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***

Patient Information

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

Patient First Name: _____MI: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip: _____

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

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Best # to confirm appointment: Home or Cell

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

Start & End Dates: _____ **to** _____

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Emergency Contact Information

Name:_____Relationship:_____Phone:_____

Insurance Information

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:_____

****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.**

If no one will be added, please print NONE

Name of individual (Please Print)	**Relationship to Patient**
_____	_____
_____	_____

Patient Signature: _____ **Date:** _____

MacInnis Dermatology – Consent Form

Please initial and sign at the bottom

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 consultants 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.
Initials_____

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 :_____/_____/_____

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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 35% added fee of total balance.

- 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.

_____ _____ _____/_____/____

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