



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**



HISTORY AND INTAKE FORM

Name: _____ Date: _____

Reason for today's visit: _____

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please circle all that apply)

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

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
Other _____

Hay Fever/Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Squamous Cell Skin Cancer
None

Do you wear Sunscreen?
If yes, what SPF?

Yes

No

Do you tan in a tanning salon?

Yes

No

Do you have a family history of Melanoma:
If yes, which relative(s)? _____

Yes

No

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: _____



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: _____



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

1528 Walnut Street, Suite 1101
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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. |

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:** _____



'No-Show' Policy

Dear valued Skin and Laser patients:

We schedule our appointments so that each patient receives the right amount of time to be seen by our physicians and staff. That's why it is very important that you keep your scheduled appointment with us and arrive on time. As a courtesy, and to help patients remember their scheduled appointments, Skin and Laser sends phone calls and/or text message reminders in advance of the appointment time.

If your schedule changes and you cannot keep your appointment, please contact us so we may reschedule you, and accommodate those patients who are waiting for an appointment. As a courtesy to our office as well as to those patients who are waiting to schedule with the physician, please give us at least 24 hours' notice. If you do not cancel or reschedule your appointment with proper notice, we may assess a \$25.00 "no-show" service charge to your account. This "no-show charge" is not reimbursable by your insurance company. You will be billed directly for it.

Thank you,

Skin and Laser Surgery Center of Pennsylvania.