



Dear Patient,

Thank you for choosing Northside Dermatology LLC for your dermatologic healthcare. We are committed to provide you with the best possible dermatologic care and the highest level of respect and service. We want you to feel welcomed, comfortable, and cared for in our professional environment. Our mission is this:

“We value our relationship with each patient and aim to provide exceptional personalized service and dermatologic care.”

On pages 2 through 6 of this welcome package you will find three forms: Patient Registration Form (2 pages), Medical History Form (2 pages) and Financial Responsibility Form (1 page). Please print and complete these forms prior to your initial visit with us. In order to establish a complete and accurate record for you in our system, we ask that you fulfill the following on your first visit: 1) arrive 15 minutes prior to your scheduled appointment, 2) bring your three completed forms and 3) bring a photo ID and your medical insurance card(s). For your convenience, we have placed a copy of our [Notice of Privacy Practices](#) on our website. You may print a copy for your reference.

We understand that it may take some time to complete these forms, and they may seem detailed, but by completing them fully and accurately, we will be able to (1) better comprehensively evaluate your condition as well as (2) ensure that the timely payment of your visit charges occurs.

We believe that successful healthcare stems from a solid alliance between physician and patient. We look forward to developing a healthy alliance with you. If you have any questions, feel free to call our office at (317) 849-6600.

Sincerely,

Christine Kuhn MD

Northside Dermatology LLC
9865 E 116th St Suite 200
Fishers, IN 46037

Phone: 317-849-6600

www.northsidederm.com

PATIENT REGISTRATION FORM (CONT.)

Medical Emergency Contact Information:

Name: _____ Relationship: _____

Telephone Number: _____
Daytime Evening Cell

Primary Care Physician: _____

Pharmacy of Choice: _____ Phone # (with area code): _____

Can we leave a message with medical information on your telephone voicemail? **Yes No**

Signature of Patient or Parent/Legal Guardian

Date

Notice of Privacy Practices: Pursuant to the Health Insurance Portability and Accountability Act of 1996, I acknowledge that I have received a copy of [Notice of Privacy Practices](#).

Initial _____

Consent to Treat: I request and give consent to my physician to provide and perform such medical/surgical care, tests, procedures, drugs and other services and supplies as are considered necessary or beneficial by my physician for my health and well-being. I acknowledge that no representations, warranties or guarantees as to the results or cures have been made to me or relied upon by me.

Initial _____

Your signature below indicates that the information that was provided is to the best of your knowledge, true and accurate. Further, your signature authorizes Northside Dermatology LLC to release such medical information necessary to process insurance claims (if any). You herein authorize payment of medical benefits to Northside Dermatology LLC when an assigned claim is filed. It is the patient's responsibility to make sure insurance payments are processed and paid promptly to the physician. In the case of default payment, I promise to pay any legal interest on the balance due, together with any collection costs and reasonable attorney fees incurred to effect collection of this account or future outstanding accounts.

Signature of Patient or Parent/Legal Guardian

Date

**NORTHSIDE DERMATOLOGY LLC
PATIENT DERMATOLOGY HISTORY FORM**

Name: _____
 First Middle Last

Date of Birth: _____ SS#: _____ Occupation: _____

Name of Doctor who referred you: _____ Hobbies: _____

Primary reason for your visit (Please include: i.e. Where is it located? When did it start and how long have you had the condition? What have you tried? etc)

Current Medications (Prescription, Over the Counter, Vitamins, Herbals) Aspirin? Yes No	Medication / Product Allergies?: Yes No If Yes, please list (include type of reaction)
(1) _____	(1) _____
(2) _____	(2) _____
(3) _____	(3) _____
(4) _____	(4) _____

PLEASE CHECK THIS BOX IF YOU DO NOT HAVE ENOUGH ROOM TO LIST ALL OF YOUR "CURRENT MEDICATIONS" OR "MEDICATION / PRODUCT ALLERGIES" ON THE LINES ABOVE AND ARE INCLUDING THEM ON AN ATTACHED PIECE OF PAPER OR ON THE SECOND PAGE OF THIS FORM

Have you ever had local or dental anesthesia? Yes No If Yes, any bad reactions: Yes No
 Have you been told to take antibiotics prior to routine dental cleaning? Yes No If Yes, why? _____

Do you currently have or have you ever had diseases or conditions of the following?

Cardiovascular/Heart	Pulmonary/Lungs	Other
High blood pressure Yes No	Asthma Yes No	Diabetes Yes No
Chest pain/angina Yes No	Emphysema Yes No	Thyroid Yes No
Heart attack Yes No	Bronchitis Yes No	Kidney Yes No
Heart murmur Yes No	Chronic cough Yes No	Anemia Yes No
Irregular heartbeat Yes No	Wheezing Yes No	Bladder Yes No
Blood clots Yes No		Arthritis Yes No
	Neurological/Brain	Fainting Yes No
	Stroke/TIAs Yes No	Artificial joint Yes No
GI/Stomach	Seizures Yes No	HIV/Aids Yes No
Ulcers/GERD Yes No	Numbness Yes No	Cancer Yes No
Hepatitis Yes No	Tremors Yes No	<u>If Yes</u> Cancer, list type: _____

Past Personal Skin Problems:

_____ Melanoma	_____ Thick Scars/Keloids	_____ Psoriasis
_____ Skin Cancer	_____ Atopic dermatitis	_____ Eczema
_____ Abnormal Moles	_____ Other (specify) _____	

Any **PERSONAL** history of skin cancer? Yes No If Yes, type and date (if known)

WOMEN ONLY:

Are you pregnant? Yes No If Yes, due date: _____
 Are you trying to become pregnant? Yes No
 Are you currently breastfeeding? Yes No When was your last menstrual cycle? _____

PATIENT DERMATOLOGY HISTORY FORM (CONT.)

FAMILY HISTORY:

Any **FAMILY** history of other skin disease?

_____ Melanoma _____ Actinic Keratoses _____ Psoriasis
_____ Skin Cancer _____ Atopic dermatitis _____ Eczema
_____ Abnormal Moles _____ Other (specify) _____

Any **FAMILY** history of skin cancer? Yes No If Yes, type (if known) _____

SURGERIES:

Artificial heart valve: Yes No

Defibrillator or Pacemaker: Yes No

Artificial joints: Yes No If Yes, which joint (s) and date? _____

Organ transplant: Yes No If Yes, which organ and date? _____

Other medical conditions or surgeries not already noted?

Have you ever had a skin biopsy? Yes No If Yes, why? _____

Any complications with surgeries in the past? Yes No If Yes, why? _____

Skin care products (i.e. sunscreens, soaps, cleansers, types and brand of makeup etc)

Past skin care procedures (i.e. chemical peels, microdermabrasion, laser, etc)

Do you smoke (amount per day)? _____

Any alcohol use (amount per week)? _____

Completed by:

Signature of Patient or Parent/Legal guardian

Date

If needed, additional space for **Current Medications** and/or **Medication / Product Allergies**

Current Medications

Medication / Product Allergies

(5) _____
(6) _____
(7) _____
(8) _____
(9) _____
(10) _____

(5) _____
(6) _____
(7) _____
(8) _____
(9) _____
(10) _____

NORTHSIDE DERMATOLOGY LLC
PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

Patient Information:

Thank you for choosing us for your dermatologic care. In order to avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of the office. **This document must be read and signed by each patient** and will remain in effect for all services rendered during your time as a patient in our practice. All patients must complete a patient registration form and provide a copy of their insurance card(s). We are committed to giving each patient the best dermatologic care possible.

Insurance Claims: **Your insurance policy is a contract between you and your insurance company.**

At the time of your first visit, our staff will contact your insurance company for verification of coverage, co-pay and deductibles. **Full payment from you will be collected at the time of service for "your part" of the charges.** "Your part" of the charges is defined as any **co-pays, surgical deductibles, remaining yearly deductibles, and/or non-covered service charges** that are incurred on the date of service. **You will incur an additional \$10 processing fee if you do not pay your co-pay at the time of service.** We will file for our services with your primary insurance company. Secondary insurance will be filed if adequate information is provided at the time of service. We will make every effort to ensure that your insurance company pays "their part" of the charges. However, if your insurance company fails to pay "their part" in a timely manner, the bill that you receive at your visit(s) will then become your responsibility. Please understand that you are financially responsible for any unpaid balances for services if you fail to provide complete, current insurance information.

Method of Payment:

For your convenience, Northside Dermatology LLC accepts **Cash, Check, Visa and MasterCard**. There will be an additional charge for any returned checks.

Accounts Past Due:

Should any bills go unpaid and a collection agency referral becomes necessary, all charges incurred by Northside Dermatology LLC from the collection agency will be assessed to the patient.

Minor/Dependent Patients:

The parent(s) or guardian(s) of the minor or dependent is responsible for full payment. For unaccompanied minors, non-emergency treatment may be denied unless payment is collected at the time services are rendered. Children under the age of 18 will require the signature of the responsible parent or guardian on the registration form.

Missed appointments:

Unless an appointment is cancelled at least 24 hours in advance, you will be charged \$25 for a normal office visit or \$50 for a procedural appointment. Please help us serve you better by keeping scheduled appointments.

Your signature below indicates that you accept, understand and agree to this policy. Further, your signature authorizes Northside Dermatology LLC to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Northside Dermatology LLC when an assigned claim is filed.

Print name of Patient

Print name of Parent/Legal Guardian (if applicable)

Signature of Patient or Parent/Legal Guardian

Date

ATTENTION MEDICARE/MEDIGAP PATIENTS:

Name of Patient

Medicare Number

I request that payment of authorized Medicare benefits be either made to me or on my behalf to Northside Dermatology for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Center for Medicare & Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature

Date

Name of Patient

Medigap Policy Number

I request that payment of authorized Medigap benefits be either made to me or on my behalf to Northside Dermatology for any services furnished me by that physician/supplier. I authorize any holder of medical information about me to release to _____ any information needed to determine these benefits or the benefits payable for related services.

Signature

Date