

Ali Moiin, M.D.

A Comprehensive Dermatology Center

Troy, Medical Square Village
248-643-7677 • Fax 248-643-7679

PATIENT REGISTRATION

Name _____ SS# _____
Last First Middle
Street Address _____ Date of Birth _____ Sex: M F
City _____ State _____ Zip _____
Telephone: Home _____ Office _____ Pharmacy _____
Referred by _____ Cell Phone _____ E-Mail _____
Spouse's name _____ Employer _____
Guardian's Name (If Minor) _____

INSURED EMPLOYER INFORMATION

Employer name _____ Employment Status: FT PT Tel# _____

INSURANCE SUBSCRIBER (if not patient)

Name _____ Date of Birth _____ SS# _____

INSURANCE

Medicaid # (if applicable) _____ Medicare # (if applicable) _____

Primary Insurance Company Name _____

ID # _____ Group # _____ Tel # _____

Secondary Insurance Company Name _____

ID # _____ Group # _____ Tel # _____

HAVE YOU HAD ANY OF THE FOLLOWING:

PROBLEM/CONDITION	Yes	No	PROBLEM/CONDITION	Yes	No	PROBLEM/CONDITION	Yes	No
Heart Disease			Emotional Problems/Depression			Difficulty Healing Wounds		
High Blood Pressure			Liver Disorders			Asthma		
Kidney Disease			Hepatitis			Hay Fever		
Fainting Spells			Blood Transfusion			Eczema		
Convulsions			Bleeding Disorders			Currently Pregnant		
Eye Problems			Overgrown Scars or Keloids					

Other Medical Problems? (Please List): _____

QUESTIONS	Yes*	No	QUESTIONS	Yes*	No
Do you have any drug allergies?			Do you use tobacco?		
Is there a family history of skin cancer?			Do you use antibiotics before surgery?		

* If yes, please explain: _____

Current Medications (include aspirin, vitamins, laxatives, birth control pills, etc.):

Medication Name Reason for use

Past Hospitalizations: Date _____ Reason: _____

Past Hospitalizations: Date _____ Reason: _____

INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date _____ Signature _____

hereby authorize Dr. _____ to apply for benefits on my behalf for covered services rendered by him/her or by his/her order.

request that payment from my insurance company be made directly to Dr. _____ (or to the party who accepts assignment).

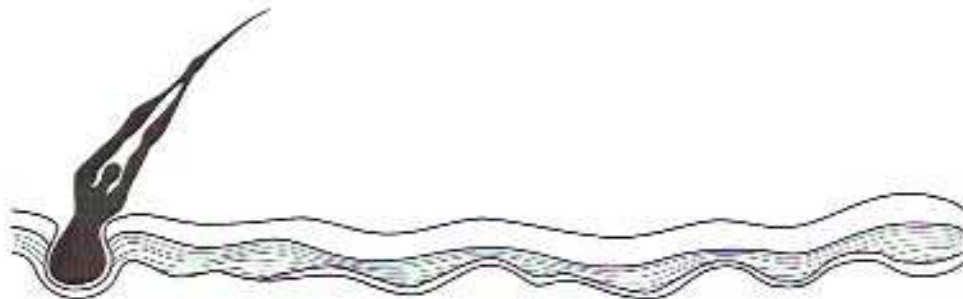
certify that the information I have reported with regard to my insurance coverage is correct.

permit a copy of this authorization to be used in place of the original. This authorization may be revoked by either me or my insurance company at any time in writing.

Date _____ Signature _____
(Patient, parent, or guardian)

**A Comprehensive
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Laser and Cosmetic Surgery



**CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION
FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS**

NAME _____

BIRTHDATE _____ SOCIAL SECURITY # _____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.
- A tool for routine healthcare operations such as assessing care quality and reviewing the competence of healthcare professionals.

I understand that I have the right:

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

I request the following numbers not to be used when calling me.

Please provide your Cell Phone Number _____

PATIENT:

X

Signature of Patient or Legal Representative

Date

Witness Signature

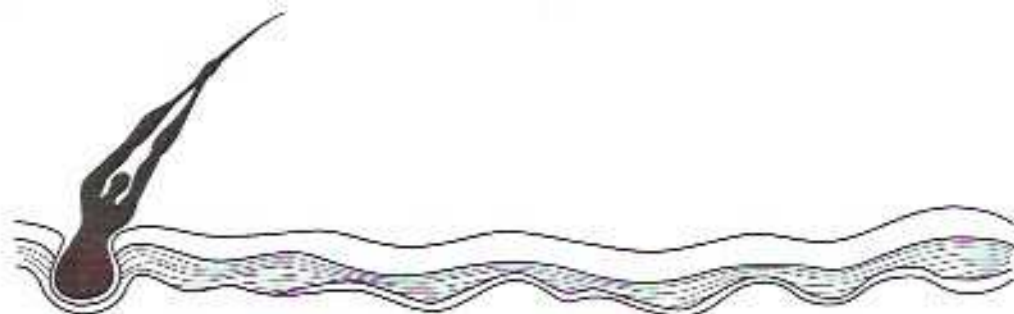
**ACKNOWLEDGEMENT OF RECEIPT
OF PRIVACY PRACTICES NOTICE**

Ali Mojin, M.D.

Diplomate American Board of Dermatology • Clinical Professor, WSU
1575 W. Big Beaver Rd • Suite C-12 • Troy, MI 48064 • Phone: (248) 643-7677 • Fax: (248) 643-7679
14555 Levan Rd • Livonia, MI 48154 • Phone: (734) 591-2000

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Effective Date: _____

A COMPREHENSIVE DERMATOLOGY CENTER

PRIVACY POLICIES

It is the policy of our practice that all physicians and staff preserve the integrity and the confidentiality of protected health information (PHI) pertaining to our patients. The purpose of this policy is to ensure that our practice and its physicians and staff have the necessary medical and PHI to provide the highest quality medical care possible while protecting the confidentiality of the PHI of our patients to the highest degree possible. Patients should not be afraid to provide information to our practice and its physicians and staff for purposes of treatment, payment and healthcare operations (TPO). To that end, our practice and its physicians and staff will—

- Adhere to the standards set forth in the Notice of Privacy Practices.
- Collect, use and disclose PHI only in conformance with state and federal laws and current patient covenants and/or authorizations, as appropriate. Our practice and its physicians and staff will not use or disclose PHI for uses outside of practice's TPO, such as marketing, employment, life insurance applications, etc. without an authorization from the patient.
- Use and disclose PHI to remind patients of their appointments unless they instruct us not to.
- Recognize that PHI collected about patients must be accurate, timely, complete, and available when needed. Our practice and its physicians and staff will
 - Implement reasonable measures to protect the integrity of all PHI maintained about patients.
- Recognize that patients have a right to privacy: Our practice and its physicians and staff respect the patient's individual dignity at all times. Our practice and its physicians and staff will respect patient's privacy to the extent consistent with providing the highest quality medical care possible and with the efficient administration of the facility.
- Act as responsible information stewards and treat all PHI as sensitive and confidential. Consequently, our practice and its physicians and staff will:
 - Treat all PHI data as confidential in accordance with professional ethics, accreditation standards, and legal requirements.
 - Not disclose PHI data unless the patient (or his or her authorized representative) has properly authorized the release or the release is otherwise authorized by law.

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- ✓ Recognize that, although our practice "owns" the medical record, the patient has a right to inspect and obtain a copy of his/her PHI. In addition, patients have a right to request an amendment to his/her medical record if he/she believes his/her information is inaccurate or incomplete. Our practice and its physicians and staff will--
 - Permit patients access to their medical records when their written requests are approved by our practice. If we deny their request, then we must inform the patients that they may request a review of our denial. In such cases, we will have an on-site healthcare professional review the patients' appeals.
 - Provide patients an opportunity to request the correction of inaccurate or incomplete PHI in their medical records in accordance with the law and professional standards.
- ✓ All physicians and staff of our practice will maintain a list of certain disclosures of PHI for purposes other than TPO for each patient and those made pursuant to an authorization as required by HIP AA rules. We will provide this list to patients upon request, so long as their requests are in writing.
- ✓ All physicians and staff of our practice will adhere to any restrictions concerning the use or disclosure of PHI that patients have requested and have been approved by our practice
- ✓ All physicians and staff of our practice must adhere to this policy. Our practice will not tolerate violations of this policy. Violation of this policy is grounds for disciplinary action, up to and including termination of employment and criminal or professional sanctions in accordance with our practice's personnel rules and regulations.

Our practice may change this privacy policy in the future. Any changes will be effective upon the release of a revised privacy policy and will be made available to patients upon request.

Receipt of Notice of Privacy Practices

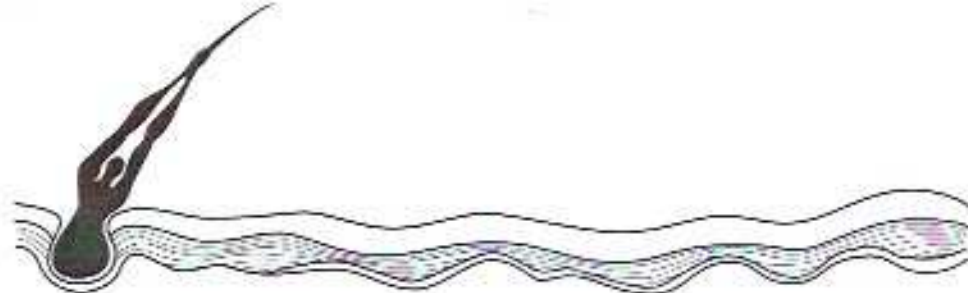
I, _____ have received a copy of A Comprehensive Dermatology Center's Privacy Practices.

Signature of Patient

Date

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FINANCIAL POLICY

Please initial each paragraph

____ Due to the many changes in insurance policies, it is no longer an easy task to interpret each individual policy. Although we try to stay aware of these changes, it is not always possible. We urge you to check with your insurance company prior to having any procedure. **It is your responsibility** to know your individual coverage. Failure to comply with this suggestion could result in you being responsible for all costs incurred. Please remember that it is **your obligation** to provide our office with your **current and correct** insurance cards, to know your individual coverage and to always provide us with any updated information. Please remember your insurance policy is between you and your insurance company, not between the insurance company and the doctor.

____ Our office will submit your claim to your insurance company as a courtesy to you. If your insurance company has not paid your account in full within 90 days, the balance will automatically be transferred to you. Please be aware that some of the services provided may be non-covered services and could be your responsibility. All patient balances past due 90 days will be reviewed for collections. All returned checks will be subject to a \$25 fee.

____ Please inform us if you have **Master Medical** through Blue Cross. We will collect the office visit payment at the time of the visit.

____ **Co-payments for ALL insurance are to be made at the time of service.** Our allowable forms of payment are cash, check, MasterCard and Visa. **We cannot wave co-pays.**

____ HMO patients must follow your primary care physician's regulations to obtain your referral. You must bring the appropriate referrals and/or authorizations from your primary care physician. We recommend that you follow up with your primary care office **The day before** your scheduled appointment to verify that your referral has been processed for your office visit with Dr. Moin. If our office does not have the appropriate information at the time of service, you will be obligated to pay at that time.

____ Your follow up appointments are essential to your care. Twenty four hour cancellation notice is required. Otherwise, we reserve the right to charge a \$35 fee for missed appointments.

____ Cosmetic procedures are not covered by any insurance company and payment is expected at the time of service. Cosmetic procedures are **not** guaranteed to work.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. I have read the financial policy. I understand and agree to this financial policy.

Please print and sign your name
(Retain one copy for your records)

Date

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