



**Welcome to Abeles Dermatology Aesthetic & Laser Arts. We are pleased to be able to help you with all of your Medical and Cosmetic Dermatology needs. Please take a few moments to read this page. Please print, read and sign the following 7 registration pages and bring them with you to your first appointment.**

- 1. Please bring a Hard Copy of your Current Active Insurance Card, Referral and Photo ID with you.**
- 2. All Copayments are due at your visit.**
- 3. If your insurance requires a referral, please provide us with one prior to your visit. If we don't have a referral and you want to be seen by a provider, you will be responsible for paying for your visit at time of service and your insurance company will not be billed.**
- 4. A parent must be present with a child under age 18 for their first visit. Children that return for future appointments without their parent will need to have a credit card on file for copayments.**
- 5. If you are making an appointment for yourself and you are planning to bring your small children with you (children under 10), please plan on bringing your children into the exam room with you. Children under 10 may not be left without a care giver in the waiting room.**
- 6. If you can't keep your medical appointment, please call us at least 24 hours prior to your visit to avoid a no show fee of \$40.**
- 7. A Credit Card on File is REQUIRED for all insurance plans, please see our financial agreement.**
- 8. We are pleased to offer Complimentary WIFI in our office.**

**We look forward to seeing you.**

**The Staff of Abeles Dermatology  
Aesthetic & Laser Arts**

## Abeles Dermatology Registration Form

**Please present ALL Insurance cards to the receptionist. If patient is a minor, and you are not the legal guardian, please speak with the receptionist immediately. Thank you.**

### **1. PATIENT INFORMATION: Please Complete All Fields Using Legal Names**

Name: (First) \_\_\_\_\_ (MI) \_\_\_\_ (Last) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_ Sex:  M  F Marital Status: Single Married Divorced Widow  
Home Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
\*Home Phone: \_\_\_\_\_ \*Cell: \_\_\_\_\_ \*Email Address: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
Employer Address: \_\_\_\_\_  
Pharmacy Name: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Care Dr: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_  
Referring Dr: \_\_\_\_\_ Town: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about Abeles Dermatology? \_\_\_\_\_

### **2. INSURANCE INFORMATION:**

Primary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ DOB of Policy Holder: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ ID# \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ DOB of Policy Holder: \_\_\_\_\_

### **3. PERSON RESPONSIBLE FOR PAYMENT:**

Name: (First) \_\_\_\_\_ (MI) \_\_\_\_ (Last) \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ SS# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relationship to the Patient: \_\_\_\_\_  
Home Address: \_\_\_\_\_  
Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

***Patient Release: Must be signed by patient if 18 or over, or by legal guardian if patient is under 18***

*I certify that the information that I have provided is correct. I authorize the release of medical information necessary to process insurance claims to insurance companies or their agencies (including Medicare) for purpose of filing and payment of medical claims. I authorize payment of medical benefits to the provider. I certify that I hereby authorize Abeles Dermatology, its providers and staff to provide my minor child in my absence with examinations and basic treatments for which additional consents are not required. I understand as the legal guardian of this child I am required to be physically present to consult with the provider on any procedures which require separate consent. I understand additional written consent may be necessary for certain types of procedures and that the legal guardian must be present for such consent.*

**Patient/Guardian Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Today's Date:** \_\_\_\_\_

Abeles Dermatology, 221 West Grand Avenue Suite 102B, Montvale, New Jersey 07645, 201.307.0075

## Abeles Dermatology Office Policy Agreement

UPDATED 3/1/18

**CO-PAYMENTS: PATIENT INITIAL \_\_\_\_\_**

Co-payments are due and collected on the day of your appointment. You may use a credit card on file for older children who are on their parents insurance policy and are seen without a parent being present.

**APPOINTMENT CANCELLATIONS: PATIENT INITIAL \_\_\_\_\_**

If I am unable to keep my scheduled appointment, I will call to cancel or re-schedule my appointment. For Regular medical appointments we require at least 1 business days cancellation notice. For Cosmetic and Surgical appointments we require at least 3 business days notice as a large block of time has been reserved for you that cannot be filled without enough notice. If I don't call Abeles Dermatology to cancel my appointment with the specified notice, and/or I have frequent last minute cancellations I may be charged the no show fees listed below.

**NO SHOW FEES: PATIENT INITIAL \_\_\_\_\_**

Failure to show up for my scheduled appointment or frequent last minute cancels will result in a \$40.00 fee for medical appointments, a \$200.00 fee for surgical appointments and the loss of my deposit for cosmetic appointments.

**INSURANCE REFERRAL POLICY: PATIENT INITIAL \_\_\_\_\_**

If my insurance plan requires a referral, I understand that it is my responsibility to obtain an updated referral from my Primary Care Provider and to make sure that Abeles Dermatology has the referral before my visit. I further understand that it is my responsibility to keep track of the number of visits I have used on my referral and the expiration date of my referral and to obtain new ones as needed. If no referral is obtained and I want to be seen by the provider, I will be responsible for paying for my visit. If the referral information the office has at the time of my visit is not correct, I will be responsible for all charges.

**INSURANCE POLICY: PATIENT INITIAL \_\_\_\_\_**

We require you to confirm that your insurance is active at each office visit. A hard copy of your insurance card is required for scanning. New patients or existing patients with a change in their insurance must provide a valid hard copy of your insurance card at the time of the visit. Should you be unable to produce this documentation, you may pay in full at the time of service and submit the claim to your insurance carrier for reimbursement. Your insurance company will consider certain services in Dermatology to be surgical or cosmetic in nature and separate deductibles, co-payments or co-insurances may apply. I understand that I am responsible for paying these charges. If my insurance does not cover a service that was performed, I am responsible for paying these charges. Each insurance plan is different; your insurance company can guide you through the specifics of your plan. I understand that by signing below I am responsible for notifying Abeles Dermatology of any changes to my insurance or contact information. If the insurance I present is not valid or the office is not in my network, I am responsible for all charges.

**ACCOUNT BALANCES: PATIENT INITIAL \_\_\_\_\_**

We require a credit card on file for all insurance plans. All account balances are due in full upon receipt of your 1<sup>ST</sup> statement. If your balance is left unpaid after 30 days, there will be a \$10 billing charge added for each billing cycle. Any balance left unpaid after 60 days, without a practice authorized payment plan, will be considered delinquent and may be submitted to a collection agency. Submission of your account to a collection agency may adversely affect your credit score and interfere with your ability to get credit. If you present a check that cannot be cashed for any reason, you are responsible for the balance and all bank/office fees charged.

**MINOR PATIENTS: PATIENT INITIAL \_\_\_\_\_**

A legal guardian must accompany children under the age of 18 to their initial appointment so that the proper forms can be filled out and signed. Follow up visits do not require a guardian's presence, unless a procedure is being performed that requires a signed consent form. If you are a college student on your parent's insurance plan, your insurance company will require a form to be completed confirming your student status. These forms are mailed to your home address and must be completed and returned within 30 days. If these forms are not returned within the time frame, you will be financially responsible for all charges.

**Patient/Guardian Name:** \_\_\_\_\_ **Signature:** \_\_\_\_\_ **Today's Date** \_\_\_\_\_

By signing this form I understand and agree to abide by the Abeles Dermatology office policies outlined on this form.

## Abeles Dermatology HIPPA Policy

### **HIPAA Policy:**

Patients over the age of 18 are protected under the Federal Health Insurance Portability and Accountability Act. This Federal Law prohibits any staff member of Abeles Dermatology from discussing appointments, medication, test results or treatment plans with anyone other than the patient. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information for them. This becomes especially important if your spouse assists with making appointments for you or if you are an adult college student away at school and your parents assist with prescriptions and appointments.

If you would like to permit someone to discuss your medical condition, confirm appointments or obtain results for you, please indicate their name(s) below. Only these individuals will be provided with information. Should you wish to update the names provided below, please ask the receptionist for a HIPAA Form.

**Name of Individual (please print)**

**Relationship to Patient**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### **COMMUNICATION WITH THE OFFICE**

#### **Office Appointments**

We will contact you regarding your **Office Appointments** using all the methods you place an **X** in below.

Home Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_  
E-mail \_\_\_\_\_  
Mobile Text \_\_\_\_\_

#### **Medical Information**

We will contact you regarding your **Medical Information** using all the methods you place an **X** in below.

Home Phone \_\_\_\_\_  
Mobile Phone \_\_\_\_\_  
Work Phone \_\_\_\_\_  
E-mail \_\_\_\_\_

***Patient/Guardian Name:*** \_\_\_\_\_ ***Signature:*** \_\_\_\_\_ ***Today's Date:*** \_\_\_\_\_

I acknowledge and understand the above HIPPA policies and have received a copy of the practice's Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996.

## Abeles Dermatology Health History Questionnaire

**Patient Name** \_\_\_\_\_ **Insurance Lab** \_\_\_\_\_ **Date of Birth** \_\_\_\_\_

Have you had any of the following conditions in the past?	Check if YES	Are you currently experiencing any of the following conditions?	Check if YES	Have you had any of the following Surgeries in the past?	Check if YES
Acne		Fatigue		Hernia Repair	
Actinic Keratosis		Fever		Joint Replacement	
AIDS		Sweats		Pacemaker	
Anxiety		Weight Gain		Removal of Gallbladder	
Atrial Flutter/ Fibrillation		Weight Loss		Tonsillectomy	
Atypical Moles		Discharge from your eyes		Other:	
Basal Cell Carcinoma		Dryness in your eyes		<b>Cosmetic Interests</b>	
Cold Sores		Itching of your eyes		Botox, Fillers, Wrinkle Treatment	
Cold Urticaria "cold hives"		Bloody nose		Fat Reduction	
Cryoglobulinemia		Dryness in the nose		Sweat Reduction	
Depression		Heart arrhythmia		Hair loss or thinning on head	
Dermatitis		Heart palpitations		Hair removal	
Diabetes		Asthma		Skin Tightening	
Eczema		Wheezing		Nail Fungus	
Glaucoma		Abdominal pain		Tattoo Lightening or Removal	
Heart Disease		Arthritis			
Heart Murmur		Joint pain		<b>Personal Habits</b>	
Hepatitis		Swelling		Are you taking Coumadin?	
Herpes Simplex		Keloid		Are you taking aspirin?	
Hirsutism		Poor healing of wounds		Do you drink alcohol?	
HIV Infection		Inflamed skin		Do you use drugs?	
Hyperhidrosis – (SWEAT) Botherome or Excessive		Itchy skin		Have you had blistering sunburns?	
Kidney Disease		Changes in skin lesion		Do you have tattoos	
Lupus		Dry skin		Do you have piercings?	
Melanoma		Hair loss		Do you use sunscreen?	
Mitral Valve Prolapse		Skin bruises easily		Have you ever had sunburn?	
Nail Fungus-Hands/Feet		Sun sensitivity and swelling		Do you use a tanning bed?	
Psoriasis		Breast lumps/mass		Do you smoke?	
Paroxysmal Cold Hemoglobinuria		Numbness/tingling		Do you plan on becoming pregnant?	
Sarcoid		Anemia		Are you pregnant?	
Seizure/Epilepsy		Excessive bleeding		Are you nursing?	
Squamous Cell Carcinoma		Bleeding/clotting disorder		<b>Family Medical History</b>	
Stroke/ TIA		Enlarge lymph nodes		Acne	
T-Cell Lymphoma		Other:		Allergies (Seasonal)	
Thyroid Disease				Atypical Moles	
Scars, Enlarged Pores Leg Veins, Brown & Red Spots		<b>Have you had any of the following Surgeries in the past?</b>		Basal Cell Carcinoma	
		Appendectomy		Eczema	
		Carpel Tunnel Release		Lupus	
		Cataracts		Melanoma	
		Endoscopy		Psoriasis	
		Heart Bypass Surgery		Sarcoid	
		Heart Valve Replacement		Squamous Cell Carcinoma	

**Abeles Dermatology Medical Compliance Form**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

List all Medications, Vitamins and Supplements that you take – if additional space is needed use back of sheet

<u>Drug Name</u>	<u>Dosage (mg)</u>	<u>By mouth</u>	<u>Topical</u>	<u>Other</u>	<u># of times per day</u>
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**List ALL medications that you are allergic to:**

**Primary Care Physician**

Name \_\_\_\_\_ Phone Number \_\_\_\_\_

**Have you had a flu vaccination between OCTOBER and MARCH? – If over 6 months old**

Yes \_\_\_\_\_ Vaccination month \_\_\_\_\_ Year \_\_\_\_\_

No \_\_\_\_\_

**Alcohol Use : How many times in the past year have you had:**

**Men 5 or more drinks in a day \_\_\_\_\_ Women 4 or more drinks in a day \_\_\_\_\_**

**Do you smoke?**

Yes \_\_\_\_\_ Amount per day \_\_\_\_\_

No \_\_\_\_\_

**For patients over age 65**

Have you ever had pneumonia vaccine? Yes \_\_\_\_\_ Month \_\_\_\_\_ Year \_\_\_\_\_

No \_\_\_\_\_

**Do you have an advance directive?**

a written statement of a person's wishes regarding medical treatment, often including a living will, made to ensure those wishes are carried out should the person be unable to communicate them to a doctor.

Yes \_\_\_\_\_ What type if known \_\_\_\_\_ No \_\_\_\_\_

# Abeles Dermatology Aesthetic & Laser Arts Financial Agreement

*Updated February 2019*

**Patient/Parent Name:** \_\_\_\_\_ **Date** \_\_\_\_\_ **Account#** \_\_\_\_\_

**Family members covered by this agreement that are currently patients:**

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My insurance plan has deductibles, coinsurances and copays that I am responsible for. I have provided a credit card number to remain on file which will be used for any balances which I may incur after all insurances have been processed.

**How Our Process Works      Patient Initials** \_\_\_\_\_

After we submit your insurance claim, your insurance company will send you an EOB (explanation of benefits in the mail) which will tell you how they processed your claim and what your balance responsibility is. Once we receive a copy of your EOB from your insurance company we will send you 1 statement in the mail showing the balance owed. Your balance is due upon receipt of our statement. If you have not responded to our statement within 30 days of the statement date, we will automatically run the credit card we have on file for you and send you an email receipt. We are happy to speak with you about your account at any time.

I have read the above and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and understand that these balances will be applied to the HSA/credit card I have provided. I authorize Abeles Dermatology to process the credit card information I have provided to them. I further attest that the credit card(s) provided are valid and will contact Abeles Dermatology should my card(s) become invalid to provide new information.

**Patient Signature** \_\_\_\_\_

# Abeles Dermatology Aesthetic & Laser Arts

## Credit Card Authorization Form

**Medent Account#** \_\_\_\_\_

I, (Cardholder) \_\_\_\_\_ authorize Abeles Dermatology to charge any balances due on my account after my insurance company processes my claims as outlined in the financial agreement that I signed.

**Please list family members covered by this credit card who are currently patients:**

\_\_\_\_\_

Name as it appears on the Credit Card: \_\_\_\_\_

Credit Card Type: MC VISA AMEX DISC **(If card 1 is HSA we require a secondary CC)**

1.Credit Card # \_\_\_\_\_ 2.Credit Card # \_\_\_\_\_

Expiration Date \_\_\_\_\_

Expiration Date \_\_\_\_\_

Auth Code (3 or 4 digits) \_\_\_\_\_

Auth Code (3 or 4 digits) \_\_\_\_\_

Cardholder Billing Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Email Address: \_\_\_\_\_

**(Your email is used to send your credit card receipt)**

Signature: \_\_\_\_\_

Date: \_\_\_\_\_