PLEASE

To make your check-in process as smooth and fast as possible:

WRITE LEGIBLY (PRINT)

FILL ALL FORMS COMPLETELY

DO NOT DATE THE FORMS BEFORE ARRIVING TO THE OFFICE

BECAUSE WE WILL SCAN THESE FORMS

- USE A BLACK OR DARK BLUE PEN - no pencils, no colors
- DO NOT FOLD OR STAPLE THE FORMS
- DO NOT USE DOUBLE-SIDED PRINTING

BRING ALL YOUR INSURANCE DOCUMENTS AND ID CARD WITH YOU
(and your military ID if you have Tricare)

BRING WITH YOU A LIST OF THE MEDICATIONS YOU USE

TAKE TRAFFIC INTO CONSIDERATION WHEN DRIVING TO OUR OFFICE

THANK YOU!

PATIENT INFORMATION

Name .... Date of birth: .... - .... - ....

First Middle initial Last

Address .... Apt. #: .... City:......................... State: ..... Zip ....

SSN: .... - .... - .... Sex (circle): M F

Is patient a full time student? (circle) Y N

Marital status (circle): Single Married Widowed Divorced

Patient's occupation: ....

Work phone (.............) ....

Employer / School: ....

Home phone (.............) ....

Is patient's insurance from this employer? (circle) Y N

Mobile phone (.............) ....

Does patient have Medicare Part B? (circle) Y N

PRIMARY INSURANCE

Name of plan ....

Patient’s relation to Insured: (circle)

Self Spouse Child Other (specify) ....

Insured's information if different from patient:

Insured's Full Name ....

Insured's Date of Birth ..... - ..... - .... **Sex**: (circle) M F

Insured's SSN .... - .... - ....

Work phone: (...........) .... - ....

Home phone: (...........) .... - ....

Insured's Address ....

Apt. # .... City .... State .... Zip ....

Employer ....

SECONDARY INSURANCE

If none, initial here ___

Name of plan ....

Patient’s relation to Insured: (circle)

Self Spouse Child Other (specify) ....

Insured's information if different from patient:

Insured's Full Name ....

Insured's Date of Birth ..... - ..... - .... Sex: (circle) M F

Insured's SSN .... - .... - ....

Work phone: (...........) .... - ....

Home phone: (...........) .... - ....

Insured's Address ....

Apt. # .... City .... State .... Zip ....

Employer ....

SPOUSE / GUARANTOR / OTHER RESPONSIBLE PARTY

If the person responsible for payment is not the patient, or if a minor or student, please fill out

Full name ....

Relation to patient ....

Address ....

Work phone (...........) ....

Apt. # .... City .... State .... Zip ....

Home phone (...........) ....

Mobile phone (...........) ....

With whom can we discuss your medical information, including emergencies?

Name .... Relation .... Phone (...........) ....

Name .... Relation .... Phone (...........) ....

I give permission for Dr. Trizna to leave a message with test results for me at phone: (........) ....

How did you hear about us?

....

I expressly state that the above information is complete and correct.

....

Signature of patient, parent, guardian or legal representative Date

....

Print name of person who signed above Relation to patient

MEDICAL INFORMATION Please list the skin problems you want to be seen for today. List one per box.

1. Main problem: **Date first noticed:**	**Treatment:** circle: improved - worsened - no change
2. **Date first noticed:**	**Treatment:** circle: improved - worsened - no change
3. **Date first noticed:**	**Treatment:** circle: improved - worsened - no change
4. **Date first noticed:**	**Treatment:** circle: improved - worsened - no change
List other problems, if any	

Please mark the box/es if you have or have had any of the following:

- ☐ anemia.
- ☐ arthritis.
- ☐ asthma.
- ☐ bleeding tendency.
- ☐ cancer of other organ.
- ☐ chronic pain. ________
- ☐ contact dermatitis.
- ☐ diabetes.
- ☐ eczema.
- ☐ epilepsy / seizures.
- ☐ excessive scarring.
- ☐ hay fever.
- ☐ heart: irregular beat.
- ☐ heart: murmurs.
- ☐ high blood pressure.
- ☐ keloids.
- ☐ kidney disease.
- ☐ liver disease / hepatitis.
- ☐ hepatitis A.
- ☐ hepatitis B.
- ☐ hepatitis C.
- ☐ pacemaker / defibrillator.
- ☐ lung disease.
- ☐ lupus.
- ☐ osteoporosis.
- ☐ peptic ulcer.
- ☐ reflux.
- ☐ psoriasis.
- ☐ thyroid: hypothyroidism.
- ☐ thyroid: hyperthyroidism.
- ☐ tuberculosis.
- ☐ immunosuppression.

List your surgeries:

List other medical problems:

Mark the box/es if you have any of these:

- ☐ tonsillectomy.
- ☐ tubal ligation.
- ☐ joint replacement.
- ☐ pacemaker.
- ☐ defibrillator.

Mark the box/es if you take any of these:

- ☐ aspirin.
- ☐ coumadin.
- ☐ steroids by mouth.

List your ALLERGIES TO MEDICATIONS (write "none" if you have no allergies):

List the medications you are currently using (including topical medications):

Date ________ Patient's Printed name ________________ Signature of Patient or Guardian ________________

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

(This is required if you want us to file for payment to your insurance company)

I assign and transfer all benefits payable to Zoltan Trizna MD, PA for the services performed by his office. I also give Zoltan Trizna MD, PA all rights to collect, sue or otherwise obtain payment of benefits from any and all responsible parties. I authorize all responsible parties to pay directly to Zoltan Trizna MD, PA all benefits and amounts due for services rendered by him or his designated representative. I understand that if Zoltan Trizna MD, PA is not paid in full by proceeds of any benefits, then this assignment does not release my obligation and liability to him to pay for all services and items provided to me or the above patient by him or his designated representative. In the event that no benefits are paid by the responsible parties, then I agree to pay Zoltan Trizna MD, PA for all charges incurred. I authorize the release of any medical information necessary to process insurance claims. A photocopy or computerized image of this authorization shall be considered as valid as the original.

Primary insurance: ________________________

Secondary insurance: ______________________

________ ____________________ ____

Date Patient's Printed name Signature of Patient or Guardian

HIPAA PRIVACY PRACTICES NOTICE - ACKNOWLEDGEMENT FORM

You can download the entire notice or read the copy at the frontdesk You may request a copy.

By signing this form I acknowledge that I had the opportunity to read, and obtain if desired, a copy of the HIPAA Privacy Practices Notice of Zoltan Trizna, MD, PA. A photocopy or computerized image of this authorization shall be considered as valid as the original.

________ ____________________________ ____________________________________

Date Patient's Printed name Signature of Patient or Guardian

________ ____________________________ ____________________________________

Date Witness: Printed name Witness: Signature

Refused to sign: _____

PATIENTS NOT USING INSURANCE: SELF-PAY AGREEMENT

I am paying for today’s services in full and I request that Dr.Trizna’s offices not file any claim for today’s visit and related laboratory services (if applicable) on my behalf to any insurer any time in the future. A photocopy or computerized image of this agreement shall be considered as valid as the original.

________ ____________________________ ____________________________________

Date Patient's Printed name Signature of Patient or Guardian

Financial and office policies **Processing insurance claims is an increasing and unfunded burden. Please help us to make it easier.**

* A valid insurance card and proof of identity (e.g. driver's license) are required for all new patients. This is necessary for filing for your insurance. If these documents are missing, full payment is requested.
* Please provide us with information on all insurance plans under which you are covered. If it is later discovered that you have other coverage and additional insurance filings are required, you will be charged a $25 processing fee per each claim that must be filed again. In addition, if your insurance does not pay because of your not giving timely and correct insurance information, you will be responsible for payment in full.
* Referrals: you should know whether your insurance requires a referral and to obtain that referral before you schedule an appointment. Referrals typically have an expiration date and a number of visits.
* As a courtesy to you, we will file your insurance claims for you if you assign benefits to Dr.Trizna. However, a copayment, coinsurance, or deductible may be due at the time of visit per your contract with your insurance company. These are calculated based on our best efforts. Any differences will be billed or refunded to you. Payment is due at the time of visit.
* Your insurance plan's benefits may change from time to time. It may not cover something that was covered last time you saw a physician.
* You are responsible for providing any changes of address, telephone number and/or insurance information whenever such a change occurs.
* You are responsible for responding promptly to requests from your insurance company to provide any additional information they may require from you. If you do not provide this information to them and they do not pay us because of your delay, your account will become due and payable in full, immediately.
* Contrary to common understanding, all procedures (e.g., treatment of warts, injections) are considered “surgical procedures” by most insurance companies and the fees for these services may apply to a separate surgical deductible, copayment or coinsurance.
* In our office, your surgery charge includes a suture removal visit. If, at the time of the suture removal you wish to discuss or treat unrelated conditions, then your will be charged for a regular office visit. Pathology or laboratory fees are separate and are billed either by Dr.Trizna or by the lab performing the services.
* We request that you call our office at least 24 hours prior to your appointment if you must cancel or reschedule. This way we can schedule someone who might have been waiting for several weeks for an appointment.
* If the appointment is on a Monday or a day following a holiday please cancel by 4 PM of the preceding Thursday or the day before the last working day before the holiday. A cancellation or rescheduling within 24 hours of a scheduled appointment, or not showing up for the appointment is considered a missed appointment. We reserve the right to charge a $50 fee for a missed appointment. Repeated missed appointments may result in our asking you to find another dermatologist for your care.
* Your account will be charged $25 for each returned check. This fee and the check’s amount will be requested to be paid in cash. You may be asked to pay cash for future visits.
* Past due accounts may be turned over to collections. Any collection fees, legal fees or attorney’s fees associated with this will be added to the amount owed.
* Fee for copies of medical records, according to regulations, are $25 for the first twenty pages of medical records, and 50¢ for each page thereafter (or as allowed by law), and for the actual costs of delivery of your choice. We need an advance notice of 2 weeks.
* Medication refills: to ensure patient safety, certain medications are not renewed over the phone, fax or mail. As of 1/1/2009, a $15 administrative fee applies for refills not done at the time of the visit.

I have read and I understand the policies outlined above and I agree to be bound by their terms.

________ ________________________ ______________________________

Date | Patient's Printed name | Signature of Patient or Guardian