Advanced Dermatology & Skin Surgery, PC
OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. The following is a statement of our financial policy, which we require that you read and sign prior to any office visit.

Regarding Insurance: We must have a copy of your insurance card. If you have an HMO insurance with which we have a contract, a proper referral is required from your Primary Care Physician containing a diagnosis, visits allowed and expiration date. Please keep track of your visit and expiration dates on your referrals. If your referral expires or your visits run out and you are seen by one of our providers, you will be responsible for the bill. If you have a PPO insurance with which we have a contract, you will be responsible for the co-pay if listed on your card. If you have not met your deductible, you will be billed and payment will be expected. You are responsible for payment regardless of any insurance company's determination of usual and customary rates. Patients will also be responsible for the bill if insurance has lapsed in coverage or is not in effect at the time of services. We accept cash, checks and credit card for payment. Please do not ask our front desk personnel to send you a bill after services have been performed, unless approved in advance by the office manager when the appointment is scheduled.

Medicare Patients: Patients are responsible for meeting their **annual $203.00 deductible** and for paying the **20% co-insurance** not covered by medicare. We do file with secondary/supplemental carriers. However, in the event that the secondary insurance does not pay within 60 days, patients will be billed the balance. We must have a copy of your supplemental insurance card as well as your Medicare card.

If you have presented us with a health insurance card with which we are not contracted in, we will be glad to assist you in giving the information that will allow you to be reimbursed from your insurance. The charge for today's visit is expected at the time of check out. Insurance companies will not pay for cosmetic procedures.

Regarding Biopsy Charges: There will be an additional fee charged by the outside lab for the processing and reading of your biopsy.

Minor Patients of Divorced Parents: A divorce decree is a legal agreement binding only the two parties who made the agreement. If we are not contacted with your insurance, payment is due at the time of services. If we are contracted with your insurance, we will submit the bill to the insurance company and the parent who is responsible for paying the medical bills will be responsible for payment, including any deductibles or coinsurance.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the Financial Policy (above). I understand and agree to this financial policy.

_____ _____
Signature of Patient or Responsible Party Date

Advanced Dermatology & Skin Surgery, PC
456 Chestnut Street, Suite 201
Lakewood, NJ 08701

Patient Name: _____
Patient's Date of Birth: _____
Patient's Social Security Number: _____-_____-_____
Patient's Address: _____
City State Zip
Patient's Home Phone Number: _____
Patient's Cell Phone Number: _____
Primary Care Physician: _____**Phone #**_____
Occupation/Former Occupation: _____
How did you hear about our practice: _____
I understand that I am financially responsible for all charges for services to me, including the balance remaining after payment of possible insurance benefits and that a finance charge will accrue on my unpaid balance older than 30 days.

I understand that if I have a biopsy, specimens may be sent to an out of state lab (NY) as the doctor sees fit. **IT IS THE PATIENT'S RESPONSIBILITY TO INFORM THE MEDICAL ASSISTANT IF THEIR INSURANCE REQUIRES THEM TO USE A SPECIFIC LABORATORY. ADVANCED DERMATOLOGY & SKIN SURGERY CANNOT ASSUME RESPONSIBILITY IF THE PATIENT HAS A DEDUCTIBLE OR COINSURANCE FOR LAB SERVICES. IT IS THE PATIENT'S RESPONSIBILITY FOR ALL BILLS THAT MAY BE INCURRED FOR SERVICES RENDERRED**. ***If I require a NJ LAB (Quest, LabCorp), it is MY responsibility to notify the physician or medical assistant.***

I authorize the release of medical information to my primary care or referring physician, to consultants if need and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature _____ Date___/___/____

SIGNATURE OF PARENT OR RESPONSIBLE PARTY (if different than patient)

Name _____
Last First M.I.
The following information is required for Medicare purposes:
Race: _____ Ethnicity: _____ Primary language: _____
Email address: _____

INSURANCE SUBSCRIBER (if different than patient)
Name of Subscriber: _____
Social Security Number _____-_____-_____
Date of Birth: _____

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NOTICE OF PRIVACY PRACTICES

This notice of privacy practices describes how medical information about you may be used and disclosed and how you can get access to this information. Our office will submit your visit with our provider to your insurance company with the information provided by you. If the insurance information you provide at the time of the visit is not correct and the claim is denied you may be responsible for the balance in full. It is **your** responsibility to provide our office with the correct information at the time of service and verify it.

The HIPAA privacy rule gives patients the right to request a restriction on uses and disclosures of their protected health information (PHI). Patient will be provided with a copy of the Notice of Privacy Practices upon request.

We can contact you through your home phone, cell phone or work phone numbers. Please indicate the preferred method for you to be contacted and please list YOUR phone number (check all that apply):

	Yes	No	Preferred
Home Telephone	☐	☐	☐
Cell Telephone	☐	☐	☐
Work Telephone	☐	☐	☐

It is **OK** to leave information/results with **Spouse/Family member listed below:**

_____ _____
Name/Relationship Cell Telephone

_____ _____
Name/Relationship Cell Telephone

_____ _____
Signature of Patient or Responsible Party Date

If I am between the ages of 18-26 I am OK with sharing medical information with my parents. ☐ ☐
Yes No

Advanced Dermatology & Skin Surgery, PC

TO HELP US GIVE YOU THE BEST POSSIBLE CARE, PLEASE CAREFULLY COMPLETE ALL QUESTIONS ON THIS FORM. Circle "yes" or "no". If unaware of an answer, leave it blank.

I. Do you take any medicine, drugs, or over-the-counter preparations or remedies? If yes, please list _____

_____

_____

II. Have you ever had or been treated for any of the following?

1. Excessive sun exposure in childhood or teen years……. yes no
2. Sunburns…….……. yes no
3. Melanoma ……..…… …. yes no
4. Skin cancer (if yes, please specify) ……. yes no
5. Keloids or excessive scars……..... yes no
6. Allergy to local anesthetics (if yes, please specify which ones) ..... yes no
7. Excessive bleeding when cut……yes no
8. Difficulty with the healing of wounds……. yes no
9. Conditions requiring prophylactic antibiotics……. yes no
10. Eczema……..... yes no
11. Asthma…… yes no
12. Hay fever……. yes no
13. Psoriasis…… yes no
14. Ulcer or intestinal disease……. yes no
15. Liver disease……. yes no
16. Lung disease (tuberculosis, other) …...…… yes no
17. Heart disease (rheumatic fever, pacemaker, artificial heart valves, etc).. yes no
18. High blood pressure…….…. yes no
19. Kidney disease…….…. yes no
20. Venereal disease…….…….…. yes no
21. Blood disorder or lymph gland disorder……...….... yes no
22. Eye disease (glaucoma, cataract, other) …….……. yes no
23. Arthritis, joint problem or bone disease……... yes no
24. Cancer (other than skin) ……...yes no
25. Neurological disorder……... yes no
26. Emotional or psychiatric problem…… yes no
27. Diabetes…… yes no

Other conditions (please specify) _____

OVER

III. Have you previously had a skin problem or been under the care of a dermatologist? (If YES please describe)

_____

IV. Are you ALLERGIC to any medicines, drugs, or over-the-counter preparations or remedies……. yes no
If YES, what are you allergic to_____

V. Prior hospitalizations or surgery…… yes no
If YES, please list and give dates

_____

VI. Have any members of your family had (specify who):

1. Asthma…….…….…….……yes no
2. Hay fever…..……. yes no
3. Eczema…….…… …...yes no
4. Psoriasis……...……. yes no
5. Melanoma……. yes no
6. Skin cancer other than melanoma……. yes no
7. Other skin conditions (specify) ……...……. yes no

VII. Social history

1. Do you smoke? yes___ no___; If yes, are you a current smoker ___or past smoker__
2. Do you drink alcohol? yes___ no ___; If yes, how many drinks per week ____
3. Have you been exposed to HIV? ……..... yes no
4. Have you been exposed to Hepatitis C or D viruses? ……. yes no
5. Are you married, single, divorced, separated, widowed? (circle one)
6. Do you do outdoor work or outdoor hobbies? ……. yes no
7. Occupation ……..

VIII. For **women** only

1. Are you pregnant? ……...…..…… yes no
2. Are you nursing? …… yes no
3. Do you have regular menstrual periods? ……. yes no

NOTE: THE DERMATOLOGICAL EXAMINATION WHICH YOU ARE ABOUT TO RECEIVE IS NOT A COMPLETE PHYSICAL EXAMINATION IT IS SUGGESTED THAT YOU HAVE A COMPLETE PHYSICAL EXAMINATION PERIODICALLY BY YOUR FAMILY PHYSICIAN OR INTERNIST.