covered service".

Secondary/Supplemental Insurance Plans
We are happy to file secondary and supplemental claims as a courtesy. In the case of non-contracted secondary carriers, the balance will become the patient's responsibility.

Non-Contracted Insurance Plan
If we do not participate with your insurance plan, payment in full will be required at the time of service. Our billing department will file a claim to your insurance company as a courtesy upon your request.

Self-Pay
Self-Pay (Uninsured) patients will be expected to pay in full at the time of service for all services rendered.

Minors
A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements. If this is a custodial parent, we can submit the charges to another parent's insurance, however, the parent presenting the child for care will be billed for the balance not covered by the insurance. Any patient over 18 will be responsible for all charges incurred.

Missed Appointments
Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a fee.

Medical Records
Copies of medical records are provided to another healthcare provider at no charge. Any additional medical records requests and/or completion of forms (i.e. disability, life insurance, cancer policies, etc.) are subject to processing fees. Please be advised that medical records requests require time to be processed and cannot be provided same day requested.

Collection Fees
Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department at 770.800.3455 option 6. Personal balances over 120 days old will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees including courts costs, attorney fees and collection agency charges.

Returned Check Fee
A $25.00 fee will be added to your account balance in addition to the amount of the check returned for insufficient funds. This total must be paid by cash or credit card within 14 days.

Procedure Deposit
Patients who are scheduled for a procedure are expected to pay the estimated out of pocket amount at time of service. This amount will consist of any applicable co-payments, co-insurance or any remaining deductible amounts. Out staff will contact your insurance company and provide you with an estimated out of pocket amount based on your plan benefits.

If you are unable to pay the total of the estimated amount at time of service, our billing staff will assist you in setting up a payment plan if deemed necessary. You will be required to make some type of payment towards your estimated amount prior to your procedure.

Pathology Fees (Dermatology only)
Cleaver Medical Group has a pathologist that performs the interpretation of our patients' biopsy specimens. Fees associated with this service are separate from the procedure performed by your treating provider.

Depending upon specific factors, your provider may send the specimen to an outside lab for slide processing and interpretation. In those instances, patients or their insurance will receive a bill from the outside lab.

Cosmetic Services
Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures.

Please be aware that you may receive a statement from other entities such as anesthesia, lab, pathology, etc. Any questions that you have regarding those charges will need to be directed to those respective offices. Cleaver Medical Group does not process the billing for these services.

By signing this form, you agree that you have read and understand your financial responsibility.

Patients Name: ____ DOB: ______________________

____ ____________________
(Signature of Patient or Guardian) **Date**

For Office Use Only:

SIGNED COPY TO CHART Staff Initials: ______________ Date: ___________________

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Updated: 01/2021

NO SHOW/MISSED APPOINTMENT POLICY

We, at Cleaver Medical Group, understand that sometimes you need to cancel or reschedule your appointment and that there are emergencies. If you are unable to keep your appointment, please call us as soon as possible (with at least a 24-hour notice). You can cancel appointments by calling the following number: 770-800-3455.

To ensure that each patient is given the proper amount of time allotted for their visit and to provide the highest quality care, it is very important for each scheduled patient to attend their visit on time. As a courtesy, an appointment reminder email, call and/or text to you are made/attempted prior to your scheduled appointment. However, it is the responsibility of the patient to arrive for their appointment on time.

PLEASE REVIEW THE FOLLOWING POLICY:

1. Please cancel your appointment with at least a 24 hours' notice: There is a waiting list to see the clinician's at Cleaver Medical Group and whenever possible, we like to fill cancelled spaces to shorten the waiting period for our patients.

2. If less than a 24-hour cancellation is given this will be documented as a "No-Show" appointment.

3. If you do not present to the office for your appointment, this will be documented as a "No-Show" appointment.

4. If you arrive 15 minutes late for your scheduled appointment you will be considered a "No-Show"

5. If you "No-Show" a regular office visit appointment with Cleaver Medical Group, we will apply a **$50.00 "No-Show"** fee to your account. If you "No-Show" a surgery/procedure, we will apply a **$250.00 "No-Show"** fee to your account. These fees will have to be paid in full before we schedule you for any additional appointments.

6. If you have 3 "No-Show " appointments within a twelve (12) month period, you will be subject to dismissal from our practice. ***You will be notified by letter if the dismissal was approved.***

I have read and understand Cleaver Medical Group's No-Show Appointment Policy and understand my responsibility to plan appointments accordingly and notify Cleaver Medical Group appropriately if I have difficulty keeping my scheduled appointments.

_______________________________________ ______________ _________________
Patient Name Date of Birth Date

_______________________________________ _____________________
Patient Signature Date

_______________________________________ _____________________
Staff Signature Date