

MILFORD MD

Cosmetic Dermatology Surgery & Laser Center

Pocono Medical Care, Inc.

www.milfordmd.com

PATIENT REGISTRATION FORM

Please present your Insurance/Medicare cards and driver's license or other photo ID upon registration.

Please print the information requested below.

Name: (last) _____ (first) _____ (m) _____

How would you like to be addressed? _____ Male Female

Age: _____ Birth Date: _____ SS: _____ Marital Status: M D W S Partnered

Mailing Address: _____

City: _____ State: _____ Zip: _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Phone: Home _____ Work _____ Cell _____

E-Mail: _____

Race: _____ Ethnicity: _____

Occupation: _____ Employer: _____

Preferred Pharmacy: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Nearest relative not living with you: _____ Phone: _____

Address: _____

Primary Health Insurance: _____ Secondary: _____

Payment: If we do not participate with your insurance or if you have not presented your insurance card, you will pay the facility's regular rates, in full, at the time of service. If we participate with your insurance company, **co-pays and deductibles must be paid at the time of service** and your primary insurance company will be billed. You are responsible for billing any secondary insurance you may have and are responsible for any additional monies owed after we receive your insurance company's payment (e.g. non-covered services). Our professional services are rendered for and charged directly to you, not your insurance company and you agree to be responsible for payments. Payment may be made by **CASH, CHECK OR CREDIT CARD**. If we are not a participating provider, a receipt will be given to you, suitable for you to submit to your insurance carrier. **You agree that cosmetic services will not be billed to your insurance company and that you are responsible for full payment before or at the time of service.**

Outside Services: Independent outside laboratory services (e.g. Quest Diagnostics) will bill you directly for any lab work. A cardiology and/or radiology group may provide an interpretation and will bill you directly for any in office testing (e.g. ultrasounds, echocardiograms).

Signature on File: I, the undersigned, request that payment of Insurance/Medicare benefits be made on my behalf to Pocono Medical Care, Inc. for any services rendered to me by this practice and its physicians. I authorize any holder of medical information about me to release to my health insurance company or the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I acknowledge receipt of a copy of this office's *Notice of Privacy Practices* (HIPAA) and *Payment Policy*, consent to receive calls at the number(s) provided above, consent to examination and treatment and agree to be financially responsible for the services rendered.

Patient/Parent/Guardian Signature: _____ Date: _____

Relationship: _____

Today's Date: _____

MilfordMD Cosmetic Dermatology Sugery & Laser Center	
Name _____	DOB _____

• **CHIEF COMPLAINT:** (DESCRIBE SYMPTOM(S) OR CONDITION(S) FOR WHICH YOU ARE SEEING THE DOCTOR)

• **PRESENT/PAST MEDICAL HISTORY:** (LIST CONDITIONS AND DATE)

SURGICAL HISTORY: (LIST TYPE, REASON FOR SURGERY, DATE, SURGEON)

• **DRUG ALLERGIES:** (LIST TYPE OF REACTION)

- | | |
|---|--|
| <input type="checkbox"/> ANESTHETICS _____ | <input type="checkbox"/> ASPIRIN _____ |
| <input type="checkbox"/> CODEINE _____ | <input type="checkbox"/> ERYTHROMYCIN _____ |
| <input type="checkbox"/> PENICILLIN _____ | <input type="checkbox"/> SULFA _____ |
| <input type="checkbox"/> TETRACYCLINE _____ | <input type="checkbox"/> OTHERS, please list _____ |

• **NON-DRUG ALLERGIES:** LATEX OTHER (SPECIFY) _____

PRE-MEDICATION REQUIRED PRIOR TO SURGERY NO YES - List drug, dosage & duration _____

• **ARE YOU CURRENTLY TAKING MEDICATION?** YES NO

If so, please list your medications, drugs, or over the counter preparations/remedies?

MEDICATION	DATE STARTED	DOSAGE (Milligrams)	HOW OFTEN

DO YOU HAVE A PACEMAKER OR INTERNAL DEFIBRILLATOR? YES NO

• **SOCIAL HISTORY:** (CHECK ALL THAT APPLY)

Do you smoke? NO YES - Frequency _____ Do you use recreational drugs? NO YES - Frequency _____

Do you drink alcohol? NO YES - Frequency _____ Hobbies _____

• **FAMILY HISTORY:**

MOTHER: living deceased / age _____ **FATHER:** living deceased / age _____

BROTHERS/SISTERS - ages: _____ **NUMBER OF CHILDREN & ages** _____

CHECK THE FOLLOWING MEDICAL CONDITIONS THAT HAVE OCCURRED IN YOUR FAMILY:

DISEASE	MOTHER	FATHER	BLOOD RELATIVE	DISEASE	MOTHER	FATHER	BLOOD RELATIVE
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Name _____ DOB _____

REVIEW OF SYSTEMS AND PAST MEDICAL HISTORY: (INDICATE ALL BELOW THAT APPLY; USE C. IF CURRENT, USE P IF PAST)

CONSTITUTIONAL SYMPTOMS:

- Fever Hair loss
- Weight loss Weight gain
- Chills Tremor
- Nutritional Deficiencies
- Other, specify _____

EYES:

- Cataracts Glaucoma
- Eyestrain Blurring
- Inflammation
- Wear glasses
- Wear contacts
- Other, specify _____
- Date of last eye exam _____

EARS, NOSE, MOUTH, THROAT:

- Hearing difficulty
- Pain Discharge
- Tinnitus (ringing in ears)
- Dizziness Wear hearing aid
- Sinusitis Postnasal drip
- Obstruction
- Gum Disease
- Chronic sores
- Herpes simplex infections
- Soreness Redness
- Hoarseness
- Other, specify _____

CARDIOVASCULAR:

- Stroke Palpitation
- Pacemaker/Defibrillator
- Heart Attack (MI)
- Rheumatic Fever
- Faintness Pain
- High blood pressure
- Heart surgery
- Edema (swelling)
- Heart valve replacement
- Other, specify _____

INFECTIOUS:

- HIV Positive AIDS Virus
- Hepatitis

RESPIRATORY:

- Asthma Chest pain
- Emphysema Tuberculosis
- Lung disease
- Breathing disorder
- Bronchitis, chronic
- Sputum, with blood
- Cough, chronic
- Upper respiratory infection, chronic
- Other, specify _____

GASTROINTESTINAL:

- Ulcer Pain
- Nausea Constipation
- Diarrhea Vomiting
- Appetite decrease
- Colon/intestinal disorder
- Other, specify _____

GENITOURINARY:

- Discharge Urgency
- Sores Incontinence
- Hesitancy
- Herpes simplex infections
- Other, specify _____

MUSCULOSKELETAL:

- Arthritis Lupus
- Joint pain Lupus of the skin
- Weakness Joint swelling
- Joint replacement
- Cold sensitivity
- Other, specify _____

INTEGUMENTARY:

- Scarring/keloids
- Herpes simplex (cold sores)
- Acne / Cystic Hives
- Accutane Use (past or current)
- Skin cancer(s) Malignant Melanoma
- Warts Contact dermatitis
- Eczema Psoriasis
- Loss of Pigment
- Other, specify _____

NEUROLOGICAL:

- Headaches Convulsions
- Seizures Migraine headaches
- Epilepsy Fainting spells
- Memory loss
- Other, specify _____

PSYCHIATRIC:

- Stress Depression
- Nightmares Insomnia
- Anxiety Suicidal Tendency
- Treatment of psychological disorder
- Other, specify _____

ENDOCRINE:

- Thyroid disorder
- Diabetes mellitus
- Excessive hair, face/body
- Other, specify _____

HEMATOLOGIC/LYMPHATIC:

- Anemia Bruise easily
- Blood clots Excessive bleeding
- Other, specify _____

ALLERGIC/IMMUNOLOGIC:

- Asthma Frequent infections
- Allergies Thyroiditis
- Vitiligo Addison's Disease
- Pernicious anemia
- Hay Fever
- Other, specify _____

MALES ONLY:

- Prostatic problems

FEMALES ONLY:

- Currently pregnant
- Currently taking oral contraceptives
- Last Mammogram
- Last PAP Smear
- Number of pregnancies
- Date of last menses _____

CANCER(S): (LIST TYPE, DATE, TREATMENT: _____)

PAYMENT POLICY

Thank you for choosing Pocono Medical Care, Inc. / MilfordMD Cosmetic Dermatology Surgery & Laser Center as a healthcare provider. We are committed to providing you with quality and affordable health care. Please read this policy, ask us any questions you may have and **sign in the space provided**.

Insurance: Dr. Marina Buckley participates in many insurance plans, including Medicare. If you have a commercial insurance, payment in full is expected at each visit at private rates. If you are not insured by a plan with which we do business, payment in full is expected at each visit. If you are insured by a plan with which we do business but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-Payments and Deductibles: All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

Non-Covered Services: Please be aware that some—and perhaps all—of the services you receive may be non-covered services or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

Proof of Insurance: All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

Claims Submission: If the physician you see participates with your insurance plan a claim will be submitted for you. If the physician does not participate with your plan you can submit the receipt to your insurance company on your own. Your insurance company may need you to supply certain information directly. It is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

Coverage Changes: If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Non-Payment: If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from the practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, your physician will only be able to treat you on an emergency basis.

Missed Appointments: Our policy is to **charge for scheduled appointments not cancelled or rescheduled within 24 hours prior to the appointment**. These charges of \$25.00 for medical office visits, \$50.00 for MediSpa services, \$150.00 for laser/cosmetic procedure fees up to \$999.00, and \$500.00 for laser/cosmetic procedure fees from \$1,000.00-\$4,999.00 **will be your responsibility and billed directly to you**. All laser liposculpture procedures missed appointment charges are outlined in our Surgical Cosmetic Procedure Financial Policy. Please help us to serve you better by keeping your scheduled appointment(s).

Deposits: A deposit will be required to secure your next cosmetic procedure. If the appointment is not cancelled or rescheduled within 24 hours, you will lose your deposit.

Consultation Fee: Within 90 days of your consult, the consultation fee of \$150.00 may be applied to any single procedure or combined procedures totaling \$500.00 or more if performed on one day.

Refunds: Any credit card refund will be less a 5% processing fee. Refunds made for amounts paid by check will be less a 2.5% processing fee.

Return Check Fee: \$35.00

Patient Name: _____

Signature: _____ **Date** _____

Communications Consent

I, _____ consent to receive calls and text messages from Pocono Medical Care, Inc. / MilfordMD Cosmetic Dermatology Surgery & Laser Center for my protected healthcare and other services at the phone number(s) listed on the registration sheet, including my wireless number provided. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system to confirm appointments.

I also consent to receiving e-mails from Pocono Medical Care, Inc. / MilfordMD Cosmetic Dermatology Surgery & Laser Center to confirm my appointment(s) and/or informing me of upcoming seminars and specials.

Please indicate your preferred delivery method(s) for the following communications. Check all that apply for each communication.

	Call Home	Call Mobile	Text	Email
Appointment related, including reminders:	_____	_____	_____	_____
Events, including seminars & VIP parties:	_____	_____	_____	_____
Special discounts and limited time promotions:	_____	_____	_____	_____

Signature: _____ Date _____

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Pocono Medical Care, Inc.

www.milfordmd.com

303 W. Harford St.
Milford, PA 18337
Tel: (570) 296-4000
Fax: (570) 296-4005

Dr. Richard Buckley
Dr. Marina Buckley

We would like to make you aware of current cosmetic procedures we offer. Please take a few moments to check off any of these procedures you may be interested in having done now or in the near future. Brochures are available for most of the procedures. Our staff will answer any questions you may have.

Please place a check mark on the treatments that interest you:

- | | |
|---|---|
| <input type="checkbox"/> Acne & Excessive Oil Treatments | <input type="checkbox"/> High Definition BodySculpting |
| <input type="checkbox"/> Arm Lift / Brachioplasty | <input type="checkbox"/> Hyperhidrosis / Excessive Sweating Treatment |
| <input type="checkbox"/> Blepharoplasty / Surgical Eyelid Lift | <input type="checkbox"/> Laser Liposuction |
| <input type="checkbox"/> Body Lift (after major weight loss) | <input type="checkbox"/> Lip Augmentation |
| <input type="checkbox"/> Brazilian Butt Lift | <input type="checkbox"/> Medical Grade Facial: HydraFacial MD |
| <input type="checkbox"/> Breast Augmentation | <input type="checkbox"/> Microdermabrasion & Peels |
| <input type="checkbox"/> Breast Reduction or Gynecomastia | <input type="checkbox"/> Mole & Skin Tag Removal |
| <input type="checkbox"/> Cellulite Reduction | <input type="checkbox"/> Mommy Makeover |
| <input type="checkbox"/> Chin or Cheek Augmentation | <input type="checkbox"/> Neck Lift / Tightening |
| <input type="checkbox"/> CoolSculpting | <input type="checkbox"/> Non-Surgical Fat Reduction on Face/Neck |
| <input type="checkbox"/> Décolletage / Cleavage / Chest Rejuvenation | <input type="checkbox"/> Non-Surgical Fat Reduction on Body |
| <input type="checkbox"/> Earlobe Repair / Otoplasty | <input type="checkbox"/> Photodynamic Therapy / Photofacial |
| <input type="checkbox"/> Face Lift (Facelift, S-Lift, Mini-Lift, etc.) | <input type="checkbox"/> Rhinoplasty (Non-Surgical) |
| <input type="checkbox"/> Face Lift (Non-surgical) | <input type="checkbox"/> Rosacea & Facial Veins Treatment |
| <input type="checkbox"/> Facial Fillers (Juvederm, Restylane, Radiesse, etc.) | <input type="checkbox"/> Scar Repair (Acne or Trauma) |
| <input type="checkbox"/> Fat Reduction on Face/Neck | <input type="checkbox"/> Skin Tightening |
| <input type="checkbox"/> Fat Reduction on Body | <input type="checkbox"/> Stretch Mark Improvement |
| <input type="checkbox"/> Fat Transfer (Rebalancing) on Face | <input type="checkbox"/> Tattoo Removal |
| <input type="checkbox"/> Fat Transfer to Buttocks, Breast, etc. | <input type="checkbox"/> Tummy Tucks |
| <input type="checkbox"/> Fraxel Skin Resurfacing | <input type="checkbox"/> Ultherapy |
| <input type="checkbox"/> Freckles, Sun Spots, Age Spot Treatment | <input type="checkbox"/> Urinary Incontinence Treatment |
| <input type="checkbox"/> Hair Removal | <input type="checkbox"/> Vaginal Rejuvenation |
| <input type="checkbox"/> Hair Restoration / Hair Transplant | <input type="checkbox"/> Vein (Spider and Varicose Veins) Treatment |
| <input type="checkbox"/> Hand Rejuvenation | <input type="checkbox"/> Wrinkle Relaxers (Botox, Dysport, Xeomin) |

The top 3 areas of concern on my face are: _____

The top 3 areas of concern on my body are: _____

Thank you again for your time to help us bring to you the best medical treatments available.

NAME: _____ **DATE:** _____