warrenton dermatology & skin therapy center

Dear Patient:

Welcome and thank you for choosing our practice.

Please bring the following with you to your appointment:

- Your completed forms, along with your current insurance card, photo identification (such as a current driver's license or state issued form of identification) and any applicable co-payment or co-insurance, which may be paid by cash, check or credit card.
- Please arrive 20 minutes prior to your appointment time *if you do not have your completed forms with you or did not complete pre-visit registration.*
- If your insurance carrier requires a written referral, please be sure to have the original signed form or fax from your Primary Care Physician before you are seen. If you are not sure whether or not you need a written referral, please contact your insurance company.
- If the patient is a minor, we do require a parent to attend the first visit to obtain accurate medical history.
- If you are at least 10 minutes late for your appointment, we will reschedule your appointment.
- Should you be unable to keep your appointment for any reason, we require 24-hour (1 full business day) notice. Failure to notify us of your cancellation for a medical appointment will result in a $75.00 charge. Failure to notify us of your cancellation for a surgery, cosmetic injection, or CoolSculpting appointment will result in a $100.00 charge. Failure to notify us of your cancellation for a Mohs surgery will result in a $250 charge. Regrettably, we have been forced to institute this policy due to a large volume of last-minute cancellations and "no-shows."

If you have any questions, feel free to call our office. We look forward to seeing you.

Driving Directions:

From N. VA - Take I-66 to the Route 29 Gainesville exit and go south onto Route 29 to Warrenton. Take the Business Route 29 / Route 211 exit (1st Warrenton exit). At the first stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

From Fredericksburg - You can take Route 3 or Route 17 North until you get to Route 29 and go north to Warrenton. Take the Business Route 29 / Rt. 211 exit (3rd Warrenton exit). At the first stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

From Culpeper - Take Route 29 North to Warrenton. Take the Business Route 29 / Route 211 exit (3rd Warrenton exit). At the first stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

From Middleburg/Winchester - Take Route 17 south to Warrenton. Take the Route 17 spur (bear right after Ben and Mary's Restaurant to the exit for Business Route 29 / Route 211. At the stop light, turn left onto Blackwell Road. Blackwell Park Lane is on the right (across from the Hampton Inn).

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PATIENT REGISTRATION FORM

Please Print and Complete the Following Information

Demographic Information: Date: _____

Patient's First Name: _____ Middle Initial: _____ Last Name: _____

Date of Birth: _____ Social Security Number: _____ Sex: M___ F___

Mailing Address: _____
(Street or P.O. Box) (City) (State) (Zip Code)

Marital Status: Single___ Married___ Partnered___ Divorced___ Widowed___

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

I would prefer to be reached by: _____Home Phone Voicemail OK? YES NO _____Cell Phone _____Patient Portal

Emergency Contact Name: _____ Phone: _____ Relationship: _____

Referring Physician: _____ Phone: _____

Primary Care Physician: _____ Phone: _____

For Minors Only: Please provide the following information for the Minor's Responsible Party

Name: _____ Relationship: _____

Date of Birth: _____ Social Security Number: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Insurance Information: All patients must present their insurance card(s) at the time of each visit.

Primary Insurance Carrier: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient: Self_____ Spouse_____ Parent_____ Other_____

Identification Number: _____ Group Number: _____

Secondary Insurance Carrier: _____

Policy Holder's Name: _____ Policy Holder's Date of Birth: _____

Relationship to Patient: Self_____ Spouse_____ Parent_____ Other_____

Identification Number: _____ Group Number: _____

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your right under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.
You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement. By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on Portability and Accountability Act of 1996 (HIPAA).
The patient understands that:

1. Protected health information may be disclosed or used for treatment, payment, or health care operations
2. The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice
3. The Practice reserves the right to change the Notice of Privacy Policies
4. The patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease
6. The practice may condition treatment upon the execution of this Consent.

HIPAA Policy

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Warrenton Dermatology & Skin Therapy Center from discussing appointment, medication, test results, or treatment plans with anyone other than the patient. Often this causes difficulty for some patients who would like family members or caretakers to obtain information for them. **If you would like to permit someone to discuss your medical condition, confirm appointments, or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information.**

Name of Individual (Please Print)	Relationship to Patient

Patient statement: I am aware of my HIPAA and Patient Rights (please request a copy at the front desk)

_____ _____

Patient signature (Parent or Guardian if patient is a minor) Date

Initial/date if no changes since last visit_____ Staff verified _____

Name: _____ Date of Birth: _____ Date: _____

Reason for today's visit: _____

Medication Name	Dosage/Frequency	Oral / IV / Other	Medication Name	Dosage/Frequency	Oral / IV / Other

Medication allergies: _____

Preferred Pharmacy: _____ Pharmacy Address: _____

ALERTS: Please answer the following questions

Yes No

□ □ Have you ever had a blistering sunburn (even as a child)?
□ □ Do you get faint or vasovagal with procedures (blood work/lab tests, skin biopsies)?
□ □ Do you have a heart pacemaker or Defibrillator?
□ □ Do you have an allergy to Lidocaine/Xylocaine/Epinephrine?
□ □ Do you have an allergy to latex?
□ □ Do you have an allergy to adhesive bandages?
□ □ Do you require antibiotics before surgical or dental procedures?
□ □ Do you or have you used tobacco (chew/cigarettes/vapes/cigars/pipes)?
□ □ Do you or have you used other illicit drugs?
□ □ Do you drink alcohol?
□ □ Do you take any blood thinning medication (Coumadin/Warfarin/etc.)?

Do you take any immunosuppressant medications (Chemotherapy/Prednisone/Methotrexate/etc.)?

□ No □ Yes, please specify _____

Do you: □ always burn □ burn first then tan □ never burn

REVIEW OF SYSTEMS: Are you currently experiencing any of the following symptoms? Please circle all that apply

Fevers/Chills
Night Sweats
Unusual Weight Changes
Loss of Appetite
Swollen Lymph Nodes
Joint Pain
Sensitivity with Hot/Cold Temperatures
Itching
Sun Sensitivity
Fatigue
Flushing
Excessive Sweating
New Onset Headaches
Hair Loss
Mouth or Throat Sores
Genital Sores
Painful Urination
Nausea/Vomiting/Diarrhea
Vision Changes
Abnormal Hair Growth
Muscle Weakness

Other: _____

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Initial/date if no changes since last visit_____ Staff verified _____

Name: _____ Date of Birth: _____ Date: _____

History and Intake Form

MEDICAL HISTORY: (Please circle all that apply)

Anemia
Anxiety
Arthritis
Asthma
Atrial Fibrillation
Bladder/Prostate Problem
Bleeding Disorder
Blood Clots
Breast Cancer
Colon Cancer
COPD
Coronary Artery Disease
Organ Transplant
Sexually Transmitted Disease
Depression
Diabetes
End Stage Renal Disease
GERD
Lupus or Connective Tissue Disorder
Hepatitis
High Cholesterol
High Blood Pressure
HIV/AIDS
Endocarditis
Heart Murmur
Seasonal Allergies
Hypothyroidism
Leukemia
Lung Cancer
Lymphoma
Prostate Cancer
Stroke
Polycystic Ovarian Syndrome
Seizures
Currently Pregnant/Breastfeeding
Thyroid Disease
Tuberculosis
Other:_____

PAST SURGICAL HISTORY: (Please circle all that apply)

Appendix Removed
Melanoma Surgery
Artificial Heart Valve Replacement
Atypical Mole Surgery
Colon: Colostomy/Colectomy
Joint Replacement, please specify location/year _____
Coronary Artery Bypass
Heart Transplant
Kidney Removed (right/left)
Hysterectomy
Mastectomy (right/left)
Liver Transplant
Prostate Removed: Prostate Cancer
Basal Cell Carcinoma Surgery
Kidney Transplant
Squamous Cell Carcinoma Surgery
Other:_____
_____
_____

SKIN DISEASE HISTORY: (Please circle all that apply)

Acne
Actinic Keratoses
Atypical Moles
Basal Cell Skin Cancer
Blistering Sunburns
Melanoma
Dry Skin
Rosacea
Eczema
Flaking or Itchy Scalp
Keloids
Herpes Simplex Virus
Psoriasis
Squamous Cell Skin Cancer
Current Tanning Bed use, approximately _____ times in lifetime
History of Tanning Bed use, approximately _____ times in lifetime
Other _____

FAMILY HISTORY: (Please circle all that apply)

Melanoma
Severe Acne (Accutane use)
Eczema
Atypical Moles
Connective Tissue Disorder
Psoriasis
Other: _____
_____

SCREENING HISTORY: (Please write in the year of last exam)

Dental Exam _____
Eye Exam _____
Pelvic Exam _____
Prostate Exam _____
Colonoscopy _____
Mammogram _____

PATIENT ACKNOWLEDGEMENTS OF OFFICE POLICIES

Insurance Information – Co-payments and Deductibles
Warrenton Dermatology & Skin therapy Center will file your claim with your insurance if we participate with your insurance plan. Otherwise, payment is required in full for all services at the time they are rendered. Should any services not be covered by your insurance, you agree to accept financial responsibility for said services. All applicable co-payments and deductibles are to be paid in full and collected at the time of your visit. Returned checks are subject to a $35.00 administrative fee. Your signature below signifies your understanding and willingness to comply with this policy.

Referral Information
If a referral is required by your health insurance plan, it is your responsibility to obtain the referral from your Primary Care Physician and assure it is available to be presented at the time of your visit. Additionally, it is your responsibility to keep track of the number of visits you have used on your referral, the expiration date of your referral and obtain new ones as needed. Should you fail to have a valid referral for your visit, insurance regulations require that you sign a financial waiver. Your signature below signifies your understanding and willingness to comply with this policy.

Insurance Cards
All patients will be required to provide valid insurance card(s), or a temporary print out at the time of their visit. Should you be unable to produce this documentation, insurance regulations require that you sign a financial waiver. Your signature below signifies your understanding and willingness to comply with this policy and that you are responsible for notifying our office of any changes to your insurance or contact information.

Deposit for Cosmetic Appointments
We require a prepaid, non-refundable $100 booking fee an appointment for Fraxel, Microneedling, and Botox/Filler injections. A prepaid, non-refundable $50.00 booking fee is required when booking an appointment for a CoolSculpting consultation. By placing and authorizing this booking fee on your account for these services, you are agreeing the fee will either go towards your service administered same day, the consultation for the service if no treatment is received or forfeiting the fee if you no-show your scheduled appointment or cancel with less than 24-business hour notice.

Cancellation Policy
We require a 24-business hour cancellation notice for all appointments. Patients that do not contact the office within the 24-business hour period to cancel their appointment will be charged a $75 fee for the missed regular medical and esthetic appointment. Failure to notify us of your cancellation for a surgery, cosmetic injection or CoolSculpting appointment will result in a $100.00 charge. Less than 48-hour notice to cancel a Mohs surgery will result in a $250 fee. Regrettably, we have been forced to institute this policy due to a large volume of last-minute cancellations and "no-shows."

Virginia Law (Section 32.1-45.1 et. Seq.)
I understand that if, during the course of care, a health provider is directly exposed to my blood or body fluids in a manner which may transmit Hepatitis B or C or AIDS, for the protection and well-being of the healthcare provider, it is important that a test be made on my blood without charge to determine whether I am carrying the virus and that under Virginia Law (Section 32.1 – 45.1 et seq.) I am deemed to have consented to said test(s) and to the release of the test results to the exposed healthcare provider. I also understand that health providers are deemed to consent to tests and the release of results to me, should I be similarly exposed.

Informed Consent for In-Office Procedures
I understand that I have the right to refuse any medical/surgical treatment recommended at any time prior to its performance. I authorize my physician to perform such procedures (shave biopsies, punch biopsies, and cryotherapy) which in his/her judgement are incidentally necessary or appropriate to carry out my diagnosis/treatment. I understand that the provider may ask other providers and /or clinical staff to participate in my care. I am aware that the practice of medicine and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of my procedure.

Delinquent Balance Information
I, the undersigned, understand and acknowledge that if an account balance is not paid in a timely fashion, I will be responsible not only for the balance due but any collection, reasonable attorney fees, and/or court costs that are incurred in the collection process. I understand that Warrenton Dermatology reserves the right to add an additional 30% if my account is sent to an outside collection agency.

_____ _____

Patient Signature (Parent or Guardian if patient is a minor) Date

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CONSENT TO TREAT A MINOR

Minor Patient Name: _____ Date of Birth: _____

In the event of my absence, I hereby give my permission for the following individuals to make decisions regarding the treatment of my child including, but not limited to, examinations, injections and/or procedures. I understand those listed below will have the authority to authorize treatment.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

I understand this signed consent will be valid until the minor child is 18 years of age, or unless so designated in writing that such consent for treatment of minor is cancelled. I will notify Warrenton Dermatology and Skin Therapy Center of any changes as to the health status of my child. I will be available by telephone should any questions arise.

_____ _____
Name of Parent or Guardian Telephone Number

_____ _____
Signature of Parent or Guardian Date

In the event of my absence, or the above-listed individuals, I hereby give my permission to the providers of Warrenton Dermatology, P.C. to treat my minor child. I understand this signed consent will be valid until the minor child is 18 years of age, or unless so designated in writing that such consent for treatment of minor is cancelled. I will notify Warrenton Dermatology and Skin Therapy Center of any changes as to the health status of my child. I will be available by telephone should any questions arise.

_____ _____
Name of Parent or Guardian Telephone Number

_____ _____
Signature of Parent or Guardian Date