PHOTODERMATOLOGY • PUVA THERAPY • PHOTOTHERAPY • LASER THERAPY

ELISABETH G. RICHARD, M.D.

Assistant Professor, Johns Hopkins University
Diplomate, American Board of Dermatology

Greetings and Welcome!

We look forward to meeting you at your upcoming appointment. Please find attached our practice's intake packet. In advance of your appointment, please note the following.

1. Please complete this packet in advance of your appointment.
2. Please bring your photo ID, insurance card(s), pharmacy card(s) and a credit card.
3. Please review the Financial and Office Policies and the Notice of Privacy Practices. You will be asked to sign these digitally at the office. These documents are also on the website, www.lightandlaser.com.
4. Please note that our financial policy requires that you keep a valid credit card on file with our office.
5. Please plan to arrive 15 minutes before your scheduled appointment so that the registration process may be completed.
6. If you are more than 15 minutes late for your appointment, you will have to reschedule.
7. Co-pays are due at the time of service.
8. Additional information and map are available on our website, www.lightandlaser.com.
9. Google maps and other GPS programs will bring you to the medical campus however may be misleading as to the building location, so please see attached map and/or the website.

Yours sincerely,

Elisabeth G. Richard M.D.

JOHNS HOPKINS AT GREEN SPRING
10753 Falls Road, Suite 355 • Lutherville, Maryland 21093 • phone: 410-847-3700 • fax: 410-847-3703
www.lightandlaser.com

JOHNS HOPKINS MEDICINE

Johns Hopkins Health Care & Surgery Center

Green Spring Station • Falls and Joppa Roads, Lutherville, MD 21093 • 410-583-2727

Welcome! Our patient friendly environment fosters the kind of one-on-one relationship you want with your doctor.

Directions to our Green Spring Station location in Lutherville, MD

GPS USERS: Enter Lutherville (not Baltimore) for directions to the Green Spring Station medical campus



- **From the Beltway (I-695):** Take Exit 23B onto Falls Road. Make the first right onto Joppa Road and the second left onto Station Drive. Turn right at the "T" intersection (you are looking at the Foxleigh Office Building) and curve around Foxleigh to the four-story building on your left, Pavilion II.
- **From the city:** Take the Jones Falls Expressway (I-83) north past the exits to the Beltway until the Expressway becomes Falls Road. Make the first right onto Joppa Road and the second left onto Station Drive. Turn right at the "T" intersection (you are looking at the Foxleigh Office Building) and curve around Foxleigh to the four-story building on your left, Pavilion II.
- We are in **Pavilion II** on the 3rd floor, Suite 355, and the elevators are in the center of the building.

PATIENT REGISTRATION FOR THE OFFICE OF ELISABETH G. RICHARD, MD

NAME: _____ D.O.B: _____ AGE: _____

ADDRESS: _____
NUMBER STREET Apt/Unit #

_____
CITY STATE ZIP CODE

MOBILE/CELL #: _____ HOME #: _____ WORK #: _____

OK to send/leave phone message? □ Yes □ No

Other individual(s) who we may speak with: _____ Relationship: _____

EMAIL: _____ MARITAL STATUS: _____

OK to send email? □ Yes □ No **PLEASE PRINT EMAIL CLEARLY**

OCCUPATION: _____ EMPLOYER: _____

EMERGENCY CONTACT NAME: _____ PHONE: _____

PHARMACY: _____ PHONE: _____

SEX: ( ) Female ( ) Male ( ) X or another legal sex ETHNICITY: ( ) Hispanic ( ) Non-Hispanic ( ) Other_____

RACE: ( ) Caucasian ( ) Black/African American ( ) Hispanic ( ) Asian ( ) Native American ( ) Other_____

RESPONSIBLE PARTY (IF DIFFERENT FROM PATIENT)

NAME : _____ DATE OF BIRTH: _____

ADDRESS: _____

HOME #: _____ MOBILE #: _____ WORK #: _____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE: _____

INSURED'S NAME: _____ Birthdate: _____ Relationship: _____

INSURED'S ID #: _____ GROUP#: _____

SECONDARY INSURANCE: _____ PHONE: _____

INSURED'S NAME: _____ Birthdate: _____ Relationship: _____

INSURED'S ID #: _____ GROUP#: _____

REFERRING PHYSICAN NAME: _____ **PHONE:** _____

PRIMARY CARE PHYSICIAN: _____ **PHONE:** _____

- ☒ I authorize the release of medical information necessary for my course of treatment to my referring physician, to my primary care physician, to consultants if needed, and as necessary to process insurance claims, insurance applications, prescriptions, and prescription authorizations.
- ☒ I authorize assignment of insurance benefits for the above patient to paid directly to the Practice, Elisabeth G. Richard MD, PA. for services rendered. I agree to pay the Practice the full amount of all bills and balances incurred by the patient that are due to the practice after payment has been made by my insurance carrier.

PATIENT/GUARDIAN SIGNATURE: **DATE:** _____

PATIENT HEALTH HISTORY FOR THE OFFICE OF ELISABETH G. RICHARD, MD

NAME: _____ **DATE OF BIRTH:** _____

MEDICAL HISTORY:

□ Psoriasis □ Eczema □ Hay Fever/Allergies □ Cancer □ Arthritis □ Vitiligo □ Asthma

□ Skin Cancer □ Heart Diseae/High Blood Pressure □ Hepatitis □ Lupus or Auto-Immune Disease

Other Medical History/Details: _____

_____

_____

_____

SURGERY HISTORY, INCLUDING CANCER AND SKIN CANCER: _____

_____

FAMILY HISTORY: □ Psoriasis □ Eczema □ Hay Fever □ Skin Cancer Other/Details:_____

_____

_____

MEDICATIONS: □ List attached. Please list _____

_____

_____

MEDICATION ALLERGIES: □ No □Yes. If yes, please list _____

_____

REACTION TO SUNLIGHT: If you spent an hour exposed to sunlight around noon for the first time in early summer, would you sunburn and/or get a rash? □ Yes □ No

SOCIAL:

Do have a health care advanced directive (aka "Living Will") □ Yes □ No

Your occupation: _____ Spouse's occupation: _____

Are you a: □ Non-smoker □ Former smoker □ Current smoker. Pack years if former/current: _____

Do you drink alcohol? □ Yes □ No If yes, how many drinks per week? _____

Do you use medical/recreational marijuana or other drugs? □ Yes □ No. If yes, please detail

_____

COMMENTS and other important information for the Doctor to know:

_____

_____

This form is confidential and part of your medical records. Thank you!

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CREDIT CARD ON FILE POLICY & CHARGE AUTHORIZATION

Our current financial policy requires that you keep a valid credit card (credit/debit/HSA) on file.

With my signature below, I hereby authorize the medical practice of Elisabeth G. Richard, MD, PA to retain my credit card information noted below in a secured manner. To capture and store the card in the PCI compliant encrypted platform, a test charge of $0.01 will be processed and the $0.01 will be refunded to that same card the same day. This office takes the security of patient information very seriously. The credit card information on file will be stored in a secure manner and will not be shared with any third parties.

After my insurance carrier has paid their portion of medical claims to the practice as assigned benefits, I hereby authorize the medical practice of Elisabeth G. Richard, MD, PA to charge this credit card for any outstanding deductibles, co-insurances, co-pays, unpaid fees and/or balances for services rendered to/for the person listed below. Charges to this credit card will not exceed $500 for any individual overdue balance. This authorization is valid for any and all dates of service for the next 12 months.

Co-pays are due at the time of service. Charges to the credit card on file are to be entered only for fees and balances due that are not covered by insurance. If a balance remains on your account three weeks after a statement is sent to you, the Practice reserves the right to charge the outstanding balance due to your credit card on file. Please keep in mind, we will not charge your card if you do not owe anything.

A copy of the credit card receipt and an account statement will be sent to the patient/guarantor if the credit card is charged. If you dispute the charge with the bank/credit card company, we reserve the right to dismiss you from the practice. This in no way compromises your ability to question your insurance company's determination of payment. This authorization will remain in effect until revoked in writing. Credit card charges are authorized as per above terms for the following patient.

PATIENT/GUARDIAN SIGNATURE:_____ **DATE:** _____

PATIENT NAME _____ DATE OF BIRTH _____

Type of Credit Card: ☐ MASTERCARD ☐ VISA ☐ DISCOVER ☐ AMERICAN EXPRESS

ACCOUNT NUMBER _____

SECURITY CODE _____ EXPIRATION DATE _____

NAME ON CREDIT CARD _____

BILLING ADDRESS WITH ZIP CODE _____

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