McLEAN DERMATOLOGY & skincare center

# NEW PATIENT REGISTRATION – PLEASE COMPLETE ENTIRE PACKET

| LAST NAME | FIRST NAME | MIDDLE NAME | |
|---|---|---|---|
| SS# | DATE OF BIRTH | Marital Status | Sex |
| Address | City/State | Zip | |
| Home Phone<br>OK TO LEAVE DETAILED MESSAGE? Y □ N □ | Cell Phone<br>OK TO LEAVE DETAILED MESSAGE? Y □ N □ | Work Phone<br>OK TO LEAVE DETAILED MESSAGE? Y □ N □ | |
| E-Mail Address OK TO CONTACT VIA EMAIL? Y □ N □ | | | |
| Primary Care Physician | | Phone | |
| Referring Physician | | Phone | |
| Preferred Pharmacy and Address (Required) | | Phone (Required) | |
| Please list the names of individuals who can receive your medical records (Please include relation to patient): | | Phone | |
| How Did You Hear About McLean Dermatology Center? | | | |

Please list your race. Check all that apply.

□ White □ American Indian or Alaska Native
□ Asian □ Black or African American
□ Other Race □ Decline to specify
□ Native Hawaiian or Other Pacific Islander

Please list your preferred language

Please list your ethnic group

□ Hispanic or Latino □ Decline to specify
□ Not Hispanic or Latino

## Primary Insurance Information (If you are the policy holder – write SELF)

| Insurance Company | Relationship to Policy Holder | Co-Pay Amount (if known) |
|---|---|---|

## Primary Insurance HOLDER Information (Complete ONLY if different than above)

| Last Name | First Name | Middle Name |
|---|---|---|
| SS# | DOB | Sex |
| Address | City/State | Zip |
| Home Phone<br>OK TO LEAVE DETAILED MESSAGE? Y □ N □ | Cell Phone<br>OK TO LEAVE DETAILED MESSAGE? Y □ N □ | Work Phone<br>OK TO LEAVE DETAILED MESSAGE? Y □ N □ |

## Secondary Insurance Information

| Insurance Company | Policy Holder Name/Relationship |
|---|---|
| Policy Holder DOB | Relationship to Patient |

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**Have you had skin cancer?**

□ YES -- IF YES, PLEASE EXPLAIN BELOW □ NO, I HAVE NOT HAD SKIN CANCER

| Type of Skin Cancer | Location | Year | Treatment |
|---|---|---|---|
| Melanoma | | | |
| Squamous Cell | | | |
| Basal Cell | | | |

**Has anyone in your family had skin cancer?**

□ YES If YES, please specify which type: □ Melanoma □ Squamous Cell Carcinoma □ Basal Cell Carcinoma □ NO family history of skin cancer

If yes, please specify which family member(s): _____

**Do you have any pre-existing health conditions?**

| | | | | | |
|---|---|---|---|---|---|
| Anxiety | YES □ NO□ | Yeast Infections with Antibiotics | YES □ NO□ | Pacemaker | YES □ NO□ |
| Arthritis | YES □ NO□ | GI Upset with Antibiotics | YES □ NO□ | Defibrillator | YES □ NO□ |
| Asthma | YES □ NO□ | Problems with Bleeding | YES □ NO□ | Artificial Joints within Past 2 Years | YES □ NO□ |
| Atrial Fibrillation (Irregular heartbeat) | YES □ NO□ | Problems with Scarring (Hypertrophic or Keloid) | YES □ NO□ | Artificial Heart Valve | YES □ NO□ |
| Cancer | YES □ NO□ | Immunosuppression | YES □ NO□ | Premedication Prior to Procedures | YES □ NO□ |
| Depression | YES □ NO□ | Changing Mole | YES □ NO□ | Allergic to Latex | YES □ NO□ |
| Diabetes | YES □ NO□ | Rash | YES □ NO□ | Allergic to Adhesive | YES □ NO□ |
| End Stage Renal Disease | YES □ NO□ | Abdominal Pain | YES □ NO□ | Allergic to Lidocaine | YES □ NO□ |
| Hepatitis | YES □ NO□ | Bloody Stool | YES □ NO□ | Blood Thinners | YES □ NO□ |
| High Blood Pressure | YES □ NO□ | Bloody Urine | YES □ NO□ | Currently Pregnant | YES □ NO□ |
| HIV/AIDS | YES □ NO□ | Chest Pain | YES □ NO□ | Planning a Pregnancy | YES □ NO□ |
| High Cholesterol | YES □ NO□ | Cough | YES □ NO□ | Breastfeeding | YES □ NO□ |
| Hyperthyroidism | YES □ NO□ | Fever or Chills | YES □ NO□ | Rapid Heartbeat with Epinephrine | YES □ NO□ |
| Hypothyroidism | YES □ NO□ | Headaches | YES □ NO□ | Organ Transplant | YES □ NO□ |
| Hearing Loss | YES □ NO□ | Joint Aches | YES □ NO□ | Kidney Disease | YES □ NO□ |
| Seizures | YES □ NO□ | Muscle Weakness | YES □ NO□ | Liver Disease | YES □ NO□ |
| Tuberculosis | YES □ NO□ | Neck Stiffness | YES □ NO□ | Coronary Artery Disease | YES □ NO□ |
| Psoriasis | YES □ NO□ | Night Sweats | YES □ NO□ | Former Smoker | YES □ NO□ |
| Eczema | YES □ NO□ | Shortness of Breath | YES □ NO□ | Current Smoker | YES □ NO□ |
| Hay Fever/Allergies | YES □ NO□ | Sore Throat | YES □ NO□ | Alcohol Use | YES □ NO□ |
| Allergic to Topical Antibiotic Ointments | YES □ NO□ | Wheezing | YES □ NO□ | Recreational Drug Use | YES □ NO□ |
| Stroke | YES □ NO□ | Thyroid Problems | YES □ NO□ | Tanning Bed Use | YES □ NO□ |
| Unintentional Weight Loss | YES □ NO□ | | | | |

**Please list all other pre-existing health conditions and past surgeries:**

**Please list ALL current medications, supplements, painkillers, vitamins, etc.**

| | | | |
|---|---|---|---|
| 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 |

**Please list any allergies to medications** □ NO KNOWN DRUG ALLERGIES □ **SENSITIVE TO LATEX** □ **SENSITIVE TO ADHESIVE**

| | | | |
|---|---|---|---|
| 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 |

**Has anyone in your family had any of these conditions?**

| Condition | Family member(s) with condition | Condition | Family member(s) with condition |
|---|---|---|---|
| Diabetes Type I or II | | Hair Loss | |
| Thyroid Disease | | Cancer (specify type) | |

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## Cosmetic Interests

I would like to know more information about the following:

- □ Aging Skin
- □ Down Turned Mouth
- □ Sun Spots (brown spots)
- □ Under Eye Circles
- □ Brown Spots on Face/Hands
- □ Stubborn fat bulges
- □ Crows Feet
- □ Facial Lines and Wrinkles
- □ Thinning Lips
- □ Facial veins
- □ Skincare Products
- □ Loss of Facial Volume
- □ Uneven Texture
- □ Acne Scarring
- □ Facial Redness

I would like more information about the following cosmetic procedures and products:

| | | |
|---|---|---|
| □ Botox | □ Fraxel Laser Skin Resurfacing (aging) | □ Laser for facial redness (IPL) |
| □ Dysport | □ Sclerotherapy (for leg veins) | □ Coolsculpting (fat removal) |
| □ Fillers | □ DPN (for brown spots on face) | □ Latisse (eyelash/brow growth) |
| □ Nutrition counseling for acne, hair loss, eczema, or psoriasis | | |

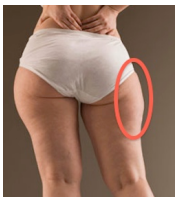
**Below, please circle any areas of concern:**

□ Love Handles fat?

□ Muffin Top?

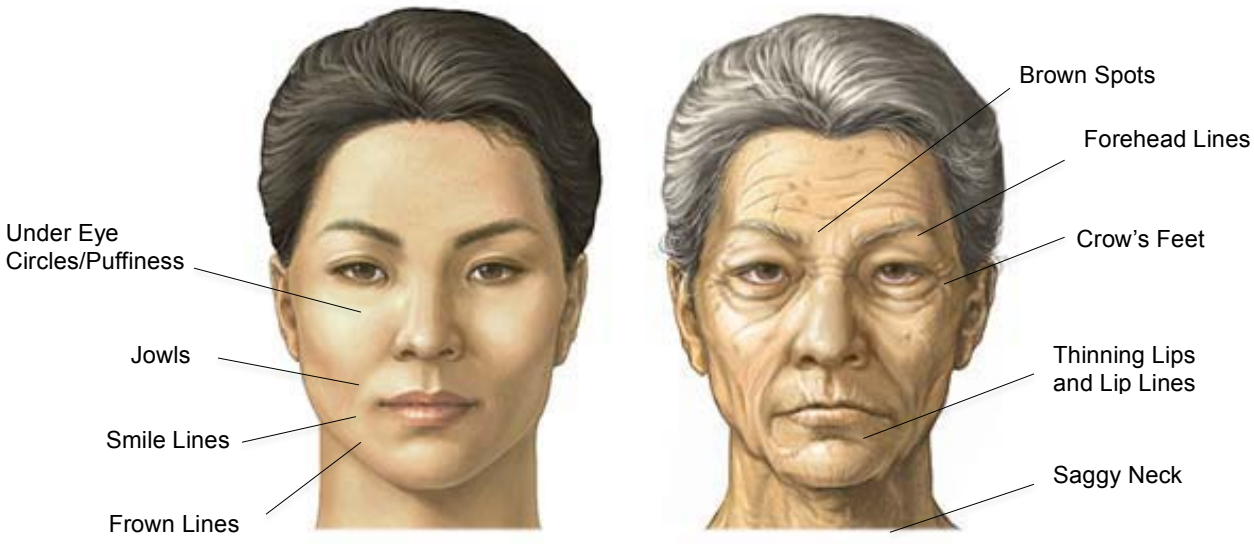
□ Stomach bulges?

□ Bra fat?



□ Saddlebags?

□ Inner thigh

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# Financial Agreement & Acknowledgement of Privacy Practices

At McLean Dermatology and Skincare Center PLLC, we are committed to providing the best dermatologic care.

NOTE: YOU MUST SIGN THIS CONTRACT TO BE SEEN BY PROVIDERS AT MCLEAN DERMATOLOGY AND SKINCARE CENTER

## INSURANCE POLICIES

A. Please note that we accept most PPO plans from BlueCross BlueShield, United Healthcare, Coventry, and Medicare as an **in-network provider.** We cannot guarantee that we are an in-network provider for your plan; it is your responsibility to verify your insurance benefits and coverage. Initial:

B. We will not submit claims to any other insurance company other than those listed above. If you have a secondary insurance in addition to one of the plans listed above, we will file a claim to your secondary insurance as an **out-of-network provider**. In such instances, we cannot guarantee complete coverage.

C. Insurance reimbursement is a contract between you and your insurance company. It is essential that you understand which services and procedures are covered by your insurance plan and obtain any necessary authorizations or referrals prior to your appointment with us.

D. It is **your responsibility** as the patient to understand your insurance plan limits and restrictions that affect coverage of services you receive.

E. If your insurance company requires you to use a specific laboratory, it is your responsibility to notify us.

## OFFICE FEES AND PAYMENTS

Initial:

A. As the patient, it is your responsible for all co-pay, deductibles, and coinsurance amounts not covered by your insurance policy.

B. Charges for all visits, treatments and procedures are due at the time of service.

C. If you have any outstanding balances with our office, they **must be paid in full before your next visit**.

D. We accept cash and all major credit cards.

E. For NSF checks (insufficient funds), a $50 NSF charge will be billed to your account.

F. If proof of insurance is not provided at the time of service, you are responsible for the entire fee for the consultation and/or procedure at the time of service, and a $150 service fee for retroactively billing your insurance will be applied to your account.

G. In the case of an account overpayment, the amount will be applied to your account as a credit unless you request otherwise.

## 24-HOUR CANCELLATION POLICY

Initial:

A. You will be billed a $50 "No Show/Cancellation Fee" for each appointment cancelled within 24 hours of your scheduled appointment.

B. You will be billed a $150 "No Show Fee/Cancellation" for all procedure appointments cancelled within 24 hours of your scheduled appointment time. (excisions, biopsies, lasers, sclerotherapy, Botox, fillers, etc.)

## COLLECTION AGENCY

Initial:

A. In the event it is necessary to refer your account to a collection agency, you will be responsible for all fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all charges accrued, including attorney fees, court costs, late fees, an 8% interest fee, and all McLean Dermatology and Skincare Center PLLC administrative fees.

A. By signing below, you authorize the release of any medical or other information necessary to process claims related to medical services received by yourself or your dependent. You assign all medical payment on your behalf or that of your dependent for services provided to be issued to McLean Dermatology and Skincare Center, PLLC Initial:

B. We are required by law to provide you with a copy of our Notice of Privacy Practices and our Financial Agreement.

By signing this form you acknowledge that you have received and read our Notice of Privacy Practices and dully understand and accept the terms of the McLean Dermatology and Skincare Center Notice of Privacy Practices and Financial Agreement.

| | |
|---|---|
| Patient Name | |
| Signature | |
| Date | |

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## To Request Information or File a Complaint

If you have questions, would like additional information, or want to report a problem regarding the handling of your information, you may contact **Lily Talakoub, M.D. (Business Owner) 6849 Old Dominion Drive, Suite 340 McLean, VA 22101 or call 703-356-5111.**
Additionally, if you believe your privacy rights have been violated, you may file a written complaint at our office by delivering the written complaint to **Lily Talakoub, M.D. (Business Owner)**.
We cannot, and will not, require you to waive the right to file a complaint with the Secretary of Health and Human Services (HHS) as a condition of receiving treatment from the office/hospital.
We cannot, and will not, retaliate against you for filing a complaint with the Secretary of Health and Human Services.

## Other Disclosures and Uses

**Directory**
[Only for hospitals.] Unless you notify us that you object, we will use and disclose your name, location, general condition, and religious affiliation in a hospital directory. This information may be provided to members of clergy and, except for religious affiliation, to other people who ask for you by name.
**Communication with Family**
Using our best judgment, we may disclose to a family member, other relative, close personal friend, or any other person you identify, health information relevant to that person's involvement in your care or in payment for such care if you do not object or in an emergency.
**Notification**
Unless you object, we may use or disclose your protected health information to notify, or assist in notifying, a family member, personal representative, or other person responsible for your care, about your location, and about your general condition, or your death.
**Research**
We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information.
**Disaster Relief**
We may use and disclose your protected health information to assist in disaster relief efforts.
**Organ Procurement Organizations**
Consistent with applicable law, we may disclose your protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.
**Food and Drug Administration (FDA)**
We may disclose to the FDA your protected health information relating to adverse events with respect to food, supplements, products and product defects, or post-marketing surveillance information to enable product recalls, repairs, or replacements.
**Workers Compensation**
If you are seeking compensation through Workers Compensation, we may disclose your protected health information to the extent necessary to comply with laws relating to Workers Compensation.
**Public Health**
As authorized by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability; to report reactions to medications or problems with products; to notify people of recalls; to notify a person who may have been exposed to a disease or who is at risk for contracting or spreading a disease or condition.
**Abuse & Neglect**
We may disclose your protected health information to public authorities as allowed by law to report abuse or neglect.
**Employers**
We may release health information about you to your employer if we provide health care services to you at the request of your employer, and the health care services are provided either to conduct an evaluation relating to medical surveillance of the workplace or to evaluate whether you have a work-related illness or injury. In such circumstances, we will give you written notice of such release of information to your employer. Any other disclosures to your employer will be made only if you execute a specific authorization for the release of that information to your employer.
**Correctional Institutions**
If you are an inmate of a correctional institution, we may disclose to the institution or its agents the protected health information necessary for your health and the health and safety of other individuals.
**Law Enforcement**
We may disclose your protected health information for law enforcement purposes as required by law, such as when required by a court order, or in cases involving felony prosecution, or to the extent an individual is in the custody of law enforcement.
**Health Oversight**
Federal law allows us to release your protected health information to appropriate health oversight agencies or for health oversight activities.
**Judicial/Administrative Proceedings**
We may disclose your protected health information in the course of any judicial or administrative proceeding as allowed or required by law, with your authorization, or as directed by a proper court order.
Serious Threat
To avert a serious threat to health or safety, we may disclose your protected health information consistent with applicable law to prevent or lessen a serious, imminent threat to the health or safety of a person or the public.
**For Specialized Governmental Functions**
We may disclose your protected health information for specialized government functions as authorized by law such as to Armed Forces personnel, for national security purposes, or to public assistance program personnel.
**Coroners, Medical Examiners, and Funeral Directors**
We may release health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information about patients of Covered Entities to funeral directors as necessary for them to carry out their duties.
**Other Uses**
Other uses and disclosures, besides those identified in this Notice, will be made only as otherwise required by law or with your written authorization and you may revoke the authorization as previously provided in this Notice under "Your Health Information Rights"
**Website**
If we maintain a website that provides information about our entity, this Notice will be on the website.