Ligresti Dermatology Associates
Patient Registration Form

□ New Patient □ Name Change □ Address Change □ Insurance Change

Please present ALL Insurance cards to the receptionist. If patient is a minor and you are not the legal guardian, please speak with the receptionist immediately. Thank you.

Patient Information: Please Complete All Fields Using Legal Names of the Parties Involved.

Name: (First)____________________ **(MI)**______ **(Last)** ____________________

Date of Birth:________________ **Age:** ________ **Sex:** □ Male □ Female

Mailing Address: ____________________________ **APT#:** ________
City:____________________ **State:** ______________ **Zip:** __________
Home Phone: __________ **Work:**__________________ **Cell:** ____________

Social Security #: _____ - _____ - _____ **Full-Time Student? YES**____ **Part-Time Student? YES**____

Marital Status (Please Circle): Single Married Separated Divorced Widowed

Pharmacy Name: ________________ **Address/Town:** ________________________

Referring Physician or Primary Doctor Name: ____________________________

Address or Town: ____________________________ **Phone #:** ________________

Insurance Information: ***PATIENT IS RESPONSIBLE FOR INFORMING OUR OFFICE OF PARTICIPATING LAB***
PARTICIPATING LAB: ______

Primary Insurance Carrier Name: ________________________________
Secondary Insurance Carrier Name: ______________________________

If Patient is Under Another Person's Insurance Plan, Please Provide the Insured's Information:

Name: (First) ______________ (MI)____________ (Last)____________________
Date Of Birth:__________ SS#: ______ - ______ - ______ Relationship to the Patient:__________
Mailing Address:____
Cell Phone: ________________ Home:____________ Work:________________

In Case of EMERGENCY who should we contact? (Name)______________ **(Phone#)**____________

Patient Release: Must be signed by patient if over 18 or by legal guardian of patient under 18.
I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process Insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider.
I certify that I hereby authorize Ligresti Dermatology Associates, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which required separate consent such as surgery, biopsy, or ward destructions. I understand additional written consent maybe necessary for these types of procedures and the legal guardian must be present for such consent.

Signature:____
Date:____________________

Ligresti Dermatology Associates, P. A.

Dominick Ligresti, MD

Certified American Board of Dermatology
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Fellow, American Academy of Dermatology
Cosmetic, Adult & Pediatric Dermatology & Laser Surgery
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FOR ALL PATIENTS/GUARDIANS PARTIES

As you are aware, most of the new & renewed insurance plans with the passage of the OBAMACARE have extremely high office & hospital deductibles, & are also with immediate office co-payments & or co-insurances.

OUR OFFICE POLICY mandates at all insured patients leave a valid credit card or equivalent on file with our office so that we can bill such card only or our balance, at the later date. We would charge your cad once we receive explanations of benefits detailing your personal responsibility from the carrier, only after the claim is processed, this may take 3 days to 3 months or in some cases even loner. We will send you a copy of the insurance explanation of benefits & WILL ONLY bill your credit card what the insurer indicated to us is YOUR PERSONAL FAMILY RESPONSIBILITY, you wouldn't book a hotel or rent a car without leaving your credit card/debit card info in advance. Your information is safe with us.

THEREFORE:

I, ____________________ AS PER OFFICE POLICY OF LIGRESTI DERMATOLOGY ASSOCIATES, ALLOW THIS OFFICE TO HOLD & STORE MY CREDIT CARD ON FILE, & ALLOW HIS OFFICE TO BILL TO MY CREDIT CARD ANY UNPAID CO-PAYS, CO-INSURANCE AND/OR DEDUCIBLES AS DOCUMENTED BY NY INSURANCE COMPANY FOR ALL DATES OF SERVICES. I WOULD RECEIVE INSURANCE EXPLANATION OF BENEFITS & A RECEIPTS OF PAYMENT.

____
NAME/SIGNATURE

____
DATE

Name on card ____________________

Billing Address ____________________
____

Credit Card Type/ Debi Card Type
() Visa
() Master Card
() American Express

Credit Card Number ______________________________ **Expiration Date** ____________
CVC Number ____________ **(Last 3 digits on the back of card or 4 digits on face of AmX Card**

Signature ____

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Quality of Life Questionnaire- ALLERGIES

Patient's Name: ______________________________ DOB: ____________________

1. Have you ever been diagnosed Allergies? YES __ NO __
2. Are you currently taking or have you within the last year or have been prescribed an over-the-counter or prescription strength medication for allergies, hay fever, or nasal congestion? YES __ NO __

If yes, please list all that apply:

____

3. Have you ever been diagnosed with asthma? YES __ NO ___
4. Is our doctor currently treating your asthma with medications? YES __NO__

If yes, please list all that apply:

____

5. Please check any/all of the following symptoms that you experience more than three times in a month or for more than three consecutive months. Please note that in the case of seasonal allergies, you may not be experiencing those now, but may experience those now, but may experience them regularly during a different season of the year.
   Please check all that apply:

- ☐ Stuff Nose
- ☐ Runny Nose
- ☐ Nasal Congestion
- ☐ Itchy Eyes
- ☐ Water Eyes
- ☐ Itchy Throat
- ☐ Sore Throat
- ☐ Cough
- ☐ Post Nasal Drip
- ☐ Headache
- ☐Trouble Sleeping
- ☐ Fatigue

Ligresti Dermatology Associates Dermatology Health History Questionnaire

Patient Name: ______________________________ Date of Birth: ____________________

Have you had any of the following conditions in the past?	Check if YES	Are you currently experiencing any of the following conditions?	Check if YES	Have you had any of the following Surgeries in the past?	Check if YES
Acne		Anemia		Appendectomy	
Actinic Keratosis		Acne		Carpel Tunnel Release	
AIDS		Bleeding/ Clotting disorder		Cataracts	
Anxiety		Bloody nose		Endoscopy	
Atrial Flutter/ Fibrillation		Breast lumps or masses		Heart Bypass Surgery	
Atypical Moles		Bumps under the skin		Heart Valve Replacement	
Basal Cell Carcinoma		Changes in skin lesion		Hernia Repair	
Cold Sores		Discharge from your eyes		Joint Replacement	
Depression		Dry skin		Pacemaker	
Dermatitis		Dryness in the nose		Removal of Gallbladder	
Diabetes		Dryness in your eyes		Tonsillectomy	
Eczema		Enlarged lymph nodes		Other:	
Glaucoma		Excessive bleeding		**Personal Habits**	
Heart Disease		Fatigue		Do you use a tanning bed?	
Heart Murmur		Fever		Are you taking Coumadin?	
Hepatitis		Hair loss		Are you taking aspirin?	
Herpes Simplex		Heart arrhythmia		Do you drink alcohol?	
Hirsutism		Heart palpitations		Do you use drugs	
HIV Infection		Inflamed skin		Do you have tattoos	
Kidney Disease		Itching of your eyes		Do you have piercings?	
Lupus		Itchy skin		Do you use sunscreen?	
Melanoma		Keloid		Have you had sunburn blisters?	
Mitral Valve Prolapse		Numbness/ tingling		Have you ever had sunburn?	
Psoriasis		Poor healing of wounds		Are you pregnant?	
Sarcoid		Skin bruises easily		Are you nursing?	
Seizure/Epilepsy		Sun sensitivity and swelling		Do you plan on becoming pregnant?	
Squamous Cell Carcinoma		Sweats		**Family Medical History**	
Stroke/ TIA		Warts		Acne	
T-Cell Lymphoma		Weight Gain		Allergies (Seasonal)	
Thyroid Disease		Weight Loss		Atypical Moles	
Other: (please list)		Wheezing		Basal Cell Carcinoma	
		Other: (please list)		Eczema	
				Lupus	
				Melanoma	
				Psoriasis	
				Sarcoid	
				Squamous Cell Carcinoma	

*List any allergies to medicine you have: ______________________________

***Current Medications:**____

____

Ligresti Dermatology Associates (LDA) PATIENT ACKNOWEDGEMENT OF OFFICE POLICIES

APPOINTMENT CANCELLATIONS:

INITIAL ____

If I am unable to keep my scheduled appointment, I will call Dermatology Associates (LDA) to cancel or re-schedule my medical appointment at least 24 hours in advance. Surgical appointments require 48 hours cancellation notice. If I do NOT call LDA as outlined above, I understand I will be required to pay a $75 no-show fee. You can call our office or e-mail us at ligrestidermatology@hotmail.com

CO-PAYMENTS:

INITIAL ____

Co-payments are due and collected on the day of my or my family's appointment. It is my responsibility to know my co-payment amount.

INSURANCE REFERRALS:

INITIAL ____

If my insurance plan requires a referral, I understand it is my responsibility to obtain an updated referral from my Primary Care Provider and to make sure that LDA has the referral before my visit. I understand it is my responsibility to keep track of the number of visits I have used on the referral and the expiration date and obtain new ones as needed. I understand should I fail to have a valid referral for my visit, LDA is not authorized to see me. It will be my decision to either re-schedule my visit or be seen that day and be considered a self-paid patient and will be responsible for all charges incurred. I understand my insurance company will not over any visit where a valid referral is not in place.

INSURANCE CARDS:

INITIAL ____

We require you to confirm your insurance is current at each office visit and that doctor is in network (if you don't want to pay higher out of network deductibles). New patients or existing patients with a change in their insurance information must provide a valid insurance card or temporary print out at the time of the visit. Should you be unable to produce this documentation, you may pay in full at the time of the service and submit the claim to your insurance company yourself. I understand that in signing below, I am responsible for notifying LDA of any changes to my insurance or contact information and if my plan requires a referral. If the insurance information or referral information I present at my visit is not correct, I understand I am responsible for all charges. None of the above-mentioned requirements causing patients to pay their bill are considered to be a "surprise bill".

ACCOUNT BALANCES:

INITIAL ____

I am responsible for the timely payment of my account balances, co-insurance and deductibles. All balances are due within 30 days of my first billing. Any balance left unpaid after 90 days without attempt at resolution will be considered for collections and may be submitted to a collection agency with will make reports to agencies that will affect my credit. If I am having financial difficulty, I understand I may contact the billing office to discuss a reasonable payment plan. If my account is sent to collections, I understand there will be an additional 15% of the total charges added to the principle balance for administrative fees as well as attorney and court charges. There is no guarantee of payment until claim is submitted and processed. If the claim is denied for any reason or if I have a deductible I will be fully responsible for the balance due at the contracted rate according to agreement with my insurance company.

COLLEGE STUDENTS:

INITIAL ____

If you are a college student on your parents' insurance plan, your insurance company will require a form to be completed confirming your student status. These forms are mailed to your home and must be completed and returned within 30 days. If these forms are not returned within the time frame, your claims will be denied and the policy holder will be responsible for all charges incurred.

Patient OR Guardian Signature: X ______________________ Date: ________

HIPAA PRIVACY POLICY:

Patients are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of LDA from discussing appointments, medication, test results or treatment pans with anyone other than the patient. Often, this causes difficulty for some patients who would like family member 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.

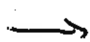
Name of Individual (please print) **Relationship to Patient**

1 ____

2 ____

I acknowledge I understand the above policies and I have received a copy of the practice' Notice of Privacy Practices (if requested) related to Health Insurance Portability and Accountability Act of 1996.

Patient OR Guardian Signature: X ______________________ Date: ________



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As of November 1st , 2017

24 HOUR Cancellation & " No Show" Fee Policy

Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care, Therefore , LIGRESTI DERMATOLOGY reserves the right to charge a fee of $75.00 for all missed appointments (" NO SHOWS ") & appointments which absent a compelling reason are not cancelled within a 24 –hour advanced notice.

" No Show" fees will be billed to the patient, This fee is not covered by insurance, & must be paid prior to your next appointment, Multiple "NO SHOWS" in any 12 month period may result in termination from our practice.

Thank you for your understanding & cooperation as we strive to best serve the needs of all of our patients.

By signing below, you acknowledge that you have received this notice & understand this policy.

______________________________ _______________
Printed Name   Date

____
Signature