SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

PATIENT REGISTRATION INFORMATION

Please print clearly. **Date**_____

How did you hear of our practice? [ ] Friend/relative [ ] Physician [ ] Internet [ ] Other_____

Name_____
(last) (first) (middle)

Address_____

City_____**State**_____**Zip Code** _____

Mobile phone (_____)_____**Home phone (_____)**_____

Email address_____**Birthdate**_____

Social Security #_____**( ) Male ( ) Female Race**_____

Marital Status ( ) S ( ) M ( ) W ( ) D Maiden name_____

Referring Physician or Referral Source_____**Phone (____)**_____

Referring Physician Address_____
(street address) (city, state, zip)

Your Occupation_____

Employer Name and Address_____
(name) (street address) (city, state, zip)

Person who does NOT live with you to contact in case of emergency

_____
(name) (relationship)

Person responsible for payment_____**Phone (____)**_____
(parent/spouse)

Address_____
(street address) (city, state, zip)

Responsible Party's Employer_____**Work Phone (____)**_____

Address_____
(street address) (city, state, zip)

Skin and Laser Surgery Center of Pennsylvania
1528 Walnut Street, Suite 1101
Philadelphia, PA 19102
(215) 735-4994 Fax (215) 735-8376

SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

HISTORY AND INTAKE FORM

Name: _____ **Date**: _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Artificial joints
Asthma
Atrial fibrillation
BPH (Benign Prostatic Hyperplasia)
Bone Marrow Transplantation
Breast Cancer
Colon Cancer
COPD (Emphysema)
Coronary Artery Disease
Depression
Diabetes
End Stage Renal Disease
GERD (Acid reflux)
Hearing loss
Hepatitis
Hypertension
HIV/AIDS
Hypercholesterolemia
Hyperthyroidism
Hypothyroidism
Leukemia
Lung cancer
Lymphoma
Pacemaker
Prostate Cancer
Radiation Treatment
Seizures
Stroke
Valve Replacement
None
Other _____

Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Mastectomy (Right, Left, Bilateral)
Lumpectomy (Right, Left, Bilateral)
Breast Biopsy (Right, Left, Bilateral)
Breast Reduction
Breast Implants
Colectomy: Colon Cancer Resection
Colectomy: Diverticulitis
Colectomy: IBD
Gallbladder Removed
Coronary Artery Bypass
PTCA
Mechanical Valve Replacement
Biological Valve Replacement
Heart Transplant
Joint Replacement, Knee (Right, Left, Bilateral)
Joint Replacement, Hip (Right, Left, Bilateral)
None
Other _____
Joint Replacement with the last 2 years
Kidney Biopsy
Kidney Removed (Right, Left)
Kidney Stone Removal
Kidney Transplant
Ovaries Removed: Endometriosis
Ovaries Removed: Cyst
Ovaries Removed: Ovarian Cancer
Prostate Removed: Prostate Cancer
Prostate Biopsy
TURP
Skin Biopsy
Basal Cell Cancer Surgery
Squamous Cell Carcinoma Surgery
Melanoma Surgery
Spleen Removed
Testicles Removed (Right, Left, Bilateral)
Hysterectomy: Uterine Cancer

Skin Disease History: (please circle all that apply)

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

Do you wear Sunscreen? Yes No
If yes, what SPF?

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma: Yes No
If yes, which relative(s)? _____

Any other family history? _____

Medications: (please list all current medications)

_____
_____
_____
_____
_____
_____

Allergies: (please list all allergies)

_____
_____
_____

Social History: (please circle one)

Cigarette Smoking
Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:
YES
NO

Language
English
Spanish
Other: _____

Race
White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Pharmacy Name:

_____

Address: _____ Zip Code:_____

SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Skin and Laser Surgery Center of Pennsylvania
1528 Walnut Street, Suite 1101
Philadelphia PA 19102
Tel: 215-735-4994 Fax: 215-735-8376

I am a patient of _____.

I hereby acknowledge receipt of The Skin and Laser Center of Pennsylvania's Notice of Privacy Practices.

Name (please print): _____

Signature: _____

Date: _____

OR

I am a parent or legal guardian of _____.

I hereby acknowledge receipt of The Skin and Laser Center of Pennsylvania's Notice of Privacy Practices with respect to the patient.

Name (please print): _____

Relationship to Patient: ( ) Parent ( ) Legal Guardian

Signature: _____

Date: _____

SKIN AND LASER
SURGERY CENTER OF PENNSYLVANIA

Dr. Jason H. Neustadter
Dr. Adam B. Blechman
Alicia Kilpatrick, PA-C

1528 Walnut Street, Suite 1101
Philadelphia, Pa 19102
Phone: 215.735.4994
Fax: 215.735.8376

Financial Policy

Thank you for choosing our office for your health care needs. We have some basic guidelines concerning insurance and financial requirements. These guidelines help us to control health care costs by reducing our billing and collection costs.

Payment Options

The law requires us to collect all co-payments and deductibles, which are collected at the time of service. If we do not collect payments, your insurance company can charge us with fraud. Please do not ask us to waive these requirements. You can pay by cash, check, or major credit card (Visa and Mastercard).

If you have a major medical plan, payment is expected on the day of your visit. Once payment is posted, we will give you a receipt containing all of the information you will need to get reimbursed from your insurance company.

Payment Liability

If you have an HMO or Managed Care Insurance, then you are required to obtain a referral from your Primary Care Physician. It is your responsibility to understand and check with member services on co-pays, coinsurance, deductibles, referrals, and non-covered services.

If your referral is not obtainable through the Navinet System on the day of your appointment, then you will have an option to reschedule or waive your rights to not use your insurance for services rendered that day. If we are unable to retrieve a valid referral for the correct date of service, then you will be responsible.

Most insurances require an authorization for surgery. Please check with your insurance company or ask the Billing Office for more information regarding insurances that need an authorization prior to surgery. We will provide the diagnostic and procedure code for you to check if an authorization is required. We will obtain the authorization through your insurance company.

Laser treatments are considered to be a cosmetic procedure by most insurances. If you need a laser treatment for a medical reason, then you need to inform the billing office to contact your insurance for pre-determination. If you decide to receive a laser treatment without authorization, then you will be responsible if your insurance denies the claim.

We participate with many different insurance plans. Please check with our billing department to see if your insurance company is included. We will be glad to submit claims to your insurance company if you provide us with all necessary information. You are responsible for any part of your bill not paid by your insurance company. Your insurance company has 60 days to respond to our claim. If your carrier has not responded in 60 days, or if your claim is denied or partially paid, you will be responsible for the balance. We will do everything we can to assist you in getting payment from your insurance carrier. I

If you are having financial troubles, please discuss them with our billing manager. Although we will work with you, we will not misrepresent any medical information to get reimbursed by your insurance company.

Your signature below will confirm that you have read and understand it is your responsibility for any balances that are due after billing your insurance or for treatments that were provided to you by one of our physicians or medical staff.

Signature: _____**Date:** _____