Carlisle
Dermatology Group

Registration Form (Please Print)

Age: Sex: ☐M ☐F

Today's date:	Primary Care Physician:	Office #:
	Physician's Address:	

PATIENT INFORMATION

Patient's last name: First: Middle:	Birth Date: / /	☐ Mr. ☐ Miss ☐ Mrs. ☐ Ms.	Marital status (circle one) ☐ Single / ☐ Mar / ☐ Div / ☐ Sep / ☐ Wid
Street address:			☐ Home Phone # ☐ Cell # ( )
City	State	ZIP Code:	Email Address:

Referred to clinic by (please check one box):

☐ Family ☐ Online ☐ Referring Provider _____ Name

☐ Friend ☐ Advert.

Race/Ethnicity: ☐ White ☐American Indian/Alaska Native ☐Asian ☐ Black/African American ☐Pacific Islander ☐ Hispanic or Latino ☐ Unknown ☐ Denied ☐ Other: _____

Primary Language:

INSURANCE INFORMATION

Name of Primary Insurance:	Policy no.:	Group no.:

Patient's relationship to subscriber: ☐ Self ☐Spouse ☐ Child ☐ Other	Subscriber's Name:	Subscriber's Date of Birth:	Subscriber's Address if different:

Name of Secondary Insurance (if applicable):	Policy No.:	Group No.:

Patient's relationship to subscriber: ☐ Self ☐Spouse ☐ Child ☐ Other	2nd Insurance Subscriber's Name:	2nd Ins. Subscriber's DOB:	2nd Ins. Subscriber Address:

Person Responsible For Bill:	Date of Birth:	Address (if different):	Telephone No.:

EMPLOYMENT INFORMATION

Employer:	Employer Address:			
Occupation/Job Title:	City:	State:	Zipcode:	Employer Phone #:

IN CASE OF EMERGENCY

Name of individual to contact in case of emergency::	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Carlisle Dermatology Group, LLC or the insurance company to release any information required to process my claims.

_____ _____

Patient/Guardian signature **Date**

Carlisle
Dermatology Group

Patient Notice of Privacy Practices

This notice describes how medical information about you may be disclosed. Please review it carefully.

Carlisle Dermatology Group will use your medical information for the following:

1. TREATMENT: Including providing medical records to consulting clinicians and insurance companies.
2. PAYMENT: We will file necessary claims to insurance companies in your name in order to obtain payment. They may request part or all of your medical record to pay the claim.
3. HEALTH CARE OPERATIONS: Any other healthcare providers involved in your healthcare.

In conjunction with these privacy practices you will need to provide the following information:

Please list the name of person(s) we may speak to regarding your health (i.e. spouse, child, significant other, etc.)

Name _____ Relationship: _____ Phone #: _____

Name _____ Relationship: _____ Phone #: _____

May we leave a message regarding your health or an upcoming appointment on an answering machine?

YES: ☐ NO: ☐

Your signature below signifies you have received our Notice of Privacy Practices for Protected Health Information.

Signature of Patient or Legal Guardian: _____ Relationship to patient: _____

Print Patient's Name or Legal Guardian: _____

Carlisle
Dermatology Group

Julian Ngo, D.O.

Medical History Form

Patient Name: _____ Date: _____

What is/are the main reason(s) for your visit today?

_____

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

	Yes	No		Yes	No
Anxiety			Hyperthyroidism (high thyroid)		
Arthritis			Hypothyroidism (low thyroid)		
Asthma			Leukemia		
Atrial Fibrillation			Lung Cancer		
Auto Immune Disease			Lymphoma		
Bone Marrow Transplantation			Prostate Cancer		
Enlarged Prostate			Radiation Therapy		
Breast Cancer			Seizures		
Colon Cancer			Stroke		
COPD (Emphysema)			Melanoma		
Coronary Artery Disease			Skin Cancer		
Depression			Eczema		
Diabetes			Psoriasis		
Kidney Disease			Precancerous Moles		
Heartburn/GERD			Pacemaker		
Hearing Loss			Artificial Joints		
Hepatitis			Family History of Melanoma		
High Blood Pressure			Family History of Skin Cancer		
HIV/AIDS					
High Cholesterol					

Please list any past surgeries: _____

Please list any allergies: _____

Do You Smoke? [Y] [N] If yes, for how long and how many packs per day _____

Do you use illicit Drugs? [Y] [N] If yes, any IV drug use? _____

Do you drink alcoholic beverages? [Y] [N] If yes, how many per week? _____

Are you or could you be pregnant? [Y] [N] If yes, what is your estimated due date? _____

Did you receive the flu vaccine? [Y] [N] Have you ever received the pneumonia vaccine? [Y] [N]

Carlisle
Dermatology Group

Julian Ngo, D.O.

Medication List and Review of Systems Form

Date: _____

Patient Name: _____ **Date of Birth:** _____

Pharmacy Name: _____ **Pharmacy Address:** _____

Please list all medications and dosages that you are currently taking:

_____

_____

_____

Problem	Yes	No
Rash	☐	☐
Problems with healing	☐	☐
Problems with scarring (keloids or thick scars)	☐	☐
Immunosuppression	☐	☐
Problems with bleeding	☐	☐
Hay fever	☐	☐
History of skin cancer or abnormal moles	☐	☐
Chest pain	☐	☐
Fever or chills	☐	☐
Night sweats	☐	☐
Unintentional weight loss	☐	☐
Thyroid problems	☐	☐
Sore throat	☐	☐
Blurry Vision	☐	☐
Abdominal pain	☐	☐
Bloody stool	☐	☐
Bloody urine	☐	☐
Joint aches	☐	☐
Muscle weakness	☐	☐
Neck stiffness	☐	☐
Headaches	☐	☐
Seizures	☐	☐
Cough	☐	☐
Shortness of breath	☐	☐
Wheezing	☐	☐
Anxiety	☐	☐
Depression	☐	☐

Carlisle
Dermatology Group

Julian Ngo, D.O.

Skin Disease History

Date: _____

Patient Name: _____ **Date of Birth:** _____

Problem	Yes	No
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	☐	☐
Do you wear sunscreen?	☐	☐
If yes, what SPF?	SPF:	
Do you tan in a tanning salon?	☐	☐
Do you have a family history of Melanoma? (If yes, mark relatives below)	☐	☐
Mother	☐	
Father	☐	
Sister	☐	
Brother	☐	
Daughter	☐	
Son	☐	
Uncle	☐	
Aunt	☐	
Nephew	☐	
Niece	☐	
Grandmother	☐	
Grandfather	☐	
Grandson	☐	
Granddaughter	☐	

Carlisle Dermatology Group

Dr. Julian M. Ngo, D.O.

Patient Financial Policy
(**Please be sure to read carefully)
(Revised 7/11/2018)

Welcome to Carlisle Dermatology Group. We are dedicated to providing you with the highest level of medical care in a compassionate and proficient manner. All patients are expected to sign and comply with our patient financial responsibility form annually. You will need to carefully read the Financial Policies described below.

Your copayment will be collected on the date of service. Any deductible, co-insurance, or payment for non-covered services is due in full at the time services are rendered. We cannot waive a co-payment, deductible, co-insurance or non-covered service amounts defined as patient responsibility under the terms of our contract with various health plans.

For your convenience we accept cash, personal checks, and most major credit and debit cards as payment options.

It is your obligation to make certain that this office is a participating provider with your insurance and that referral and prior authorization is obtained in advance of your appointment. We will file your insurance claim for you if all necessary information is received at the time of your visit. It is also your responsibility to inform our office of changes in insurance coverage and/or personal contact information. Non-emergency treatment will be denied unless non-covered charges and copays have been paid and insurance billing is approved under the insured's policy.

If payment is not received from your insurance within 90 days, you will be billed for the services rendered. You will also be billed for any services not covered by your insurance company. An account for which no payment is received within 60 days and for which no payment arrangements are made may be sent to a collection agency. The balance will also accrue monthly interest and an additional fee for the expenses related to collections. Checks returned to our office for non-sufficient funds (NSF) will incur a $30 service charge.

Additionally, if a patient has: A) A balance more than 60 days old OR, B) A minimum outstanding balance of $75.00, a payment of at least $50.00 must be paid prior to your scheduled appointment at Carlisle Dermatology Group, LLC. Payments can be made in person, via telephone, or paid at the office prior to your scheduled appointment. If the payment is not received, the appointment will be cancelled.

Patients are seen by appointment. If you cannot keep your appointment, it is your responsibility to call at least 24 hours in advance. We do understand that occasionally it will be necessary to change or cancel and appointment in less than 24 hours; however, two missed appointments without notice will be assessed a $50.00 fee. Your second missed cosmetic appointment will be assessed a fee in accordance to cosmetic type. Three missed appointments are subject to dismissal from the practice. Families of 3 or more, who missed their same day scheduled appointments and fail to provide a minimum of 24 hour notice, will incur a mandatory $250.00 service charge. Surgery, unlike office visit appointments require a 5 business day notice for cancellation. Without notification, you will be assessed a $200.00 cancellation fee for MOHS procedures and a $150.00 for a superficial excisional surgical procedure.

We try to utilize contracted laboratories for biopsies, however it is your responsibility as the patient to notify the office of in-network laboratories. When skin growths are biopsied or removed, there are two separate charges. The first being a charge for the actual biopsy/removal performed. The second being a lab charge for preparing and examining the specimen slides under a microscope. Lab charges occur on a different date. If the specimen slides require a second opinion or special stain, an independent lab (not owned by our practice) will bill your insurance carrier for the additional fees. If you have questions about these additional lab fees, please contact the lab directly as these fees are not charged by our office.

Unaccompanied minors must have a consent signed by a parent or guardian to be seen without a documented responsible party. Copays and other charges need to be paid prior the patient being seen, these charges can be paid via telephone by credit card if needed.

Should you request copies of your medical records, there is a fee charged as allowed by Pennsylvania statutes. There is also a cost associated with your request for physician "narrative reports" and /or letters not related to our insurance claims. These fees would be based on the complexity and the amount of time involved.

Our staff will be happy to answer any questions you may have about our policies.

I have read and understand the terms of this financial policy. I understand and agree that such terms may be amended from time to time by the practice. I agree to assign insurance benefits to Carlisle Dermatology Group. I authorize the release of my medical information to my primary care or referring physician, and/or consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions.

Signature of Responsible Party: _____ Date: _____

Name of Patient: _____ Patient DOB: _____

Carlisle
Dermatology Group

Dr. Julian M. Ngo, D.O.

CANCELLATION AND NO SHOW POLICY

CANCELLATIONS

We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 24-hours' notice. This will enable us to fill the appointment with another patient who is waiting for an appointment to be scheduled. With cancellations made less than 24-hours' notice, we are unable to offer that appointment time to another patient.

OFFICE APPOINTMENTS: Office appointments which are cancelled with less than 24 hours notification may be subject to a **$50.00 cancellation fee**.

SURGERY APPOINTMENTS: Without notification, you will be assessed a **$200.00 cancellation fee** for MOHS procedures and a **$150.00** for a superficial excisional surgical procedure.

NO SHOWS

Patients who do not show up for their appointment without a call to cancel an office appointment or procedure appointment will be considered a NO SHOW.
First No Show - Patients who no show one time will receive a letter acknowledging the no show. The letter will include a copy of this policy.
Second No Show - If a no show occurs a second time, the patient **will** receive a bill for the fees associated with a missed appointment or a missed surgery (see fees above). The fee **must be paid** before a third appointment is scheduled.

Third No Show - If a patient no shows a third time, he/she will be dismissed from the practice.

We understand that special unavoidable circumstances may cause you to cancel and unable to give a 24 hour notice or to No Show. Fees in this instance may be waived but only with management approval.

Our practice firmly believes that good physician/patient relationship is based upon understanding and good communication. Questions about cancellation and no show fees should be directed to the Office Manager (717-701-8251).

Please sign that you have read, understand and agree to this Cancellation and No show Policy.

_____ _____

Patient's Name (Please print) Date of Birth

_____ _____

Signature of Patient or Patient Representative Date

Carlisle
Dermatology Group

PATIENT CONSENT FORM

CHARGES FOR SERVICES RENDERED

All charges for office services are due at the time of my visit to Carlisle Dermatology Group (the practice). If an insurance claim is filed by the Practice, I request that payment of all benefits be made on my behalf to the Practice.

FINANCIAL RESPONSIBILITY

I understand that I am financially responsible for all charges for medical services rendered on my behalf, including those not paid or reimbursed by my insurance company. I am aware of the fact that my insurance carrier may deny payment for the services rendered. Therefore, payment is denied, I agree to be personally liable and fully responsible for such payment.

SHARING/DISCLOSING HEALTH INFORMATION

I authorize the Practice to share, disclose, or otherwise release medical information about me to my insurance company or any other authorized entity involved in my healthcare in accordance with the provisions of HIPAA (i.e., related to treatment, payment, or healthcare operations). I further authorize the Practice to gain access to medical records with information relevant to my treatment from any and all other healthcare providers, including but not limited to hospitals, laboratories, physicians, and others.

TREATMENT

I further authorize and consent to the Practice's physician(s) and their assistants and other Practice professional staff providing outpatient medical treatment, supplies, services, equipment and other items related to my healthcare to me as determined to be necessary in their professional judgment. I have been informed of the nature and purpose of the treatment modalities, the approximate estimated duration of my healthcare, and that I am able to withdraw my consent for treatment either orally or in writing whether prior to or during the anticipated treatment period.

EMERGENCY MEDICAL CARE

In the event that a life-threatening emergency occurs while I am in attendance at the Practice in which emergency medical care or treatment is required, I hereby authorize the Practice and its related providers to arrange for the care and treatment necessary to address my emergency medical condition. I further authorize the treating facility or medical personnel to provide emergency medical care and treatment and I agree to be responsible for all medial and related costs associated with such emergency and follow-up medical treatment.

_____ _____

Patient Signature Date

CARLISLE DERMATOLOGY GROUP,LLC

Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to your individually identifiable health information. Please review it carefully. Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to provide you with this confidentiality of health information that identifies you. We are also required by law to provide you with this notice of our legal duties and the privacy practices that we maintain in our practice concerning your PHI. By federal and state law we must follow the terms of the notice that we have in effect at the time The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this notice. Any revision or amendment to this notice will be effective for all your records that our practice has created or maintained in the past, and for any of your records that we may create or maintain in the future. Our practice will post a copy of our current Notice of Privacy Practices in our most current Notice at any time.

1. **HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI)**

Uses and Disclosures for Treatment, Payment, and Health Care Operation:

Treatment. We may use or disclose your PHI to physicians, nurses, and all other health care personnel who provide you with your health care services or are involved in your care. For example, we may ask you to have a laboratory test (such as blood or urine tests), and we may use the results to help us reach a diagnosis and treat you accordingly.

Payment. We may use and disclose your PHI to obtain payment for your health care services. For example, we may contact your health insurer to certify that you are eligible for benefits and we may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment.

Health Care Operations. We may use and disclose your PHI to operate our practice. As examples of the ways in which we may use and disclose your information for our operations, our practice may use your PHI to evaluate the quality of care you received from us or to conduct cost-management and business planning activities for our practice. We may disclose your PHI to other health care providers and entities to assist in their health care operations.

B. Others Involved in Your Healthcare:

Unless you object, we may disclose your PHI to a family member, other relative, friend or any other person that you identify that directly relates to that person's involvement in your health care. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.

C. Emergencies

We may use or disclose your PHI in an emergency treatment situation.

Other Permitted and Required Uses and Disclosures that may be made without your authorization or opportunity to object:

We may use or disclose your PHI in the following situations without your authorization, these situations include:

1. Required by law, legal proceedings, or law enforcement. We make disclosure when a law requires that we report information to government agencies and law enforcement personnel about victims of abuse, neglect, or domestic violence; when dealing with crime; or when ordered by a judicial or administrative proceeding.

2. Public Health. We report information about births, deaths, and various diseases, to government officials in charge of collecting that information, and we provide coroners, medical examiners, organ procurement entities, and funeral directors, necessary information relating to an individual's death.

3. Health Oversight Activities. We may disclose your PHI to assist the government when it conducts an investigation or inspection of a health care provider or organization.

4. Research. We may disclose your PHI to researchers conducting research that has been approved by an Institutional Review Board or Privacy Board.

5. Public Safety. We may disclose your PHI to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.

6. Military. We may disclose your PHI for military and or national security purposes.

7. Worker's Compensation. We may disclose your PHI as necessary to comply with worker's compensation Laws.

8. Appointment Reminders. We may disclose your PHI to contact you and remind you of appointment.

I. YOUR HEALTH INFORMATION RIGHTS

1. You have the right to inspect and have the office copy PHI. You have the right the inspect and obtain a copy

Of the PHI that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

2. **You have the right to request restriction on certain uses and disclosures of your PHI.** We will consider your request, but are not required to accept it. These requests must be in writing.

3. **You have the right to obtain a paper copy of this notice.** Ask the front desk for a copy of this notice.

4. **You have the right to Amend.** You may ask us to amend your PHI if you believe it is incorrect or incomplete. To request an amendment your request must be made in writing. You must provide us with a reason that supports your request. Our practice will deny your request if it is not submitted in writing or does not state the reason for the request. We may also deny your request if the information is accurate and complete in our opinion.

5. **You have the right to receive a list of disclosures we have made.** Such as disclosures required by law, disclosures to government officials, and disclosures for worker's compensation. The request must be made in writing and must state the time period. Our practice may charge a fee for the costs of copying, mailing, labor and supplies associated with your request.

II. CHANGES TO THIS NOTICE OF PRIVACY PRACTICES

We reserve the right to change this notice at any time in the future. We will post a current copy of this Notice of Privacy Practices in our waiting room as well as on our website at www.carlisledermatology.com