New Jersey Dermatology & Aesthetics Center

☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

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

<u>Patient Information:</u> Please Complete All Fields Using Legal Names of the Parties Involved.

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

Date of Birth: _____ Age: _____ Sex: □ Male □ Female Marital Status: Single Married Divorced Widow

Mailing Address:_____

City: _____ State: _____ Zip: _____ Social Security#:_____

Home Phone: _____ Cell: _____ Email:_____

Occupation: _____Employer: _____ Work Phone: _____

Pharmacy Name: _____ Town: _____Phone#:_____

Primary Doctor Name: _____ Town: _____Phone#:_____

Referring Physician _____Town: _____ Phone#:_____

New Patients: How did you hear about us? _____

Primary InsurancePlan:_____ID#_____

Primary Insurance Plan Holder's Name:_____ DOB:_____ Relationship:_____

Mailing address of Plan Holder if different from patient: _____

Home Phone of Plan Holder: _____ Cell phone of Plan holder:_____

Secondary Insurance Plan: _____ID#_____

Secondary Insurance Plan Holder's Name:_____ DOB:_____ Relationship to patient:_____

Patient Release: MUST BE SIGNED BY PATIENT <u>OR IF PATIENT IS A MINOR, THE LEGAL GUARDIAN</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 understand I am responsible for co-insurances, copayments and deductibles. If I am not insured or New Jersey Dermatology & Aesthetic Center does not participate in my plan I am responsible for payment in full at the time of service

I certify that I hereby authorize New Jersey Dermatology & Aesthetic Center, its providers and staff to provide my minor child in my absence with examinations and basic treatments following the initial visit <u>for which additional consents are not required</u> I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

I agree to receive news and information about the practice via email, which may include offers and announcements for special events or offers from the practice and my physician. _____ (initial)

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ Date: _____

Name of Legal Guardian if applicable: _____

New Jersey Dermatology & Aesthetics Center

Patient Name: _____ DOB: _____

Our goal is to provide you and your family with the very best care in a warm, supportive environment. We wish to provide you with information that helps us to maintain this goal and through our Patient Policies. These Policies manage expectations and assure understandings to develop a long-lasting relationship. We remain available for any questions you may have.

Appointment Cancellations and No Shows

- I understand late cancellation or missing an appointment keeps other patients from being seen.
- I understand failure to give 24-hours' notice of cancellation for a medial appointment will result in a charge of $50; failure to provide 48-hours' notice for a surgical or cosmetic procedure may result in a charge of $100 or forfeit of my cosmetic deposit or one treatment in my laser package.
- These charges cannot be billed to my insurance company.

Late Arrivals for Appointments

- I understand New Jersey Dermatology & Aesthetic Center (NJDAC) will do its best to accommodate me should I arrive late for an appointment. I understand arriving late means I have forfeited my appointment time and will need to wait to be worked back into the schedule if possible or be placed with another provider who may have availability. I also understand that there may be times when these accommodations are not available, and I will be asked to reschedule my visit.

Co-Payments, Deductibles and Co-insurances and Balances

- Copayments are due and collected at check in on the day of the appointment. I understand I may be charged a $25.00 administrative billing fee for each co-payment that is not paid at the time of service.
- Insurance Deductibles, including Medicare, will be verified prior to your visit. All unmet deductibles will be collected at the time of service.
- Medicare patients without a secondary insurance will be charged their 20% co-insurance at the time of service.
- All balances are due in full within 30 days of my first billing.
- Any balance left unpaid after 90 days without attempt at resolution will be considered for collections.
- Should my account be sent to collections, I understand I will be responsible for an additional 15% administrative collection fee plus any attorney / court fees which may be added to my account during efforts to obtain payment.
- I am responsible for any bank fees associated with returned check fees plus a $25.00 administrative processing fee. Any returned check must be paid in full via credit card or cash within 15 days of notice or legal efforts to collect balance will be instituted.

Referrals

- *It is my responsibility to know if my insurance plan requires a referral to see a specialist and will obtain referrals, track usage, and verify New Jersey Dermatology & Aesthetic Center has referrals in their office prior to my visit.*
- I understand that should I fail to have a valid referral for my visit, NJDAC is not authorized to see me. I will either need to reschedule my appointment or pay in full at the time of service for my visit.
- If I decide to see the provider without my referral my insurance company will not reimburse me, and I will be considered a self-pay patient for that visit and be responsible for the balance at the time of service.
- I understand trying to contact the referring office to obtain or inquire about my referral at the time of my visit with NJDAC will not allow enough time to maintain my scheduled appointment and doing so will forfeit my scheduled time at NJDAC.

Insurance Policies

- I will confirm my insurance is current at each visit. If there is a change to my insurance I will provide a valid insurance card or temporary print out at the time of my visit.
- If I am unable to produce this documentation I will either need to reschedule my appointment or pay in full at the time of service for my visit. I will be responsible for submitting my receipts to my insurance company should I wish to be reimbursed for my visit.
- My insurance carrier may consider certain routine services in dermatology to be surgical in nature and separate co-insurances, deductibles or co-payments may apply. Each insurance plan is different, and I understand it is my responsibility to understand my policy and what will be covered.
- I understand in signing below that I am responsible for notifying NJDAC contact information. If insurance or referral information I present at the time of my visit is not correct, I will be responsible for all charges incurred.

New Jersey Dermatology & Aesthetics Center

Minor Patients

As a practice specializing in Pediatric and Adolescent Dermatology, we recognize the stress a family may encounter navigating the healthcare of the children under the best of circumstances. We also recognize this may be even more difficult in families where the parents are not together. We are here to provide treatment and support to you and your children, not to be incombered in the legal issues and responsibilities of the family.

- I understand a ***legal guardian*** MUST ACCOMPANY my child under the age of 18 to their initial appointment.
- I understand a ***legal guardian*** MUST ACCOMPANY my child under the age of 18 to subsequent appointments where an additional consent will be required.
- I understand as significant information is needed at the initial visit and treatment plans are created, it is essential for a parent/ legal guardian to be present at the initial visit. ***Children without legal guardian at their initial visit will be rescheduled***. Notes from legal guardians with permission to treat is not acceptable.
- I acknowledge that Grandparents, older siblings, step-parents etc. are not considered legal guardians without a court document that must be presented at the time of service.
- I understand that unless documents are provided showing otherwise, both parents are assumed to make appointment and treatment decisions for their child. Disagreements on approach to treatment is between the parents to discuss.
- I understand Payment (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. **We will collect payment due from the parent who brings the child to the visit.** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- I understand there may be times when I may allow my adolescent child to be unaccompanied for a follow-up visit and all payments that are due at the time of service will be handled by me either prior to the visit or with the credit card on file for my child.

Insurance Inquiries

- From time to time I may receive a letter from my insurance company requesting information about my coverage.
- I understand that claims will not be paid without my providing this information.
- I will reply to all insurance inquiries within 30 days of receipt or may be responsible for the entire balance.

Credit Card on File

- We have implemented a policy requiring a credit card held on file. As you may be aware, the current healthcare market has resulted in insurance policies increasingly transferring costs to you, the insured.
- Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and we have received an EOB. At that time, you will receive a statement.
- Should the patient balance not be paid within 30 days of the statement date, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.
- This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Cosmetic Deposits

A significant amount of time is reserved for our patient's cosmetic appointments, and therefore a deposit of $200 is required for all injectable and laser appointments, payable at the time of scheduling. Aesthetician services require a 50% deposit to schedule your appointment. Your deposit will be charged immediately and will be noted as a credit on your account. The deposit will be applied to the total charges on the day of your treatment. Cancellations/ reschedules with greater than 48-business-hours-notice will be refunded or applied to the new appointment in full. Changes made with less than 48-business hours-notice may forfeit the deposit in total.

Patient or Legal Guardian Signature: _____Date: _____

Name of Legal Guardian: _____ Relationship: _____

New Jersey Dermatology & Aesthetics Center

Name:_____ Height:_____ Weight : _____ Date:_____

Have you had any of the following conditions?	CHECK IF YES		CURRENT SYMPTOMS	CHECK IF YES		SURGICAL HISTORY	CHECK IF YES
ACNE			ACNE			APPENDECTOMY	
ACTINIC KERATOSIS			DISCHARGE FROM EYES			CARPEL TUNNEL	
AIDS			DISCHARGE FROM NOSE			CATARACTS	
ANXIETY			DRYNESS IN EYES			ENDOSCOPY	
ATRIAL FLUTTER/FIB			BLOODY NOSE			HEART BYPASS	
ATYPICAL MOLES			DRYNESS IN NOSE			HEART VALVE	
BASAL SKIN CANCER			DRY SKIN			HERNIA REPAIR	
BREAST CANCER			ITCHING			JOINT REPLACEMENT	
CANCER: OTHER			MOLES CHANGING			PACKEMAKER	
COLD HIVES			KELOID			GALLBLADDER	
COLD SORES			HAIR LOSS			TONSILLECTOMY	
DEPRESSION			POOR HEALING OF WOUND			LUMPECTOMY	
DERMATITIS			INFLAMED SKIN			MASTECTOMY	
DIABETES			CHANGES IN SKIN LEISION			MOHS SURGERY	
DRY SKIN			SKIN BRUISING EASILLY			**PERSONAL HABITS**	
ECZEMA			SUN SENSITIVITY			SMOKING:: Current Smoker – Quit – Never Smoked	**Circle one**
GLAUCOMA			LUMP/ MASS UNDER SKIN			DAILY ASPIRIN USE	
HEART DISEASE			WARTS			COUMADIN USE	
HEART MURMUR			SCABIES			ALCOHOL USE- Never, occasionally, frequently	**Circle one**
HEPATITIS			FEVER			TATTOOS	
HERPES SIMPLEX			WEIGHT GAIN			PIERCINGS	
HIGH CHOLESTEROL			WEIGHT LOSS			USE SUNSCREEN	
HIRSUTISM			SWEATS			HISTORY OF SUNBURN	
HIV INFECTION			OTHER; Please list below:			HISTORY OF BLISTERING SUNBURN	
HYPERTENSION						USE TANNING BEDS	
KIDNEY DISEASE						ARE YOU PREGNANT	
LUPUS						ARE YOU NURSING	
MELANOMA						DO YOU PLAN ON BECOMING PREGNANT	
MITRAL VALVE PROLAPSE						**FAMILY HISTORY (mother, father, sibling, grandparent)**	**If yes who?**
PAROXYSMAL COLD HEMONGLOBUNURIA						BASAL CELL CANCER	
PSORIASIS						SQUAMOUS CELL CANCER	
SARCOID						MELANOMA	
SCABIES						MOLES	
SEIZURE/EPILEPSY						ECZEMA	
SQUAMOUS SKIN CANCER						OTHER CANCERS	
STROKE/ TIA						LUPUS	
T-CELL LYMPHOMA						SARCOID	
THYROID DISEASE						OTHER (PLEASE LIST)	
WARTS							

LIST CURRENT MEDICATIONS:

_____

ALLERGIES TO MEDICATIONS:

_____

New Jersey Dermatology & Aesthetics Center

Patient Name: _____

HIPAA

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 SKC Dermatology from discussing appointments, medications, 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 or adult children assist 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 about you. Should you wish to update the names below, please ask the receptionist for a HIPAA form.

Please place a check mark next to the following methods we may use to contact you regarding your appointments and medical information and indicate below any persons authorized to speak with our office on your behalf.

You may leave a message	**Regarding Appointments**	**Regarding Medical info**
Home Answering Machine	_____	_____
Mobile phone Voice Mail	_____	_____
Mobile text	_____	_____
Work Phones	_____	_____
With another person that may answer	_____	_____
Information through the mail	_____	_____
Information through email	_____	_____

Name of Individual (please print)	**Relationship to Patient**
_____	_____
_____	_____
_____	_____

Patient/ Guardian Signature: _____ Date: _____

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