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NEW PATIENT REGISTRATION

PATIENT'S NAME: _____

DOB: _____ MM/DD/YY

GENDER: M F Non-Binary Prefer not to answer

MARITAL STATUS: S M D W

PHONE NUMBER: _____

ALT PHONE: _____

OK TO LEAVE MESSAGES? YES OR NO

EMAIL: _____

ADDRESS: _____

CITY: _____ **STATE** _____ **ZIP** _____

ETHNICITY: _____

PERFERRED LANGUAGE: _____

SOCIAL SECURITY #: _____

PRIMARY CARE DOCTOR: _____

HOW DID YOU HEAR ABOUT US: _____

History and Intake Form

PATIENT'S NAME: _____

DOB: _____ MM/DD/YY

Preferred Language: _____

Race: _____

Preferred PHARMACY NAME: _____

PHARMACY Phone #: _____

PHARMACY City or Zip code: _____

REASON FOR VISIT: _____

**Have you had your flu shot this season? yes no
Have you had your pneumonia vaccine? yes no N/A

Past Medical History: (please CHECK all that applies)

Anxiety, Coronary Artery Disease, Thyroid Problems, Arthritis Depression, Leukemia, Asthma, Diabetes, Lung Cancer, Atrial fibrillation, End Stage, Renal Disease, Lymphoma Bone Marrow, GERD, Prostate Cancer, Transplantation, Hearing Loss, Radiation Treatment, Breast Cancer, Hepatitis, Seizures, Colon Cancer, High Blood Pressure, Stroke, COPD, HIV/AIDS, High Cholesterol, NONE

Other _____

Past Surgical History: (please CHECK all that applies)

Appendix Removed, Joint Replacement within 2 years, Bladder Removed, Kidney Biopsy (Nephrectomy), Mastectomy (Right, Left, Bilateral), Kidney Removed (Right, Left), Lumpectomy (Right, Left, Bilateral), Kidney Stone, Removal Breast Biopsy (Right, Left, Bilateral), Kidney Transplant,

Breast Reduction, Ovaries Removed: Endometriosis, Breast Implants, Cyst Colectomy, Colon Cancer, Resection Ovaries Removed, Ovarian Cancer, Colectomy, Diverticulitis Prostate Removed, Prostate Cancer Colectomy, IBD, Prostate Biopsy, Gallbladder Removed, TURP (Prostate Removal), Coronary Artery Bypass, Spleen Removed, Mechanical Valve Replacement Testicles Removed (Right, Left, Bilateral), Biological Valve Replacement, Replacement Knee (Right, Left, Bilateral), Joint Replacement, Hip (Right, Left, Bilateral)
NONE

Other: _____

Skin Disease History: (please CHECK all that applies)

Acne	Cancer Blistering	Fever/Allergies
Actinic	Sunburns	Melanoma
Keratoses	Dry Skin	Poison Ivy
Asthma	Eczema	Precancerous Moles
Basal Cell Skin	Flaking or Itchy	Psoriasis
	Scalp Hay	Squamous Cell Skin
		Cancer NONE

Other _____

Do you wear sunscreen?

- Yes If yes, what SPF? _____
 No

Do you tan in the tanning salon?

- Yes
 No

Do you have a family history of Melanoma?

- Yes
 No

If yes, which relative(s) _____

Medications: (Please enter all current medications)

Allergies: (Please enter all allergies)

Social History: (Please CHECK all that apply)

Cigarette Smoking:

- Currently Smokes
- Has smoked in the past
- Never smoked
- Former Smoker

Alcohol Use:

- EtOH-None
- EtOH- less than 1 drink a day
- EtOH-1-2 drinks per day
- EtOH-3 or more drinks per day

ALERTS: (please CHECK all that applies)

Allergy to Adhesive, Allergy to lidocaine, Allergy to topical antibiotics, Artificial heart valve, Artificial joint replacement, Blood thinners, Defibrillator, MRSA, Pacemaker, Require antibiotics prior to surgical procedure, Rapid heart beat with epinephrine, Pregnant or currently trying to get pregnant, NONE

Patient/Patient's Guardian

Date

Financial Policies & Payment

Your health coverage is a contract between you and your insurer, not the physician. Third party payers (commercial and government insurers) reimburse the physician according to a negotiated fee schedule. However, if issues arise, the patient is ultimately responsible for payment. As a courtesy to our patients, we will submit your claim to the insurer. You will then receive an EOB (explanation of benefits) in the mail/by email directly from your insurer detailing the amount you are required to pay, if any. We are now in the era of managed care. Insurance companies are concerned about the rising costs of healthcare. In an attempt to control their costs, they share the burden of paying for your healthcare with you. Please understand that we did not select your insurance plan. You will be responsible for any co-payments and/or deductibles or non-covered services specified by your insurer at the time of service. A deductible is the amount of money your insurance company requires you to pay before your plan "kicks in" and covers the rest. You should assume every procedure done in a dermatology office will be applied to your deductible.

We reserve the right to collect deductibles and coinsurance up-front PRIOR to certain procedures. We are contractually obligated with your insurer to collect these charges. There are no exceptions.

If your insurance requires a REFERRAL to see a specialist, it is your responsibility to ensure our office has that referral PRIOR to your visit. If we do not have a referral, your insurance will not cover the visit and you will be responsible for the cost of the visit. You will also be financially responsible if your health plan is not a plan our office participates in.

We accept payment in the form of cash, personal check, Visa, Mastercard, Discover and American Express. There is a \$25 returned check policy.

Patients with Out of Network Coverage

If we are not a provider with your insurance plan, you are expected to pay 100% of the charges at the time service is rendered. A claim form will be given at the end of the visit to submit to your insurance company.

Patients with No Insurance Coverage

Self pay patients are required to pay the office visit fee before seeing the physician. If procedures are deemed necessary, the patient will be responsible for these costs as well. We will discuss the estimated charges before the procedure is performed. For larger procedures, such as surgical removal of skin cancer, full payment is required the day the procedure is performed. An estimate of the cost will be provided prior to your surgery.

Pathology and Lab Fees

Diagnostic fees for skin biopsies or excisions are the patient's responsibility. Facilities our practice uses include DermPath to name a few. If you have questions about a bill received from one of these entities, you should call the phone number listed on the statement. We do not have the authority to discuss charges or your account balance with these laboratories.

Financial & Collections Policy

As a courtesy, we will file an insurance claim to any carrier we participate in for our services. In order to properly file or appeal a claim, we must have each patients' current valid insurance card. We will ask for this item when scheduling your first appointment. This ensures we have the most pertinent information on file and we can verify insurance eligibility prior to or on the date of service, thus helping make your visit more efficient.

In order to continue to provide outstanding medical care, we make every effort to collect money owed to our practice for previous treatment. All patient balances are due 30 days from receipt of the statement from our office, or at any follow up visits. If, after several attempts, we fail to collect the outstanding balance, you may be unable to schedule future appointments until that balance is paid in full.

Patient Signature

Date

AUTHORIZATION TO DISCUSS MEDICAL INFORMATION WITH DESIGNATED PARTIES

PATIENT'S NAME: _____ DATE OF BIRTH: _____

I VOLUNTARILY REQUEST AND AUTHORIZED DR. SAIRAH KHOKHER AND THE STAFF OF K DERMATOLOGY & AESTHETIC CENTER, TO DISCUSS AND RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAME ABOVE TO THE FOLLOWING: PLEASE DESIGNATE FAMILY AND FRIENDS WITH WHOM WE CAN SHARE YOUR MEDICAL INFORMATION WITH:

DESIGNATED PARTY: _____

RELATIONSHIP TO PATIENT: _____

DESIGNATED PARTY: _____

RELATIONSHIP TO PATIENT: _____

_____ INITIAL: I understand that I may revoke this authorization at any time through a written request.

_____ INITIAL: I understand that my treatment cannot be contingent upon my signing of this authorization.

Signature of Patient / Patient's representative

Date

Printed name of Patient/Patient's representative

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required by State and Federal laws, including the HIPAA rules, to safeguard general health related information about you. We have a **Notice of Privacy Practices** that explains how your protected health information is handled and how we may use and/or disclose your protected health information. The Notice of Privacy Practices is provided to patients (and /or their authorized representatives) when they first become our patient and a copy of its available on our website:www.kdermnj.com

We are asking you to sign this form to show that we offered you a copy of our Notice of Privacy Practices. Personal copies can be requested from our staff. By signing below, you are only acknowledging that you were offered or received a copy of the Notice of Privacy Practices. You may refuse to sign this acknowledgement if you wish. You are not making any statements about the content of the Notice of Privacy Practices and about your agreement or disagreement with any portion of it.

Acknowledgement

I acknowledge that K Dermatology & Aesthetic Center LLC has offered or provided me with a copy of its Notice of Privacy Practices, which describes how medical information about me may be used and/or disclosed, and how I can access this information.

I understand if I have any questions or complaints I may contact the office 732-677-2049. I also understand that I am entitled to receive updates if K Dermatology & Aesthetic Center LLC amends or changes its Notice of Privacy Practices in a material way.

Signature of Patient / Patient's representative

Date

Printed name of Patient/Patient's representative

Date

NO SHOW/CANCELLATION POLICY

We understand that there are times when you must miss an appointment due to emergencies or work and family obligations. 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 where another patient fails to cancel and we are unable to schedule you for a visit due to a seemingly "full" appointment schedule.

Appointment Policy:

- A 24 hour notice is needed to cancel/change an appointment. If 24 hour notice is not given the following will apply:
 - Appointments for **examinations, consultations, evaluations, and checkups** will incur a \$25 fee.
 - Appointments for **surgical procedures** will incur a \$50 fee due to the large block of time set aside for the procedure.
 - Appointments for **cosmetic procedures** will incur a \$100 fee due to the block of time and ordering of specific materials.

If you "NO SHOW" for your appointment, you are responsible for the fees above

Any fees are charged to the patient and are **NOT** covered by insurance. Any fees are **due at the time of the patient's next office visit.**

By signing this form, the patient acknowledges that they have been informed of, and consent to the K Dermatology & Aesthetic Center, LLC cancellation policy.

Signature of Patient / Patient's representative

Date

Printed name of Patient/Patient's representative

Date