Patient Registration

Please print and answer all questions in full Date: _____

Patient Information (please complete using your name as listed on your insurance card)
First Name: _____ Middle Initial: _____ Last Name: _____
Current Mailing Address: _____
Apt. City State Zip Code
Home Phone: _____ Cell Phone: _____ Work Phone: _____
Date of Birth: _____ Marital Status: (circle one) S M D W Sex: M F
Occupation: _____ Employer: _____
Email:_____

Insurance Information
All patients must provide a copy of their insurance card at the time of their visit.

Referring Physician Information
Referring Physician: _____ Phone: _____

Emergency Contact Information
Name: _____ Relationship: _____ Phone: _____

Medical Information
Reason for Visit: _____
Have you been treated by Dr. Buscemi or Dr. Gruen (circle one) in the past? No _____ Yes _____
Current Medications: _____ N/A
Allergies to Medications: _____ N/A
Medical Problems: _____ N/A
Do you have a Personal History of skin cancer: No _____ Yes _____ Type (if known): _____
Do you have a Family History of skin cancer: No _____ Yes _____ Type (if known): _____
Do you smoke? No _____ Yes _____ Former: _____

Do You: (please check all that apply):

_____ Tan Excessively _____ Are Nursing
_____ Have Problems with Anesthesia _____ Are Pregnant _____ Have Been Exposed to HIV
_____ Develop Keloid Scars after Surgery _____ Bleed Easily _____ Have a Prosthetic Joint or Pacemaker

Patient Release

I hereby authorize Libby Buscemi, MD PC to release to my insurance company or representative necessary information including the diagnosis and the records of any treatment or examination that may be necessary for either medical care or in processing applications for financial benefit. I also authorize and request my insurance company to pay directly to the above named doctor for services rendered under her supervision.

E-Prescribing Consent

I authorize the electronic transmission of my prescriptions directly to a pharmacy as well as the viewing of my past medication history from other providers and/or pharmacies.

Signature: _____ Date: _____

Pharmacy Information

Name of Pharmacy: _____

Address & Phone: _____

Patient Acknowledgements of Libby Buscemi, MD PC Office Policies

Insurance and Referral Information

Co-payments, Deductibles and Coinsurances
Payment is required for all services at the time they are rendered. All applicable co-payments will be collected at the time of Service. ***Please be aware that any deductibles and coinsurance are considered the patient's responsibility as determined by your contract with your insurance company.*** An administrative billing fee of $15 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over to collections, interest and/or collection fee, at the provider's current rate may be charged on all balances owing to the provider that are past due. Your signature below signifies your understanding and willingness to comply with this policy. ***I am also aware that should my health insurance plan require a referral, it it my responsibility to obtain the referral*** from my Primary Care Provider and assure it is available to be presented at the time of my visit. I further understand it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referrals and obtain new ones as needed. I understand that should I fail to have a referral for my visits, I will be required to fill out a waiver that will require my credit card information. If a credit card is not available, I understand that my appointment will be rescheduled.

_____

Patient Signature Date

Insurance Cards

New patient or those patients with a change in their insurance information must provide a valid insurance card at the time of their visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

_____

Patient Signature Date

Cancellation Policy

Should you be unable to keep your appointment, please contact our office to cancel. Failure to contact the office 24 hours prior to your visit will results in a $50.00 fee for routine office visits. This fee is not reimbursable by your insurance company.

_____

Patient Signature Date

HIPAA Policy

I have been informed that the U.S. government requires that I sign this notice of Privacy Practices. The privacy regulations were created by the U.S. Health Insurance Portability and Accountability Act of 1996 (HIPAA) to protect patient privacy.

I understand that the full text of the Act is available to me upon request.

In order to request any amendments, restrictions or disclosures I must make a written request to the privacy officer.

_____

Patient Signature Date