Patient Registration Form

Alison Ehrlich, MD, MS
Alisonehrlichmd.com
4910 Massachusetts Avenue, NW, #308
Phone 202-695-1000 Fax 202-503-1791

Date:	MRN No:

DEMOGRAPHIC INFORMATION

First Name:	Last Name:	MI:
DOB:	SSN:	Age:
Marital Status: (Circle One) Married Single Widow Divorced		Sex:
Address:	City:	State:
Apt/Unit	Zip Code:	Country:
Race: (Circle One) African American/Black Caucasian/White Asian American Indian/Alaskan Native Nat Hawaiian/Pacific Islander Other Unknown Declined		
Ethnicity: (Circle One) Hispanic or Latino Not Hispanic or Latino Unknown Declined		

CONTACT INFORMATION

Enter and Place a check in the box your primary phone number:	Cell: ☐	Home: ☐	Work: ☐
Email Address:			
Employer:		City, State:	

EMERGENCY CONTACT INFORMATION

Name:	Relationship:	DOB:	Phone:

PHARMACY AND PROVIDER INFORMATION:

Preferred Pharmacy:	Pharmacy Phone:
Pharmacy Address:	
Referred Physician:	Primary Care Physician:

How did you hear about us? (Circle One) Physician Family/Friend Health Plan Website/Internet Seminar/Lecture Student Health ER Other

INSURANCE/BILLING INFORMATION:

Primary Insurance	
First Name:	Last Name:
Primary Ins:	Policy ID#
Policy Holder:	Group #:
Relationship to Policy Holder:	
If patient is not policy holder, what is the holder's DOB? mm/dd/yyyy	**Address?** (If not the same as patient)

Alison Ehrlich, MD,MHS
Alisonehrlichmd.com

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have rights to privacy regarding my protected health information. I understand that this information can and will be used to:

-Coordinate my care with those providers who are involved in my treatment either directly or indirectly.
-File reports with public health and safety organizations.
-Conduct research activities.
-Respond to workers' compensation, law enforcement or other government requests.
-Conduct routine healthcare operations such as quality assessments, business procedures and physician certifications.

I acknowledge that I have read, reviewed, and understand your Notice of Privacy Practices and description of uses and disclosures of my health information. I understand that this practice has the right to change its Notice of Privacy Practices over time. I may contact this organization to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my request restrictions, but if you do agree then you are bound to abide by such restrictions.

I have the right to: obtain a copy of my medical record, request how we communicate with you, obtain a copy of this privacy notice, choose someone to act for you if you are unable to make decisions on your own.

My preferred contact method: (Please Check One)

____ Cell Phone ____ Home Phone ____ OK to receive text messages ____ OK to receive email

Preferred Contact:
If you would like to your information regarding your medical condition and diagnosis, access to medical records, prescription pick-up and appointment scheduling with another person, please indicate below:

Name:_____ **Telephone:**_____ **Relationship:**_____

Consent to HIPAA Policy:

Patient Name:_____

Relationship to Patient (if patient is a minor or unable to sign):_____

Signature: _____

Date:_____

V7.29.20

Alison Ehrlich, MD, MHS

A NOTICE TO OUR PATIENTS REGARDING OUR OFFICE POLICY

In an attempt to keep our patients informed and to ensure proper reimbursement for the services rendered, we ask that you carefully read the following instructions. By working closely together, we can provide you with a better care and avoid confusion in the future. Dr. Ehrlich does not participate in any health insurance plans. However, we will be happy to provide you with a copy of services (including relevant codes) so that you may submit to your insurance carrier(s).

Payment Policy: It is your responsibility to pay in full for services rendered at the time of service.

Labs and Pathology: We will submit these charges to your insurance

Cancellations: We ask for a 24hr notice for cancellations. We reserve the right to charge a $25.00 fee for all medical visits and a $75.00 fee for all procedural visits (including patch testing).

Prescription Refills: We request at least 48 business hours to refill prescriptions. If your pharmacy plan requires a prior authorization, please allow several additional days for non-biologics and two weeks for biologics.

Telehealth/Virtual Visit: If I request a telehealth visit (virtual visit), I consent to participate in such a visit and understand that I may terminate such visit. I understand that during the visit there technology issues may arise and the Dr. Ehrlich may request an alternate visual platform to complete the visit.

Forms and letters: We will send a letter of update to your referring physician. If you were not referred and would like a letter sent to your physician, please inform our staff. If you would like your previous medical records reviewed by Dr. Ehrlich, we can assist in faxing a release of records.

_____

PATIENT NAME

_____

SIGNATURE

_____

DATE

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PAST SURGICAL HISTORY (Please list all past surgeries or Procedure)

Date	Procedures	Complications

PAST DERMATOLOGIC PROCEDURES: (Please list all past cosmetic or non-cosmetic procedures)

MEDICATIONS/SUPPLEMENTS (Please list all current and/or supplements

Medication/Supplement	Dosage	Indication (Why are you taking this medication?)

ALLERGIES: (Please list all allergies, including medications, latex and/or foods) **If none, please check here: □ NKDA**

FAMILY HISTORY: (Is there a Family History of the following? Please note relationship and age of relative)

SOCIAL HISTORY:

Smoker?	Currently / Former / Never If currently, how many cigarettes per day?____
Do you drink alcohol?	Y / N If Yes, how much_____per week?
Do you use recreational drugs?	Y / N If Yes, which ones and how often?
Do you feel safe at home?	Y / N
What is your relationship status?	Single / Dating / Engaged / Married / Divorced / Widowed

OTHER MEDICAL ISSUES WE SHOULD BE AWARE OF:

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Name:	Date:	MRN No:

Current Issue(s):

PAST MEDICAL HISTORY (Circle all that apply currently or in the past)

Anxiety	Depression	Keloids
Abnormal Scarring	Diabetes	Leukemia
Arthritis	Difficulty Healing Wounds	Lung Cancer
Asthma	End Stage Renal Disease	Lung Disease
Artificial Heart Valve	Fever Blisters	Lymphoma
Artificial Joints	GERD	Migraines
Atrial Fibrillation	Hearing Loss	Neuralgia
Back or Neck problems	Heart Disease	Pacemaker/Defibrillator
Bone Marrow Transplantation	Hepatitis B or C/ Liver Disease	Prostate Cancer
Breast Cancer	High Blood Pressure	Radiation Treatment
Blood Clotting Disorders	High Cholesterol	Seizures
Colon Cancer	HIV/AIDS	Skin Cancer
COPD	HSV (Herpes Type I or Type II)	Stroke/ Heart Attack
Coronary Artery Disease	Kidney Disease	Thyroid Disorder
Other:		

PAST DERMATOLOGIC HISTORY (Circle all that apply currently or in the past)

Acne	Dry Skin	Osteoporosis
Actinic Keratoses	Eczema	Poison Ivy
B-Cell Lymphoma	Flaking or Itchy Scalp	Precancerous Moles
Basal Cell Skin Cancer	Hair loss	Psoriasis
Blistering Sunburns	Hay Fever/ Allergies	Seasonal Allergies
Contact Dermatitis	HPV	Squamous Cell Skin Cancer
Cyst	Leiomyosarcoma	Warts
Dermatitis	Melanoma	
Other:		

ALERTS (Circle all that apply)

Allergy to Adhesive	Defibrillator
Allergy to Lidocaine	MRSA
Allergy to Topical Antibiotics	Pacemaker
Artificial Heart Valve	Required antibiotics prior to surgical procedure
Artificial Joint Replacement	Rapid heartbeat with epinephrine
Blood Thinners	Are your Pregnant?
Other:	

Alison Ehrlich, M.D.,M.S.

4910 Massachusetts Ave NW #308

Phone: 202-695-1000 Fax: 202-503-1791

MEDICARE PRIVATE CONTRACT

This agreement is between **Alison Ehrlich, M.D. M.S.,** whose principal place of business is 4910 Massachusetts Ave NW Suite 308, Washington, DC 20016 and:

Beneficiary:_____

Who resides at:_____

Medicare ID#:_____

And is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997. The Physician has informed Beneficiary or his\her legal representative that **Physician has opted out of the Medicare program effective on 10/23/2019.** Beneficiary of his\her legal representative agrees, understands and expressly acknowledges the following:

Initial

_____ Beneficiary or his\her legal representative accepts full responsibility for payment of the physician's charges for all services furnished by the physician.

_____ Beneficiary or his\her legal representative understands that Medicare limits do not apply to what the physician may charge for items or services furnished by the physician.

_____ Beneficiary or his\her legal representative agrees not to submit a claim to Medicare or ask the physician to submit a claim to Medicare. Page 2 of 2 Private Contract

_____ Beneficiary of his\her legal representative understands that an Medicare payment will not be made for any items or services furnished by the physician that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

_____ Beneficiary or his\her legal representative enters into this contract with the knowledge that he\she has the right to obtain Medicare-covered items and services from physicians and practitioners who have not opted out of Medicare, and the beneficiary is not compelled to enter private contracts

that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.

_____ Beneficiary or his\her legal representative understands that Medi-Gap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare. Beneficiary or his\her legal representative acknowledge that the beneficiary is not currently in an emergency or urgent health care situation. Beneficiary or his\her legal representative acknowledges that the beneficiary is not currently in an emergency or urgent health care situation.

Beneficiary or his\her legal representative acknowledges that a copy of this contract has been made available to them.

Executed on:

_____

Date

By:

_____

Beneficiary or his\her legal representative

AND:

_____

Alison Ehrlich, M.D., M.S.

Foxhall
FH
DERMATOLOGY
COSMETICS

Dr. Ehrlich
Good Faith Estimate for Health Care Items & Services

Patient Name:	Patient Date of Birth:	
Does a patient request a good faith estimate? Yes or No	Signature:	
Provider/Facility Name: Dr. Alison Ehrlich / Foxhall Dermatology		
Provider/Facility Street Address: 4910 Massachusetts Ave, NW Suite:308		
City: Washington	State: D.C	ZIP Code: 20016
Phone: 202-838-3016		
National Provider Identifier (NPI): 1750376497	Taxpayer Identification Number (TIN): 83-4281568	
Date of Good Faith Estimate: _____/_____/_____		
Expected Charges:		
Provider Name: Dr. Ehrlich		
Total Estimated Cost: $		