

Bradley S. Kurgis, D.O., Inc.
REGISTRATION FORM
(Please Print)

PATIENT REGISTRATION

PATIENT INFORMATION						
LEGAL NAME	LAST.	FIRST	M.		DATE	
PATIENT ADDRESS			APT#	CITY	STATE	ZIP
HOME PHONE ()			BUSINESS PHONE ()		CELL PHONE ()	
SEX	DOB	AGE	MARITAL STATUS		SOC SEC #	
PRIMARY CARE PHYSICIAN				E-MAIL		
EMPLOYER				OCCUPATION		
ADDRESS				CITY / STATE		ZIP

RESPONSIBLE PARTY INFORMATION						
RESPONSIBLE PARTY NAME	LAST.	FIRST	M.	D.O.B.	SOC SEC #	RELATIONSHIP
MAILING ADDRESS			APT#	CITY	STATE	ZIP
HOME PHONE ()			BUSINESS PHONE ()			
EMPLOYER			OCCUPATION			
ADDRESS			CITY / STATE			ZIP

PATIENT EMERGENCY INFORMATION	
NAME	RELATIONSHIP
HOME PHONE ()	BUSINESS PHONE ()

Medical Care Release Consent

Patient Name: _____ DOB: _____

I give permission to release medical information that may include but not limited to appointments, prescriptions, and test results to the following designated people. I understand that due to HIPAA guidelines, medical information will only be discussed with me and those listed below.

1. _____ Relationship: _____ Tel # _____
2. _____ Relationship: _____ Tel # _____
3. _____ Relationship: _____ Tel # _____

Signature: _____ **Date:** _____

____ Yes, please sign me up for your email list so I can be the first to hear about specials, promotions, and news from Dr.Kurgis' office.

E-mail address: _____

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HISTORY AND PHYSICAL INFORMATION

Patient: _____ Date of Birth: _____

Pharmacy: _____

Are you allergic to any medications? Yes No If yes, please list below:

1. _____ 2. _____ 3. _____

List all the medications you are currently taking: (including prescriptions, over-the-counter meds, vitamins, and herbals)

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

Do you have now, or have you ever had any of the following diseases or conditions: (Please check YES or NO)

	YES	NO		YES	NO
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis B or C	<input type="checkbox"/>	<input type="checkbox"/>
Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Joint Deformity	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Organ Transplant	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid	<input type="checkbox"/>	<input type="checkbox"/>

Please answer the following questions:

	YES	NO	Skin:
Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	When you are exposed to sun do you: <input type="checkbox"/> Burn only <input type="checkbox"/> Burn then Tan <input type="checkbox"/> Tan only
Contraception?	<input type="checkbox"/>	<input type="checkbox"/>	Do you use a tanning bed? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you smoke	<input type="checkbox"/>	<input type="checkbox"/>	Have you ever had skin cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you drink alcohol?	<input type="checkbox"/>	<input type="checkbox"/>	Has anyone in your family had skin cancer? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you use recreational drugs?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have any problems healing? <input type="checkbox"/> YES <input type="checkbox"/> NO
Do you bleed easily?	<input type="checkbox"/>	<input type="checkbox"/>	Do you develop keloids (scars) after surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO

Family History

	YES	NO	Afflicted Family
Autoimmune Disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

List any surgical procedures you have had in the last 12 months:

Patient Signature _____ **Date** _____

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Financial/Office Policies

This document provides you with the Financial Policies used by Dr. Kurgis. Your signature and initials are required on this form in order to be seen by any of our providers. If you have any questions or need explanations, please ask a staff member.

Consent to Pay for Services Rendered: Payment is required for all services at the time the services are rendered. If we are contracted providers (in-network) with your insurance plan, we are required by contract with your insurance company, to collect your co-payment(s)/co-insurance and any unmet deductible. It is your responsibility to verify with your insurance plan if we are a contracted provider and to understand your coverage benefits under your policy. Insurance coverage is not a guarantee of payment by your insurance company. If your insurance company fails to respond or does not respond promptly, we will forward the balance to you for payment. Should your insurance company pay after you have already paid us, we will promptly refund you any overpayment due to you. We accept Visa, MasterCard, Discover, American Express, and Care Credit for your convenience. Our billing is done in house. Please call our office at (805) 434-5563 and ask for the billing department.

We will call to confirm most appointments two days in advance. If you are more than 15 minutes late by our clock, you will be asked to reschedule your appointment. Cancellations must be made 24 hours prior to your appointment.

We charge \$50.00 for missed appointments.

Cancellations for surgical appointments including MOHS Surgery must be made 24 hours prior to your appointment.

A fee of \$200.00 may apply if a 24 hour notice is not given.

We have a 24 hour answering service available for cancellations, you may call our main number (805) 434-5563.

Please read and initial the following specifics regarding our payment and collection processes.

- _____ (initials) I understand I will be responsible for any remaining balance not covered by my commercial insurance company, Medicare and/or my supplemental policy. Please contact your insurance company for this information.
- _____ (initials) I understand that procedures performed in the office are often separate billable services that are not included in the office visit. I understand that many insurance companies apply these procedures to a deductible or co-insurance and may not be covered under the co-payment. I will be responsible for any unmet deductible or co-insurance at the time of service. It is my responsibility to know and understand what my policy benefits are with my insurance company.
- _____ (initials) I understand that if I have a surgical procedure or biopsy done at Dr. Kurgis office, there are two charges. First is the provider charge for collecting the Biopsy and the second is a charge to examine the specimen by a Pathologist, chosen by my attending Physician. Because Pathologists are also medical doctors, I will be billed separately for these pathology charges by the Pathologist who does the reading.
- _____ (initials) I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory company I need to use. It is my responsibility also to inform my provider of this at the time services are-rendered.
- _____ (initials) We refer to delinquent accounts to action professionals collection agency. At that time the patient will be dismissed from the practice.
- _____ (initials) I understand that a \$25 returned check fee will be assessed to my account for any checks returned by my financial institution. I also understand that payment of the check and fee will be due immediately and I will no longer be able to issue a check as payment to the practice.
- _____ (initials) I have read the above stated financial policy and agree to meet my financial obligation in accordance with this policy.

Print Patient Name

Date of Birth

Signature Patient or Legal Guardian/Responsible Party

Date

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgment, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgment.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

Employee Signature

Date