Abeles Dermatology
Aesthetic & Laser Arts

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. <u>Please print, read and sign the following 7 registration pages and bring them with you to your first appointment.</u>

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 avoid being charged.**
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 <u>ALL</u> 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. <u>PATIENT INFORMATION</u>: 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: __________________

*****Cell Phone: ___________________*****Email Address: _____________________Home Phone: ________________

Occupation: ___________________Employer: _________________________ Work Phone: __________________

Employer Address: ____

Pharmacy Name: ____________________ Town: _____________________ Phone: ________________________

Primary Care Dr: ____________________ Town: _____________________ Phone: ________________________

Referring Dr: _______________________ Town: _____________________ Phone: ________________________

<u>How did you hear about Abeles Dermatology?</u> ____

2. <u>INSURANCE INFORMATION</u>:

Primary Insurance: ______________________________ID#_______________________________________

Name of Policy Holder: _____________________________________DOB of Policy Holder: _________________

Secondary Insurance: ____________________________ID#_______________________________________

Name of Policy Holder: _____________________________________DOB of Policy Holder: _________________

3. <u>PERSON RESPONSIBLE FOR PAYMENT</u>:

Name: (First) _____________________________ (MI) _____ (Last) ____

Date of Birth: _____________ SS# ______ - _____ - ______ Relationship to the Patient: __________________

Home Address: ____

Employer Name: ______________________________ Occupation: _____________________________________

Home Phone: ______________________Work Phone: ____________________ Cell Phone: __________________

<u>Patient Release: Must be signed by patient if 18 or over, or by legal guardian if patient is under 18</u>

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 Office Policy Agreement

UPDATED 1/03/20

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 24 HOURS (1 business day) cancellation notice. For Cosmetic and Surgical appointments we require at least 72 HOURS (3 business days)** notice. If I don't call Abeles Dermatology to cancel my appointment with the specified notice, the following fees apply:

NO SHOW AND SAME DAY CANCEL FEES: PATIENT INITIAL ______
Failure to show up for my scheduled appointment or frequent same day cancels more than 1 per qtr. will result in a $75.00 fee for medical appointments and a $200.00 fee for surgical appointments. No shows or same day cancels for a cosmetic appointment will be result in the loss of my $200 cosmetic deposit.

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 1ST 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.____

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_______

ave 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			**Cosmetic Interests**	
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			**Personal Habits**	
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) Bothersome 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			**Family Medical History**	
Stroke/ TIA			Enlarge lymph nodes			Acne	
T-Cell Lymphoma			Other:			Allergies (Seasonal)	
Thyroid Disease						Atypical Moles	
Scars, Enlarged Pores Leg Veins, Brown & Red Spots			**Have you had any of the following Surgeries in the past?**			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 <u>Medications</u>, <u>Vitamins</u> and <u>Supplements</u> that you take – if additional space is needed use back of sheet

Drug Name	Dosage (mg)	By mouth	Topical	Other	# of times per day

<u>List ALL medications that you are allergic to:</u>

____

<u>Primary Care Physician</u>

Name____________________________ Phone Number__________________________

<u>Have you had a flu vaccination between OCTOBER and MARCH? – If over 6 months old</u>
Yes ____ Vaccination month ___________ Year ______
No ____

<u>Alcohol Use : How many times in the past year have you had:</u>
***<u>Men</u>* 5 or more drinks in a day _____ *<u>Women</u>* 4 or more drinks in a day _____**

<u>Do you smoke?</u>
Yes _____ Amount per day ___________
No _____

<u>For patients over age 65</u>

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

Patient/Parent Name: ____________________________Date____________ Account# __________

Family members covered by this agreement that are currently patients:

____

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.

<u>Please list</u> family members covered by this credit card who are <u>currently</u> patients:

____

Name as it appears on the Credit Card:__________________________________

Credit Card Type: <u>MC</u> <u>VISA</u> <u>AMEX</u> <u>DISC</u> **(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:______________________