STEVEN GOULDER MD
Skin Cancer, Mohs Surgery and Surgical Dermatology Specialist

PATIENT REGISTRATION FORM

Today's Date: ____/____/_____

Please print and complete all information. Thank you!

PATIENT INFORMATION:

Patient's Last Name:_____ First Name:_____ Middle:_____ Birth Date: ___/___/___

Email:_____ Cell Phone: _____ Home Phone: _____

Responsible party or legal rep.: _____ Relationship to patient (if applicable): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Employer: _____ Work Phone:_____ Occupation: _____

Business Address: _____ City: _____ State:_____ Zip:_____

Marital Status: ____ Spouse's name: _____Birth Date: _____SS#: _____

Spouse's or Responsible Party's Employer: _____

INSURANCE:

Name of **Primary Insurance**: _____

Claims Address: _____ City: _____ State:_____ Zip:_____

Policy or ID#: _____ Group #:_____

Policyholder's Name: _____ Relationship to patient: _____

Name of **Secondary Insurance** (if any):_____

Claims Address: _____ City: _____ State:_____ Zip:_____

Policy or ID#: _____ Group #:_____

Policyholder's Name: _____ Relationship to patient: _____

EMERGENCY CONTACT:

Name: _____ Relationship to patient: _____ Cell Phone #: _____

Home Address: _____ City: _____ State:_____ Zip:_____

REFERRING PHYSICIAN INFORMATION:

How did you learn of our Practice? _____

Primary Care Physician: _____ Phone #: _____

Referring Physician / Dermatologist: _____ Phone #: _____

I verify that the above information is accurate: SIGNATURE: _____ Date: ____/____/____ V1.1.2022

PATIENT HISTORY FORM

Date: _____/_____/_____ *Please Circle:* New Patient Return Visit

Name: _____ DOB: _____/_____/_____

Gender: _____ Occupation: _____ Referring Physician: _____

Reason for todays visit: _____

_____

Duration: _____ Has your current skin condition ever itched (please circle)? Y N

Has your current skin condition ever bled (please circle)? Y N

Have you tried medications or had treatment in the past for your current condition? If so, please list:

_____

Family History – Check if any blood relative has:

Allergies	( )	Asthma	( )	Arthritis	( )
Eczema	( )	Diabetes	( )	Heart Disease	( )
Hay Fever	( )	Skin Cancer	( )	Hypertension	( )
Hives	( )	Malignant Melanoma	( )	Tuberculosis	( )
Psoriasis	( )	Other Cancer	( )	None	( )

Personal Past Medical History or Current Disease of:

	Yes	No		Yes	No
Headache/Seizure	( )	( )	Hepatitis C (or liver disease)	( )	( )
Psychiatric	( )	( )	HIV/AIDS	( )	( )
Eyes/Ears/Nose/Throat/Mouth	( )	( )	Blood/Bleeding Disorders	( )	( )
Lungs	( )	( )	Heart Attack	( )	( )
Stomach/Bowels	( )	( )	Stroke	( )	( )
Kidney Disease	( )	( )	High Blood Pressure	( )	( )
Rheumatologic	( )	( )	Heart Disease/Murmur/Rhythm	( )	( )
Allergic/Immunologic	( )	( )	Artificial Heart Valve	( )	( )
Organ Transplant / Lymphoma	( )	( )	Artificial Joint	( )	( )
Blistering Sunburn	( )	( )	Diabetes/Thyroid Disease(circle)	( )	( )
Melanoma	( )	( )	Radiation Therapy	( )	( )
Skin Disorder (incl. cancer)	( )	( )	Pacemaker/Defibrillator	( )	( )

If you answered yes to any above, please explain: _____

Other major medical illnesses/surgeries: _____

Allergies (drug, food, pet): _____

Do you take antibiotics prior to seeing a dentist? If yes, explain: _____

Current Medications (include aspirin, vitamin E, herbs, and non-prescription): _____

_____

Do you use alcohol? _____ /week Do you Smoke? _____ packs/day

Do you have a history of substance abuse? _____Have you ever used tanning booths? _____

Advanced Care Plan:

Do you have an Advance Care Plan or Surrogate Decision Maker (ex. Living Will, Health Care Proxy) YES NO DECLINE

If YES please provide name of Surrogate Decision Maker _____

PATIENT SIGNATURE: _____ Date: _____/_____/_____ v.1.2.2022

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Receipt of Notice of Privacy Practices
Written Acknowledgement Form

The Notice of Privacy Practices for the office of the Midwest Skin Cancer Institute, a division of the Illinois Dermatology Institute, LLC – the office of Dr. Steven Goulder - is available for your review at the front desk and on our website at www.drgoulder.com. Should you wish to receive your own copy to take with you please ask our staff. The Notice of Privacy Practices may change from time to time and you are welcome to request a revised copy at your next visit, call our office and request a copy, or mail a written request.

Section 1 of this document provides your acknowledgement that you have read our Notice of Privacy Practices.

Section 2 requests your designation of a family member or other designee that we may contact and discuss your medical care in the event of an emergency.

Section 3 provides the opportunity to opt in or opt out of receiving marketing communication from our office.

Section 1 - Acknowledgement

I acknowledge and understand the Notice of Privacy Practices for the office of Dr. Steven Goulder, a division of the Illinois Dermatology Institute, LLC.

_____ _____
Patient Name Today's Date

_____/_____/_____ _____
Date of Birth MRN (office use)

Section 2 – Emergency Designee

The office and personnel are authorized to contact the party listed below to discuss and handle my medical care in the event of an emergency or to receive message information on my appointments and test results:

_____ _____ _____-_____-_____
Designated Person Relationship Phone Number

Section 3 – Marketing Communication (This section is required by new HIPAA Guidelines)

IDI may wish to share new products, discounts or service information directly to you, our patient. The information may be communicated via phone call, letter, or email. You have the right to Opt In or Opt Out of any marketing communications by checking your preference below. (You are able to change your decision at any time by notifying our office.)

☐ I wish to opt IN and receive marketing and other communications via email, phone call or letter.

Email address: _____

☐ I wish to opt OUT; I do not wish to receive marketing information.

_____

I understand the information provided to me in the Notice of Privacy Practices and I have indicated my response to the questions in each section above.

_____ _____-_____-_____
Patient Signature Patient Phone Number

Internal Use Only: If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient. Presented (date/time):_____ By Staff Member_____ v1.2.2022

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Patient Responsibility Policy

Thank you for choosing the Midwest Skin Cancer Institute, a division of the Illinois Dermatology Institute, LLC – the office of Dr. Steven Goulder. Our primary mission is to deliver the best and most comprehensive care available. An important part of our mission is to help make the cost of optimal care as easy and manageable for our patients as possible by the offering the following payment options.

Payment Options: You can choose from: ☐ Accepted Insurance Plans ☐ Cash, Check, Visa or MasterCard

For patients with medical insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your medical treatments. However, if we do not receive full payment from your insurance carrier within 90 days of the date of service, you will be responsible for payment of all your treatment fees and the collection of your benefits directly from your insurance carrier.

If you are covered by one of our accepted insurance plans, and can provide a valid insurance card or other evidence of coverage at or before the time of service, we will bill your insurance carrier for your non-cosmetic dermatology services. These dermatology services may be applied towards your deductible, subject to copayment or coinsurance, in which case you will be financially responsible**. You are responsible for knowing the policies of your insurance, such as: co-pay, coinsurance, deductible, pre-existing conditions, policy exclusions, effective date, termination date, in-network physicians, referrals, etc.** All co-payments must be paid on the date of service. **If you have HMO insurance, you are responsible for your referrals.** Referrals are typically only valid for 90 days from the issue date and are only good for as many visits as your primary doctor has approved. **It is the patient's responsibility to check to see if we are in-network.**

Illinois State law requires insurance carriers to pay claims within 30 days of reception. Insurance carriers who fail to comply with these state standards are subject to additional requirements and penalties. In situations when your insurance provider pays its portion and leaves you accountable for the remaining balance, you will be accountable to submit this payment within receipt of two billing statements. When however, your insurance provider delays or withholds payment, for 90 days or longer, both the insurance and patient portions will become your responsibility. If no payment is received after 90 days your account will be subject to be turned over to a collection agency.

For surgery patients with a **High Deductible Health Care Plan (HDHP),** the *total payment* for your procedure will typically be your personal out-of-pocket expense unless your high deductible has been met. If you have a HDHP and require a procedure, the practice will attempt to contact your insurance company to confirm eligibility and an estimate of your covered benefits. Prior to the procedure, you are required to pay in full for your estimated out-of-pocket expense related to the procedure (co-pay, coinsurance, deductible). Such amount may be paid by credit card. Mohs surgery patients with a HDHP, are required to pay a portion of your out-of-pocket expense ($1000.00) prior to your surgery. Any remaining balance is due within thirty (30) days of our receipt of payment from your insurance company if applicable, or within 90 days of your surgery if you have not met your high deductible.

For self-pay patients, the Midwest Skin Cancer Institute requires payment in full on the day of your treatment by Cash, Check, Visa or MasterCard. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case.

All prices quoted prior to the completion of non-cosmetic dermatology office visits and procedures are only estimates and can change based on the complexity of the office visit and procedures performed during the day of service.

Surgical appointments that are cancelled with less than 24 business hours notice, or no-shows, are subject to a $100 cancellation fee.

If a tissue specimen is sent to a pathology laboratory you will be billed separately for that additional procedure.

Payment for cosmetic treatments is due in-full at the time of service. The Illinois Dermatology Institute charges $30 for returned checks.

My signature states that I have read and fully understand the above Patient Responsibility Policy and agree to its terms:

_____ _____

Patient, Parent or Guardian Signature Date

_____

Patient Name (Please Print)