Bradley S. Kurgis, D.O., Inc.

REGISTRATION FORM

(Please Print)

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	☐	☐	Diabetes	☐	☐
Heart Attack	☐	☐	Hepatitis B or C	☐	☐
Heart Murmur	☐	☐	Arthritis/Joint Deformity	☐	☐
Irregular Heartbeat	☐	☐	Organ Transplant	☐	☐
Pacemaker	☐	☐	HIV	☐	☐
Artificial Heart Valve	☐	☐	STD	☐	☐
Mitral Valve Prolapse	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Thyroid	☐	☐

Please answer the following questions:

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

Family History

	YES	NO	**Afflicted Family**
Autoimmune Disorders	☐	☐	_____
Cancer	☐	☐	_____
Diabetes	☐	☐	_____
Heart Disease	☐	☐	_____
High Blood Pressure	☐	☐	_____
Skin Cancer	☐	☐	_____
Skin Disease	☐	☐	_____

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

_____

_____

Patient Signature _____ **Date** _____

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REGISTRATION FORM

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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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REGISTRATION FORM

(Please Print)

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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REGISTRATION FORM

(Please Print)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES / USE AND DISCLOSURE FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. We provide this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. If terms of our Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

_____ _____

Signature of Patient or Legal Representative — Date

_____ _____

Printed Name of Patient — Legal Relationship to the Patient *(If required)*

We cannot discuss your health information with anyone other than yourself unless you authorize us to do so. Please list below names of the individuals you authorize our office to discuss care with.

I give you permission to share my health information with:

1. Name _____ Relationship _____ Phone_____

2. Name _____ Relationship _____ Phone_____

Consent to text for appointment reminders and other healthcare communication.

If you approve, we may contact you via text messaging to remind you of an appointment or provide general health reminders or information. I understand that once I have consented to receive communications via text, I still have the right to revoke the consent at any time.

The cell phone number I authorize to receive text messages for appointment reminders and general health information is _____. Please initial _____.

Or

_____ **I decline** to receive communications via **text**.

Revocation – Use this area to document revocation of a previous form of communication.

_____ I hereby revoke my request to receive future appointment reminders or healthcare updates via text.

Patient signature_____ Date requested: _____

Reminder - Keep information to the minimum necessary and encrypt emails and texts whenever possible