HCH Physician Practices
Patient Registration and Consent to Treat

Primary Care Physician: _____
Pharmacy: _____

Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip Code: _____
Home Phone: _____ Cell Phone: _____
SSN: _____ Marital Status: _____
Email Address: _____
Employer: _____
Full-Time Part-Time Self-Employed Disabled (DATE)_____ ___Retired (DATE):_____
Student: Yes No Name of School:_____
Do you consider yourself Hispanic or Latino: YES NO Primary Language: _____

Guarantor: _____ DOB: _____
Relationship:_____ SSN:_____
Employer : _____

Emergency Contact: _____ Relationship: _____
Phone:(**MUST BE DIFFERENT THAN PATIENTS**)_____

PROVIDE CARD AT CHECK IN
Primary Insurance: _____
Subscriber's Name: _____ DOB: _____
Relationship to Patient: _____ SSN: _____
Address (if different): _____
Cardholder's Employer: _____

PROVIDE CARD AT CHECK IN
Secondary Insurance: _____
Subscriber's Name: _____ DOB: _____
Relationship to Patient: _____ SSN: _____
Address (if different): _____
Cardholder's Employer: _____

Do you have an Advanced Directive and/or Living Will? YES No

Patient/Guardian Signature_____Date:_____

HCH Physician Practices

AUTHORIZATION SIGNATURE FORM FOR HIPAA, CONSENT FOR CARE,
FINANCAIL AGREEMENT OF BENEFITS/RELEASE OF INFORMATION
NOTICE OF OUTSOURCED LABS

Please Print

HIPPA

Patient Name:_____

PRINT

Your signatures on this form acknowledges receipt of this notice, and that you have been given the opportunity to review it and ask questions regarding its concerns.
Please designate below the individuals (i.e. family members, caregivers, power of attorney, etc.) with whom we may discuss your care. Other than the entities listed in the Notice of Privacy Practice any individual not listed below will not be given information about your care without your permission.

_____

_____

_____

Please list any restrictions regarding the use and disclosure of your health information:

_____

_____**INITIALS**_____

NOTICE TO OUR PATIENTS REGARDING OUTSOURCED LAB

The purpose of this notice is to inform you that your lab specimens may be sent to an outside lab and you will be billed separately. Signature of this form authorizes such lab to bill your insurance carrier for services and for payment to be made to such lab. Quite often the insurance companies apply this amount to the patient's deductible. Any deductible and coinsurance will be the guarantor's responsibility.

INITIALS_____

CONSENT FOR CARE/FINANCIAL AGREEMENT/RELEASE OF INFORMATION

I wish to receive care at the HCH Physician Practices of Harrison County. While I am at the office, I permit its employees and all other persons caring for me to treat me in ways they judge are beneficial to me. I understand that this care may include tests, examinations, and medical and surgical treatment. No guarantees have been made to me about the outcome of these tests.
The undersigned patient agrees and obligates him/herself to pay the account for his/her treatment in accordance with the regular rates and terms. I understand that after reasonable notice, delinquent accounts may be tuned over to a collection agency and/or an attorney for collection. Should it be necessary to place this account in the hands of an attorney for collection, I agree to pay costs of collection, including any court costs and legal fees.
I herby authorize payments directly to HCH Physician Practice. I understand that I am financially responsible to HCH Physician Practice for the charges not covered by this assignment. I also hereby authorize the release of any medical information necessary to process claims for payment. OUT OF NETWORK NOTICE: acknowledge that the provider or supplier may be out of network with respect to my insurance plan. The out of network provider is not bound by payment provisions of my health plan and that I may contact my health plan for assistance.

INITIALS_____

SIGNATURE_____**DATE**_____
(PATIENT)

SIGNATURE_____**DATE**_____
(RESPONSIBLE PARTY)

WITNESS_____**DATE**_____

The Dermatology & Skin Cancer Center of Southern Indiana

New Patient Information Sheet

Patient Information: (please print)

Patient Name: _____ Age: _____Date of Birth: _____ Date: _____

Medical Information:

Primary Care Physician:_____ Pharmacy:_____

Are you allergic to any medications? ☐ No ☐ Yes If yes, please list them and your reaction.

_____

Reason for today's visit: _____

Past History: Do you have any medical problems? Please List_____

_____

Do you have a pacemaker?	**NO**	**YES**
Do you have an artificial joint?	**NO**	**YES**
Do you have to take antibiotics before you go to the dentist?	**NO**	**YES**
Have you had an organ transplant?	**NO**	**YES**

List all medications you are currently taking including aspirin, vitamins, and over-the-counter medications:

_____

_____

Review of Systems: *Do you have any current problems with the following?*

			Please describe:
Fevers, chills, unexplained weight loss?	NO	YES	
Vision changes? Red eye?	NO	YES	
Change in voice/hoarseness? Ear pain? Hearing changes?	NO	YES	
Chest pain? Shortness of breath?	NO	YES	
Blood in urine? Pain with urination?	NO	YES	
Coughing? Wheezing?	NO	YES	
Nausea? Vomiting? Changes in bowel movements?	NO	YES	
Joint pain? Muscle aches? Bone pain? Morning joint stiffness?	NO	YES	
Headaches? Dizziness? Confusion?	NO	YES	
Mood changes? Depressed	NO	YES	

mood?			
Cold intolerance? Heat intolerance? Excessive thirst?	NO	YES	
Excessive bleeding? Excessive bruising?	NO	YES	

Personal history: Skin Cancer? ☐ No ☐ Yes
If yes, please list type/location on body/year for each:_____

_____

Has anyone in your family had: ☐skin cancer ☐ melanoma ☐ psoriasis ☐ asthma/hay fever/eczema

Occupation: _____ Hobbies: _____

Are you pregnant or breast feeding? ☐ No ☐ Yes How many weeks? _____

Do you use sunscreen? ☐ No ☐ Yes Do you use a tanning booth? ☐ No ☐ Yes

Use tobacco products? ☐No ☐Yes Amount/day _____ Drink alcohol? ☐No ☐Yes Drinks/week_____

Reviewed by _____ **Page 2**

The Dermatology and Skin Cancer Center of Southern Indiana

Patient Consent and Authorization Form

PLEASE INITIAL EACH LINE ITEM

CONSENT FORM

_____ I give my permission for the Physicians and staff of The Dermatology and Skin Cancer Center of Southern Indiana to treat me as deemed necessary in the exercise of their professional judgment.

_____ The most commonly encountered procedures in a Dermatology office are skin biopsies/cryotherapy/skin lesion removal/curettage/ and administration of local anesthesia. Each procedure has a small risk of scarring that may or may not be noticeable (common), mild pain (common), infection (uncommon), bleeding (rare), or allergic reaction (rare). I understand that a photographic image may be taken of any biopsy or surgery site performed for the sole purpose of identification of said site and insurance claims. I expressly consent to having said photograph taken. **If you are allergic to any type of local anesthesia you must inform your provider immediately. **

_____ I understand that medical care requires my cooperation, and I will follow my doctor's orders and prescriptions. If indicated, I will make and keep appointments for follow-up care and call the office to note any changes or concerns in my condition.

_____ I understand that I may be billed by an outside laboratory for work that is performed in this office, if my insurance company does not have a contracted lab or facility, or if services are not covered by my insurance company. I will notify my provider of any special requests on sending pathology or specimens to specific labs, and understand that it is my responsibility to notify the provider each time I have an appointment.

_____ I hereby certify that I have read the foregoing CONSENT and fully understand the contents thereof.

_____ I understand that this consent is good for one year from date of signature, unless I, the patient, request otherwise.

_____ _____

Patient/Name of Legal Guardian/Patient Representatives **Print** Date

_____ _____

Patient/Name of Legal Guardian/Patient Representatives **Signature** Date