CENTER FOR DERMATOLOGY & SKIN SURGERY

Today's Date: _____

PATIENT INFORMATION

Patient's Name: _____
(First) (Middle) (Last)

Street Address: _____

City: _____ State: _____ Zip: _____

Patient's Date of Birth: _____ Gender:_____ Email: _____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

Race (Circle one): Caucasian, Hispanic, Non-Hispanic, African American, Asian, Other, Decline to Specify

Ethnicity(Circle one): Hispanic, Non-Hispanic, Other

Marital Status (Circle one): Married, Single
If Married Spouse Name: _____

If Child – Name of Guarantor:_____

RESPONSIBLE PARTY OTHER THAN PATIENT

Name: _____
(First) (Middle) (Last)

Street Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____ Gender:_____

Home Phone: _____ Cell Phone: _____ Work Phone:_____

INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insurance: _____

Subscriber Name: _____

Subscriber's DOB:_____Gender: _____

Policy ID #: _____

Group #: _____

SECONDARY INSURANCE

Name of Insurance: _____

Subscriber Name: _____

Subscriber's DOB: _____Gender: _____

Policy ID #: _____

Group #: _____

CENTER FOR DERMATOLOGY & SKIN SURGERY

Patient Name: _____ DOB: _____ Date: _____

Height: _____ Weight: _____

PAST MEDICAL HISTORY

(please circle all that apply)

Anemia
Anxiety
Arthritis
Asthma
Atrial fibrillation
Benign prostatic hyperplasia (enlarged prostate)
Blood Disease
Cerebrovascular accident (stroke)
Chemotherapy
Chicken Pox
Chronic obstructive lung disease (COPD)
Arteriosclerosis (heart disease)
Depressive Disorder
Diabetes
Elevated Blood Pressure (Hypertension)
End stage renal disease (kidney)
Epilepsy
Gastroesophageal reflux disease (GERD)
Hearing loss
Hypercholesterolemia (high cholesterol)
Hyperthyroidism (high thyroid level)
Hypothyroidism (low thyroid level)
HIV / AIDS
Jaundice
Inflammatory disease of liver
Malignant Lymphoma
Malignant tumor : lung /breast /colon
Pacemaker
Prostate cancer
Radiation therapy / treatment /management
Skin Rash
Surgical Biopsy of Skin

Other : _____ None: _____

SKIN DISEASE HISTORY

(please circle all that apply)

Acne
Actinic Keratosis (precancerous lesions)
Basal Cell Carcinoma
Contact Dermatitis due to poison Ivy
Dysplastic nevus of skin (atypical moles)
Eczema
History of allergies/hayfever
None: _____
Melanoma
Itchy Scalp
Psoriasis
Rosacea
Squamous Cell Carcinoma
Sunburn of second degree
Other: _____

MEDICATIONS

MEDICATION:	DOSAGE:	HOW OFTEN:	REASON FOR TAKING:
_____	_____mg	_____	_____
_____	_____mg	_____	_____
_____	_____mg	_____	_____
_____	_____mg	_____	_____
_____	_____mg	_____	_____
_____	_____mg	_____	_____
_____	_____mg	_____	_____

ALLERGIES

(please enter all allergies)

_____ _____
_____ _____
_____ _____

CENTER FOR DERMATOLOGY & SKIN SURGERY

SOCIAL HISTORY

(please circle all that apply)

Cigarette Smoking:
Never Smoked
Quit: Former smoker
Occasional smoker
Daily Smoker – if yes, how many? _____

Alcohol Use:
None
Occasional Drinker
Daily Drinker (two or more drinks per day)

What is your occupation: _____

Do you wear sunscreen? YES / NO SPF #: _____
Do you tan in a tanning salon? YES / NO
Do you have a family history of melanoma? YES / NO - If yes, which relative(s): _____
Any Other Pertinent family history? _____

PHARMACY INFORMATION

Name of Pharmacy: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

PRIMARY CARE PROVIDER/REFERRING PROVIDER

Name of PCP: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Name of Referring Provider: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

CENTER FOR DERMATOLOGY & SKIN SURGERY

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I have received a copy of the Privacy Practices provided by Center for Dermatology & Skin Surgery LLC. I understand that it can be found on our website, www.centerfordermatologynj.com

_____ _____

Print Patient's Name Date of Birth

_____ _____

Signature of Patient / Parent or Guardian Date

MY PROTECTED HEALTH INFORMATION MAY BE DISCLOSED TO:

Self_____ Phone: _____

Spouse/Significant Other: _____Phone: _____

Parent/Guardian:_____Phone: _____

Children: _____ Phone:_____

_____Phone: _____

_____ Phone: _____

Other: _____Phone: _____

I GIVE PERMISSION TO CENTER FOR DERMATOLOGY & SKIN SURGERY TO CONTACT OR LEAVE A MESSAGE REGARDING TEST RESULTS/PRESCRIPTION REFILLS ON THE FOLLOWING:

Home Phone Voicemail Home #: _____

Cell Phone Voicemail Cell #: _____

Work Phone Voicemail Work#: _____

CENTER FOR DERMATOLOGY & SKIN SURGERY

PATIENT FINANCIAL AGREEMENT AND MEDICAL CONSENT

- **Insurance Changes -** It is the responsibility of the patient/guardian to provide correct information and notify the practice of any changes to your insurance coverage, so that we can correctly file claims and accurately determine out of pocket costs. The patient is responsible for providing a current referral when/if required.
- **Co-Payments -** Co-payments are due at the time of service. If you are unable to remit your co-payment amount, the practice reserves the right to reschedule your appointment for another day/time that is convenient for you.
- **High Deductible Health Plans -** Due to the recent increase in high deductible health plans, patients with a remaining in-network balance, will be responsible for a deposit, due at the time of service. Charges for all visits will be billed to your designated insurance carrier for services rendered by Center for Dermatology & Skin Surgery. The pre-payment will be applied to the account and any remaining balance, as determined by the insurance carrier will be billed to the responsible party on the account. This does not apply to Original Medicare patients.
- **Prior Balances -** Prior balances, including those resulting from care to your dependent/minor, are due upon receipt of a statement or at the time of a scheduled appointment, whichever comes first. If you are unable to make payment at the time of the scheduled appointment, please contact the billing office to make arrangements for the balance. If you are unable to remit payment, the practice reserves the right to reschedule your appointment for another day/time that is convenient for you.
- **Missed/Late Appointments/No show -** There will be a $50 charge for missed/late appointments in addition to any other charges you may incur. The Practice reserves the right to discharge any patient for missing an appointment (This policy applies to all patients).
- **Insurance and Billing -** It is your responsibility to provide us with accurate and complete information concerning your primary, secondary (if applicable), and tertiary (if applicable) insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. Center for Dermatology & Skin Surgery bills insurance as a courtesy to our patients. Services that have not been paid by your health insurance carrier will become the guarantor's responsibility to pay in full, which shall include charges incurred for any laboratory testing and pathology. The patient acknowledges and understands that the laboratory/pathology services are separate from the provider's fee. The guarantor is responsible for all charges and fees associated with denied claims from incorrect or incomplete insurance information. It is the guarantor's responsibility to ensure our Practice's network status/participation with your insurance plan. Questions regarding coverage should be directed to your insurance company.
- **Credit Card on File –** Center for Dermatology & Skin Surgery implemented a credit card on file policy as a convenient method of paying for the portion of your services that your insurance policy requires you to pay such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure.
- **Self-Pay Patients -** It is our policy to collect payment at the time of service, this includes physician fees and/or pathology fees, if this is not collected at the time of service, you will be billed for the balance.
- **Phone Calls -** For any phone number provided by you to the practice at which you may be contacted, you consent to receive calls or text messages, included but not restricted to communications regarding billing and payment for items and services, unless you notify the practice to the contrary in writing. Calls and text messages include but are not limited to pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic communication used by the practice and/or its affiliates, contractors, servicers, clinical providers, attorneys, or its agents, including collections agencies.
- **Collections and Legal Activity -** If Center for Dermatology & Skin Surgery does not receive prompt payment, we reserve the right to transfer your balance to outside collections after being 90 days past due. If an account is referred to outside collections, we reserve the right to dismiss the patient from the practice. I authorize all Providers associated with Center for Dermatology & Skin Surgery to release information for the purpose of payment, treatment, and routine healthcare operations, including medical research studies. I authorize payment of medical benefits to all Providers associated with Center for Dermatology& Skin Surgery
- **Consent to Treat -** I voluntarily request a physician, and/or Advanced Practice Provider (Nurse Practitioner or Physician Assistant), and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I waive my rights to any photographs and videos taken before, during and after procedures for the purposes of my medical record. I also understand these photographs or videos may be published in a variety of sources and in the event that they are published, I will not be identified as by name. I expect no compensation for these photographs and videos and waive all my rights to any claims for payment or royalties. I also release Center for dermatology & Skin Surgery from any liability in connection with the use of such photographs and videos.

By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Your signature indicates your understanding and compliance with this policy.

Print Patient Name	**Patient Signature / Date**
Print Guardian (If patient is under 18 years of age)	**Name Guardian Signature / Date** (If patient is under 18 years of age)