Carlisle Dermatology Group

Age: Sex at Birth: ☐ M ☐ F

Registration Form (Please Print)

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.

If you are 65 yrs or older, do you have a HEALTHCARE PROXY in the event that you are unable to make your own medical decisions?

No: ☐ **Yes:** ☐ **(If YES, Name of Healthcare Proxy: _____)**

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

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			High Cholesterol		
Arthritis			Hyperthyroidism (high thyroid)		
Asthma			Hypothyroidism (low thyroid)		
Atrial Fibrillation			Leukemia		
Auto Immune Disease			Lung Cancer		
Bone Marrow Transplantation			Lymphoma		
Enlarged Prostate			Prostate Cancer		
Breast Cancer			Radiation Therapy		
Colon Cancer			Seizures		
COPD (Emphysema)			Stroke		
Coronary Artery Disease			Melanoma		
Depression			Skin Cancer		
Diabetes			Eczema		
Kidney Disease			Psoriasis		
Heartburn/GERD			Precancerous Moles		
Hearing Loss			Pacemaker		
Hepatitis			Artificial Joints		
High Blood Pressure			Family History of Melanoma		
HIV/AIDS			Family History of Skin Cancer		

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

Did you receive the COVID-19 vaccine? Y N Dates Of Doses: _____

Carlisle Dermatology Group

Medication List and Review of Systems Form
Date: _____

Patient Name: _____ Date of Birth: _____

Height: _____ Weight: _____

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

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	☐	

Patient Financial Policy

(Revised 1/2026)

Welcome to Carlisle Dermatology Group, LLC. 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 responsibility form annually. Please carefully read the Financial Policies described below.

Your co-payment 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 service 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 our office is a participating provider with your insurance and that referral and/or prior authorization is obtained in advance. We will file your insurance claim for you if all necessary information is received at the time of your appointment. 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. We do not bill preventative service codes. Dermatology is a "problem orientated" specialty and we only address and treat one body system "the skin", therefore we do not meet the criteria required to bill preventative codes.

If payment is not received from your insurance within 90 days, you will be billed for 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 120 days and for which no payment arrangements are made may be sent to a collection agency. The balance will include an additional 33.33% fee for the expenses related to collections. Any future appointments will be cancelled and your account will be rendered inactive until payment is received in full. Checks returned to our office for non-sufficient funds (NSF) will incur a $30.00 service charge.

Additionally,

***Patients are seen by appointment. If you cannot keep your appointment, it is your responsibility to call at least 24 hours in advance. We understand that occasionally it will be necessary to change or cancel an appointment in less than 24 hours; however, a fee may be assessed for cancellation within 24 hours and/or for a No Show. Families of 3 or more, who missed their same day scheduled appointment and fail to provide a minimum of 24-hour notice, will incur a $250.00 fee.

***Surgery, unlike office visit appointments, requires 10 business day notice for cancellation. If a Mohs surgical procedure is cancelled within 10 business days, you will be assessed a cancellation fee of $200.00. If a surgical procedure is cancelled within 10 business days, you will be assessed a cancellation fee of $100.00.

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 review of specimen by a Dermapathologist. 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 fees, please contact the lab directly as these fees are not charged by our office.

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

Should you request copies of your medical records, there is a fee charge as allowed by Pennsylvania statues. 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, LLC. I authorize the release of my medical information to my primary care, 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 _____ Pt. DOB: _____

CANCELLATION AND NO SHOW POLICY

(Revised 07/2024)

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 canceled with less than 24 hours notification may be subject to a **$50.00 cancellation fee**.

SURGERY APPOINTMENTS: Cancellations require a notice of at least 10 business days. If a MOHS surgical procedure is canceled within 10 business days, you will be assessed a cancellation fee of $200.00. If an excisional surgical procedure is canceled within 10 business days, you will be assessed a cancellation fee of $100.00.

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 & Second No Show - Patients who no show may be subject to a **$50.00** no show fee. A letter acknowledging this as well as a copy of our policy will be sent to patient for each occurrence. This fee must be paid prior to scheduling any additional appointments.

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 occur and may not allow you to cancel appointments within a timely manner, fees in this instance may be waived but only with management approval.

Our practice firmly believes that a good physician/patient relationship is based upon understanding and good communication.

Questions about cancellations 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

Patient Consent Form

(revised 03/2022)

CHARGES FOR SERVICES RENDERED

All charges for office services are due at the time of my visit to Carlisle Dermatology Group, LLC (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, if 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 medical and related costs associated with such emergency and follow-up medical treatment.

_____ _____

Signature of Patient or Patient Representative 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)

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

i. **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.

ii. **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.

iii. **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:

i. 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

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

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

i. 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.

CARLISLE DERMATOLOGY GROUP,LLC

Notice of Privacy Practices

2. YOUR HEALTH INFORMATION RIGHTS

A. **You have the right to inspect and have the office copy PHI.** You have the right to 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.

B. **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.

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

D. **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.

E. **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.

3. CHANGES TO THIS NOTICE OF PRIVACY PRACTICE

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