New Patient Registration
WELCOME TO OUR PRACTICE!

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Deborah Kessler Hudak, MD

Today's Date: _____/_____/_____ Chart#:_____

First Name: _____MI:_____Last Name: _____

Birthdate: ____/_____/_____ SSN_____-_____-_____

**********This section must be completed if patient above is a minor**********

Responsible Party: _____
Address: _____Zipcode_____
Birthdate: ____/_____/_____ SSN: _____-_____-_____

Patient's Relationship to Responsible Party: ☐ Spouse ☐ Child ☐ Other

****

Patient's Addresss: _____Zip Code_____

City: _____ State: _____

Home Phone: ( ) _____-_____ Work Phone: ( ) _____-_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary Care Physician: _____Primary Care Phone: ( ) _____-_____

Primary Policy Information:

Plan Name: _____Name of Policy Holder: _____

Policy Holder Birthdate: _____/_____/_____ Policy Holder SSN: _____-_____-_____

Patient's Relationship to Policy Holder: ☐ Spouse ☐ Child ☐ Other

Subscriber ID #_____Group #_____

Secondary Policy Information:

Plan Name: _____Name of Policy Holder: _____

Policy Holder Birthdate: _____/_____/_____ Policy Holder SSN: _____-_____-_____

Patient's Relationship to Policy Holder: ☐ Spouse ☐ Child ☐ Other

Subscriber ID #_____Group #_____

Extended Patient Information

Employer: _____Employment Status: ☐ Full Time ☐ Part Time ☐ Retired

School:_____School Status: ☐ Full Time ☐ Part Time ☐ Retired
Employer/School Address:_____
Emergency Contact:_____Emergency Contact Phone:(___)____-_____

A copy of your insurance card(s) is required at each visit for verification of information. If you are without a card you must have all the required information available when you present to the office. Payments for office services are due on the day of the visit. We will attempt to bill charges to your insurance company if you provide valid insurance information. Payment may be made by cash, check, credit card, or debit. Notice any additional fee for certain administrative services such as disability forms, letter of medical necessity, and returned check will be the patient's responsibility.
Patient/Physician Agreement: I, the undersigned, authorize Dr. Hudak to release any information acquired in the course of my examination to my insurance company(s) or other physicians and medical facilities. I understand that the medical insurance may not completely cover the fee(s) for professional services provided to me, and I agree that I am responsible to cover any fee(s) not covered. A photocopy here forth shall be valid as the original I am aware that I may inquire of my physician the fee(s) for any professional services required and/or rendered.

Patient/Guardian Signature_____**Date:**_____

Financial Policy

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Thank you for choosing All About Aesthetics as your health care facility. **We value your patronage.** Please review and sign our financial policy.

We are required to verify health insurance coverage: therefore, proper identity (i.e. driver's license) may be requested prior to the visit. We appreciate your patience and understanding during this process. Having current and accurate information allows us to process you claim promptly and correctly.

Regarding insurance with which we participate: We will file a claim with your insurance company. You are responsible for the co-pay and any deductible at the time of service. Please make sure that the **new patient registration form** is completed entirely and accurately, especially if you are not the employee of the company (primary insured) offering the insurance coverage. Information regarding the employee (primary insured) is now required by insurance companies to process claims. Any unanticipated co-pays/deductibles must be paid upon receipt of the first statement sent per month.

Regarding HMO's requiring a referral: You are required to obtain a written referral from your primary care provider prior to each visit. It is your responsibility to make sure that you have the referral with you or the referral is already in our office on the day of the scheduled visit. HMO contracts do not allow providers to see patients without the appropriate referral on file.

Regarding non-cover services: Cosmetic Services or services that your insurance company determines are not medically necessary: therefore, payment is accepted at the time of service. Examples of these services are Botox, Sclerotherapy, and removal of skin tags, normal moles, or benign keratoses.

Regarding general responsibility for payment: The patient is responsible for payment of any office visits or procedures for which your insurance company denies payment. We will attempt to advise you when we think a procedure may not be covered by insurance. However, it is sometimes not possible to predict whether a company will reimburse prior to submitting the insurance claim. We advise that prior to any procedure, you should check with your insurance company regarding reimbursement.

Regarding insurance we do not contract with: The total cost of the visit is due at the time of the service.

Regarding medical record release: A service fee may be accessed for copying medical records and a release form must be signed prior to releasing the information.

Regarding disability forms: Disability forms can be very time consuming to research and complete. A $5.00 service fee will be accesses for each form that requires completion. The fee will be payable at the time the form is presented. You will be notified when the form has been completed so you may arrange to pick it up; these forms will not be mailed.

Regarding responsible Party: We realize that many families are in a state of change. Divorced, separated, single parents, and blended families are now common. In many of these families, the question of who is financially responsible for the child's care can be complicated. The policy in this office is that the parent who request treatment for the minor is responsible for payment at the time of service.

Regarding refund policy for procedures: Refunds will be given within 7 days of payment for all service. After the 7 day period, a Gift Certificate will be given to be used on any other service or product.

For your convenience, we accept cash, check, credit cards, and debit cards. A $25.00 service fee will be accessed for each returned check to cover the corresponding bank and related costs.

If at any time you have a billing question, you may ask to speak to someone from the business office to discuss these issues.

PLEASE CALL AND CANCEL AT LEAST 2 BUSINESS DAYS BEFORE YOUR APPOINTMENT TO HELP US ACCOMIDATE ALL PATIENTS.

Thank you fro thoroughly reading and understanding our financial policy. Your signature below indicates that you have read, understand, and agree to this financial policy.

_____/____/_____

Patient/Responsible Party Signature **Date**

Patient Questionnaire

Name of Patient:_____

Patient's Date of Birth:_____

How did you hear about Dr. Hudak?_____

If you last saw Dr. Hudak after June 2004, did you receive a letter from Raleigh Eye Center telling where she was located? YES/NO

If you were a patient of Dr. Hudak's when she was at Raleigh eye center, did you request a copy of your medical records? YES/NO

If yes, did you receive everything that you requested? YES/NO

Medical History

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Name: _____DOB:_____Date:_____

Past Medical Illnesses, please circle and explain.

Allergies
Skin Disorder
Bleeding Tendency
Auto-immune Disorder
Lymphatic Disorder
Respiratory/Lung Disorder
Digestive Tract Disorder
Hearing Disorder
Eye Disorder
Joint/Back/Musculoskeletal Disorder
Kidney/Bladder Disorder
Hair/Nail Disorder
Thyroid Disorder
Heart Disease/High Blood Pressure
Diabetes
Stroke
Neurological Disorder/Seizure
Psychiatric Disorder

Explain:_____
_____
_____
_____
_____
_____
_____

Review of Systems, circle and explain. Anything not circled will be assumed as "normal."

Seasonal Allergies
Unexplained Fevers
Unexplained Fatigue
Nosebleeds
Cough
Easy bruising
Swollen ankles
Irregular heartbeat
Wheezing
Chest Pain/Pressure
Difficulty hearing
Urinary/Kidney Infection
Bladder spasms
Urinary/stool incontinence
Headaches
Migraines
Breast Disease
Female Organ Disease
Rashes
Mouth/gum ulcers
Changes in skin moles
Diarrhea
Hemorrhoids
Constipation
Blood/mucus in stool
Heartburn
Reflux
Abdominal pain
Difficulty swallowing
Dizziness
Light-headedness
Fainting
Anxiety
Depression
Cancer
Leg Pain/ Arm Pain
Joint pain/arthritis
Arm/leg weakness
Numbness
Pneumonia
Glaucoma
Cataract
Diplopia
Burning/Dry Eye
Macular degeneration
Red eye
Floaters/Flashes
Head Injury
Frequent urination
Pain in feet
Epilepsy
Gout
Prostate Disease
Others

Explain:_____
_____
_____
_____
_____
_____

Medical History

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Family History, circle and write relation to you.

Diabetes_____
Hypertension_____
Macular Degeneration_____
Glaucoma_____
Rheumatoid Arthritis_____
Thyroid Disease: _____
Heart Disease/Stroke_____
Cancer_____
Other_____

Social History, circle and tell how often.

Cigarette/Tobacco use_____
Alcohol use_____
Married/Single_____
History of addiction_____
Occupation_____

Drug Allergies and Reactions:
Sulfa_____
Penicillin_____
Erythromycin_____
Other_____
_____
_____

Surgical History, give name of surgery and year it was performed:
_____
_____
_____
_____
_____

Vaccinations:

When was your last tetanus shot? _____
When was your last flu shot? _____
When was you last pneumovax? _____
Are you up to date on your vaccinations? _____

Medical History

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Medications and Over-the Counter Drugs, name, and dose, what it is taken to treat:

Exercise you get regularly:

Reviewed by: Name and date.

PATIENT INFORMATION, MEDICAL RECORD RELEASE, AND HIPPA AUTHORIZATION

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Patient Name: _____

Mailing Address: _____
_____

Referred by: _____ Primary Care Provider_____

How did you hear about Dr. Deborah K. Hudak? _____

RELEASE OF INFORMATION

Please tell us how you wish to be contacted. Please check all that apply.

Oral/Written Communication
_____ Home ( ) _____-_____

____OK to leave a detailed message
____Leave a message with call name and #
____OK to mail correspondence to the home

_____ Work ( ) _____-_____

____OK to leave a detailed message
____Leave a message with call name and #

Please tell us with whom we are allowed to discuss and/or disclose your Personal Health Information.

Spouse Adult Children Parents Personal Representative

Names of above: _____ Phone: ( ) _____-_____
Names of above: _____ Phone: ( ) _____-_____
Names of above: _____ Phone: ( ) _____-_____

My signature below authorizes the release of medical information to my primary care or referring physician and to process insurance claims/applications, prescriptions, and labs. I also authorize payment of medical benefits to the physician for services rendered.

My signature below also indicates that I have read and been offered a copy of the Notice of Privacy Practices,

Patient/Responsible Party Signature:
_____Date:_____

The patient information included on this form is true to the best of my knowledge. I herein authorize payment of medical benefits by my insurance carrier to the physician when an assigned claim is filed. (TO FILE INSURANCE, YOUR SIGNATURE IS REQUIRED)

Patient/Responsible Party Signature:
_____Date:_____

EMAIL CONTACT SHEET

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Would you like to be notified about our office aesthetic services, products, and events via email?

YES NO

Patient Name: _____

Date of Birth: _____

Email Contact: _____

(EMAIL ACCOUNTS WILL BE KEPT TO A MINIMUM!)