

Today's Date _____ Circle: Male or Female Age: _____ Date of Birth: _____

Name: _____ Social Security #: _____ Marital Status: M S D W

Address: _____ Apt# _____

City: _____ State: _____ Zip Code: _____

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

Cell Phone: (_____) _____ Email: _____

Emergency Contact Name _____ Relationship _____ Phone# _____

Primary Doctor: _____ City _____ Phone# _____

Referring Doctor: _____ City _____ Phone# _____

PRIMARY INS:

Staff will insert a copy of your insurance card

Who is the primary cardholder of your insurance (i. e., subscriber) and the relationship to the patient?

Self _____ Spouse _____ Parent _____ Other _____ Subscriber's SS # _____

Subscriber's Name: _____ Circle: M or F DOB: _____

Subscriber's Address: _____

Subscriber's Place of Employment: _____ Subscriber's work phone: _____

SECONDARY INS:

Staff will insert a copy of your insurance card

Who is the primary cardholder of your insurance (i. e. subscriber) and the relationship to the patient?

Self _____ Spouse _____ Parent _____ Other _____ Subscriber's Social Security #: _____

Subscriber's Name: _____ Circle: M or F DOB: _____

Subscriber's Address: _____

Subscriber's Place of Employment: _____ Subscriber's work phone: _____

Dermatological Patient Medical History Form and HIPAA

Name _____

Reason for Visit: _____

Have you been seen in our office before? Y N

Do you have any relatives with skin cancer? Y N

Have you had skin cancer(s) in the past? Y N

Are you pregnant or trying to become pregnant? Y N

Past Medical History (Check "Yes" or "No" if you have or had any of the following):

Heart Disease Y N Diabetes Y N

Artificial Heart Valve Y N High Blood Pressure Y N

Heart Murmur Y N Bleeding disorder Y N

Lung Disease Y N Healing Problems Y N

Liver Disease Y N Keloids Y N

Stroke Y N Pacemaker Y N

Dementia Y N Defibrillator Y N

Cancer (other than skin) Y N Joint replacement Y N

Hepatitis B or C Y N HIV/AIDS Y N

Other medical problems: _____

Please list the medications you are currently taking (write on back if necessary):

Do you take: Aspirin? Y N Plavix? Y N Coumadin? Y N

Please list any allergies you have to medications or tape: _____

Do you use tobacco? Y N If yes, how much? _____

Do you use alcohol? Y N If yes, how much? _____

Pharmacy Name and Phone number _____

BIOPSY RESULTS: I authorize the Philadelphia Institute of Dermatology to leave a message containing biopsy results at the following number:

Phone # _____.

I do NOT give permission for my health information to be discussed with anyone.

I do authorize the following person(s) to have access to my private health and/or billing information:

Name _____ Phone _____

Name _____ Phone _____

HIPAA: a privacy policy is available upon request and is posted in our waiting room.

Patient Signature _____ Date _____

Philadelphia Institute of Dermatology
Financial Policy

It is imperative that a current copy of your insurance card is provided for accurate billing. Every patient's insurance policy is different and it is beyond the ability of our staff to know the benefits of every plan. Our office can never guarantee coverage for any service provided by our office. If you are unsure of your coverage benefits, call the customer service number on your insurance card.

Return check fee \$30.00

Labs: Our office utilizes some outside facilities for blood work, biopsies, cultures, etc. Insurance and/or billing are handled separately by these facilities. You will receive a separate explanation of benefits from your insurance carrier. You may also receive a separate bill from the lab, depending on the benefits of your plan.

Medicare patients: We are participating providers of the Medicare part B program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the copayment. Our office will file your secondary/supplemental carrier claims. However, in the event that the secondary does not pay, patients will be billed for the balance.

Medicare Authorization: I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Supplemental Authorization: (Medicare patients)

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

HMO, POS, PPO, Commercial or other managed care patients: You will be responsible for paying your annual deductible, copayment, coinsurance and charges for any non-covered, cosmetic services or over-the-counter products at the time of the visit. If your health plan requires a referral for specialty services, you will need to obtain one before your date of service. If a valid referral is not received by your appointment time, you will be expected to pay for the office visit.

Self-Pay: Payment is required at the time of service.

It is the policy of this office that the adult presenting the child for treatment is responsible for payment of the patient portion at the time of service (e.g., deductibles, copayments, and non-covered services).

Our collection agency will handle any outstanding account over 60 or 90 days.

Please advise our Billing Dept. (x229) on any changes of names, address or insurance.

If you need to cancel or change an appointment, please contact our office to do so at least 24 hours before your scheduled appointment. Less than 24 hours notice will result in a \$30.00 fee.

My signature below indicates that I have reviewed and/or have access to a copy of my physician's Notice of Privacy Practices.

I have read the financial policy, and I understand and agree to this policy.

Signature of patient or responsible party

Date