Dermatology and Skin Cancer Institute Registration Form (Revised 01/01/2019)

Patient name: ______________________________ Sex: ☐ M ☐ F

Email Address: ______________________ Date of birth: ____________ Age: ______

Address: ____

Home Phone: ____________________ Cell Phone: ____________________

Marital Status: ☐ single ☐ divorced ☐ married ☐ widow Emergency contact: ____________________

Emergency contact phone #: ______________ ____________________

Release my *PHI Authorization to: ______________ Relationship: ________ Phone: ____________

Insurance Subscriber's Name ______________ **Subscriber's date of birth** ______________

Relationship to Patient: Circle one: Self Spouse Child Other ______

Pharmacy Information Pharmacy Name: ______________ Phone Number: ______________

Pharmacy Address: ______________________________

Government REQUIRED Information

Language Preference: ☐ English ☐ Spanish ☐ Other: ____________________

Race: ☐ White ☐ American Indian / Alaskan Native ☐ Asian or Asian American

☐ Black / African American ☐ Hawaiian or Pacific Islander ☐ Other: ______________

Ethnicity: ☐ Hispanic or Latino ☐ NOT Hispanic or Latino

Receipt of Notice of Privacy Practices Written Acknowledgement

I have had an opportunity to read the office's Notice of Privacy Practices. I acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended notice at each appointment.

How did you hear about us? Circle One: Friend Colleague Facebook Internet Search

Preferred Contact Method? Circle One: Email Home Phone Mobile Phone

Is it okay to leave a detailed message on your voicemail? Yes or No

Your Doctors – **Records CANNOT be sent without a FAX NUMBER**

Your Family Doctor:

Doctor Name: ______________________________ **FAX:** ______________

Surgery Patients: Referring dermatologist or other doctor to whom you would like surgical records sent:

Doctor Name______________________________ **FAX** ______________

Signature for Office Policies/Financial Policy/Authorization to Pay

I have read the document regarding DSCI Office Policies, Financial Policy and Authorization to Pay / Release Medical records in cooperation with my insurance company. I am aware that copies of this document available upon request or can be downloaded from the DSCI website: www.361derm.com

______________________ ______________________ ____________

Signature of Patient or Responsible Party **Printed Name if other than Patient** **Date**

Dermatology and Skin Cancer Institute History and Intake Form (rev 3/8/17)

Patient Name: DOB: DATE:

Past Medical History: (please circle all that apply)

Anxiety Arthritis Asthma	GERD (Reflux)	Lung Cancer
Atrial fibrillation	Hearing Loss	Lymphoma
BPH (Large Prostate)	Heart Attack	Prostate Cancer
Bone Marrow Transplant	Hepatitis *A B C*	Radiation Treatment
Breast Cancer Colon Cancer	High Blood Pressure	Seizures
COPD	HIV/AIDS	Stroke / mini-stroke / TIA
Coronary Artery Heart Disease	High Cholesterol	*Blood Clots*
Depression	Hyperthyroidism	*Pulmonary Embolism*
Diabetes	Hypothyroidism	*Tuberculosis*
End Stage Kidney Disease	Leukemia	*Other:* ______________

Past Surgical History: (please circle all that apply)

		Skin Disease History: (circle all that apply)
Appendix Removed Bladder Removed	Kidney Removed (Right, Left)	Acne
Breast Mastectomy (Right, Left)	Kidney Stone Removal	Actinic Keratoses (pre-cancer)
Breast Lumpectomy (Right, Left)	Kidney Transplant	Asthma
Breast Reduction Breast Implants	Ovaries Removed: Endometriosis	Basal Cell Skin Cancer
Colon Removal for Colon Cancer	Ovaries Removed: Cyst	Blistering Sunburns
Colon Removal for Diverticulitis	Ovaries Removed: Ovarian Cancer	Dry Skin
Colon Removal for Chrohn's Disease	Prostate Removed: Prostate Cancer	Eczema
Gallbladder Removed	Prostate Biopsy	Flaking or Itchy Scalp
Coronary Artery Bypass Heart Surgery	Prostate Removed: TURP	Hay Fever/Allergies
PTCA / Heart Stents	Skin: Basal Cell Cancer	Melanoma
Valve Replacement: Mechanical vs. Biological	Skin: Squamous Cell Carcinoma	Poison Ivy
Heart Transplant	Skin: Melanoma	Precancerous Moles
Joint Replacement, Knee (Right, Left)	Spleen Removed	Psoriasis
Joint Replacement, Hip (Right, Left)	Testicles Removed (Right, Left)	Rosacea
Joint Replacement within last 2 years	Hysterectomy: Fibroids	*Squamous Cell Skin Cancer*
Joint Surgery (Non-replacement)	Hysterectomy: Uterine Cancer	*Fever Blisters / Cold Sores*
Other Surgeries:	*Other Organ Transplant:*	Other:

Do you wear Sunscreen? ☐ Yes ☐ No
If yes, what SPF? ______________
Tan in a tanning salon? ☐ Yes ☐ No
Family history of Melanoma? ☐ Yes ☐ No
If yes, which relative(s)? ______________

Smoking: daily occassional never former
quit when? ______________

Alcohol: ☐ *none* *# drinks per day* ________
Recreational Drug Use ☐ Yes ☐ No
Occupation: ______________
Retired: ☐ Yes ☐ No
Family history of Other Skin Cancer? ☐ Yes ☐ No
If yes, which relative(s)? ______________

MEDICATIONS (inlcude Aspirin, Herbal meds, Vitamins):

IF YOU HAVE A LIST, WE CAN PHOTOCOPY IT!

Example Aspirin 81mg 1x daily

NAME	DOSE	FREQUENCY

ALLERGIES TO MEDICATIONS:

PATIENT NAME: ______________________________

DATE: ______________________________

Do you currently have or do you have history of the following?

Symptom	Yes	No
Changing mole(s) – experiencing currently?		
Rash – experiencing currently?		
Fever or Chills – experiencing currently?		
Problems with healing?		
Problems with scarring (hypertrophic or keloid)?		
Yeast infections with antibiotics?		
GI / stomach problems with antibiotics?		
History of fainting?		
Problems with Bleeding?		
Allergy to adhesive?		
Allergy to topical antibiotic ointments?		
Allergy to Latex?		
Allergy to Lidocaine?		
Rapid heartbeat with Epinephrine?		
Allergy to Clindamycin?		
Do you have a pacemaker?		
Do you have a defibrillator?		
Do you need premedication prior to dental work?		
History of Organ Transplantation?		
Immunosupression?		
Are you on Aspirin, Fish Oil, Vitamin E or any Blood Thinners?		
Pregnant or planning pregnancy?		
Breastfeeding/Nursing?		
History of Melanoma or Melanoma In-Situ?		
History of Basal Cell or Squamous Cell Carcinoma?		

Dermatology and Skin Cancer Institute

Authorization to Release Protected Health Information (PHI) rev 5/17

According to the Health Insurance Portability and Accountability Act (HIPAA), Dermatology and Skin Cancer Institute is required to obtain a patient's permission in the form of written authorization to discuss any aspect of your medical information with another party.

Unless authorized, HIPAA excludes DSCI from discussing the PHI of any patient without written authorization. This includes (A) providing information to parents regarding a child **OVER** the age of 18, (B) providing the information of parents with children **UNLESS** he/she is a designated Power of Attorney, C) providing the information from one spouse to spouse.

If later it is decided by a patient that he/she would like to authorize us to share PHI with another party, this form will need to be amended before we can do so, **without exception.**

This form grants us authority to share information with the parties of your choice. If you would like to grant another individual to obtain access to your PHI, please indicate below:

I, ______________________________, authorize DSCI to disclose Protected Health Information (PHI) in my healthcare record with the following parties:

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

Name: ______________________________ Relationship: ______________________________

I understand that I may inspect or copy the protected health information to be used or disclosed. Additionally, I may revoke this authorization in writing by contacting your office, attention Administrator.

_____ I do not allow my PHI to be shared with anyone other than myself

Printed name: ____ DOB: _____/_____/_____

Signature: ____ Date: _____/_____/_____

Dermatology and Skin Cancer Institute

455 W. Pennsylvania Avenue, Ste 127
Fort Washington, PA 19034
215.793.9755

1240 S. Broad Street, Ste 200
Lansdale, PA 19446
215.361.3376

Office Policies including Financial Policy (rev 01/17/2019)

Patient Name: ____ Date: ________________

Thank you for choosing The Dermatology and Skin Cancer Institute for your skin care needs. We are committed to providing you with the best possible care. In an effort to ensure your visit and the billing process goes as smoothly as possible it is important that you understand our office policies. We are happy to discuss any questions you may have.

Appointment Cancellation / "No-Show" Policy

We kindly request at least 24 hours' notice when cancelling or rescheduling your appointment. It is difficult to fill a cancelled or rescheduled appointment – especially when given little or no prior notification. You may be preventing another patient from receiving much needed treatment/care. Conversely, the situation may arise where another patient fails to cancel their scheduled appointment and we are unable to schedule you for an "emergency" visit or regular appointment, due to a seemingly "full" appointment book. If you need to change an appointment please extend the courtesy of giving us at least 24 hours' notice so we can treat another patient. If you fail to comply with this policy on two occasions, **a $25 non-refundable administrative fee** will be assessed to your account. Please help us provide the best care for you and our other patients by keeping your scheduled appointment. As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive your reminder call or message, the cancellation policy will still remain in effect.

Dermatology and Skin Cancer Institute Office Financial Policy

All patients are required to complete our patient information registration form. ***Please verify your address, phone, driver's license, insurance information, and credit card information at each visit.*** If current health insurance information cannot be provided at each visit you will be responsible for payment in full at the time of the visit. Please be advised that the contract between you and your insurance company is a separate contract from that between you and our clinic. ***It is your responsibility to be knowledgeable of your own insurance coverage/benefits/eligibility. It is your responsibility to alert our staff should your coverage change from your last visit or be discontinued. If we do not participate with your insurance, you will be billed at self-pay rates.***

Co-pays are required at the time of each visit prior to being seen. **Some HMOs require referrals.** We can retrieve electronic referrals, but if your insurance requires a paper referral, you must pick that up from your doctor and bring it with you to your appointment. As a courtesy, insurance claim forms will be prepared and sent to your insurance company on your behalf. If you are uncertain if a procedure is covered, please contact your carrier prior to your appointment to find out.

DSCI requires our patients to provide a valid credit card to be stored by our credit card processor under secure (SSL) protocol. With your authorization below, we will charge your credit card for any balance due once your insurance company has paid their portion of your covered charges. This includes **your deductible, co-insurance, additional co-pay, and/or any non-covered charges. A receipt of this payment will be emailed to you. Please be aware that the balance on your account is your responsibility.** If you do not have insurance or your insurance does not cover the services rendered, payment is expected in full at the time of service. Payment will be due **prior** to procedure. If this is a financial hardship, payment arrangements can be made. Credit Cards are accepted by our practice as a convenience to you. As part of the Fair Credit Billing Act, patients of the practice agree to not submit dispute charge requests with their credit card company or banking facility without making a good-faith effort to resolve a problem with the practice. Personal checks are accepted as well; **personal checks that are returned for non-sufficient funds are subject to an administrative fee of $35.**

Purchases for cosmetic services and products eligible for return will be for office credit only within 14 days of purchase. Pre-payment for unused cosmetic services can be returned minus full consultation fees and a 5% administrative fee up to 3 months after initial purchase. Ala carte prices will be used for services already completed in calculating refunds for pre-paid packages. After 3 months, no returns will be accepted. No refunds will be given for completed services.

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SUMMARY STATEMENT FOR SIGNATURE

I have read and understand the DSCI Office Policies including the Financial Policy and agree to be bound by its terms.

I understand I will be charged a $25 non-refundable admin fee if I no-show or cancel with < 24 hours' notice on 2 occasions.

I understand that accounts with unpaid balances after 60 days may be forwarded to a collection agency or District Court.

I accept responsibility for any co-pay due. I understand the co-pay is NOT-REFUNDABLE once I have been evaluated by a provider.

I accept responsibility for any deductibles, co-insurance amounts, and the full cost of non-covered services.

I understand that I am required to keep a credit card on file with the practice.

I understand DSCI will send at least (1) one statement prior to charging my credit card. Thereafter, I authorize DSCI to charge my credit card on file for the amount owed up to $250.

Authorization to Pay / Authorization to release medical records: I request that payment of authorized Medicare and/or Insurance benefits be paid directly to Dermatology & Cosmetic Surgery Institute, PC. I permit a copy of this authorization to be used in place of the original. I authorize the release to the Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries, or to my medical insurance carriers any information regarding this or related claims. Additionally, if I have "Medigap" / Secondary Insurance coverage, I request benefits be paid on my behalf for any services furnished. I authorize the Dermatology and Skin Cancer Institute to release to my "Medigap" carrier information needed to determine my benefits.

______________________________ ______________________________ ____________________

Signature of patient or responsible party   Printed name if other than patient   Date

DSCI - Important Information to understand regarding Insurance Policies (rev 6/2016)

What is a referral?

A referral is an important process in your medical care. When you join an HMO, the primary care physician (PCP) you select will coordinate ("refer") your care to a specialist (Dermatologist) to ensure you get the most appropriate care. Your insurance carrier mandates that you get this referral from your PCP. Please contact your PCP within three (3) business days of your appointment in our office to determine if they issued you the referral. Without a referral, we will have to reschedule the appointment.

What is a co-pay and co-insurance?

A ***co-pay*** is the amount you have to pay to access medical care according to your insurance contract. In some cases, it might be $10-$30 but with some insurances, it would be a percentage of your bill (10-20% is common). **Once you have been evaluated by a provider in the practice, your co-pay is NOT REFUNDABLE.** ***Co-insurance*** is the remaining balance after the insurance company has paid their portion. With the new Medicare products being offered by commercial insurance companies, some Medicare patients do have a co-pay as well as their co-insurance to pay.

What is a deductible?

A deductible is the amount of money that a patient must pay out of pocket before the insurance company is responsible for any charges. The average deductible ranges from $100 to $1500 and once this is met by patient the insurance company will begin to pay for covered charges. **There is no way for us to know how much your deductible is since there are so many different insurance plans in existence.** Every medical service in this office will generate a charge, so if you are concerned that you will have to pay out of pocket, please contact your insurance company prior to having a procedure done. Medicare patients are responsible for their deductible at the beginning of each year.

Why do I have to pay my co-pay and/or deductible?

When you sign up with an insurance carrier, you sign a contract which stipulates that you are obligated under the conditions of that contract to pay your co-pay, co-insurance, and/or deductibles. This means you are required to pay a co-pay, co-insurance, and/or deductible for all office visits, including follow-up examinations and outpatient surgical procedures done in our office. If you do not meet this obligation, your insurance company has the right to deny the charges which would leave you responsible for the entire cost of the services rendered during your visit.

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Please note: Depending on your insurance, you may receive bills from outside laboratory companies (i.e. Quest laboratory, pathology companies, etc). If you receive a bill from an outside company, please call that company's phone number and speak to their representative regarding the matter.

Why can't you just "write off" my co-pay and/or deductible?
Since your insurance contract stipulates that you must pay a co-pay and/or deductible, waiving this fee would violate your contract. When we signed up with your insurance company our contract states we will collect co-pays and/or deductibles owed by the patient. If the doctor gives you a "discount" by waiving your co-pay and/or deductible and then bills the insurance company without giving them the same "discount", it is considered insurance fraud.

Why do you collect the co-pay instead of billing me like my last doctor?
It is much more efficient to collect the co-pay at the time of service. Otherwise, it becomes more difficult and expensive to deal with administratively. This policy is non-negotiable.

Medication Refill Requests

Refills may be called in during regular office hours. Please have the following information available when you call one in: patient's name, date of birth, phone number, name of medication, strength and dosage, and the pharmacy you want it called in to. Please make sure we have your complete pharmacy information including name, complete address and telephone number.

Please allow 48 business hours for medication to be called in to your pharmacy.
DSCH does not refill prescriptions after business hours, weekends, or on holidays.

- Plan ahead: You should contact our office three (3) days before your medication is due to run out. However, if you are using a mail order company; please contact us fourteen (14) days before your medication is due to run out.
- Be patient: some medications require prior authorizations. The extra paperwork required from your insurance company may take days to process and may delay your needed medication. Please anticipate a 7-to-10-day approval process.
- Any refill request will require a review of your medical records, etc. Certain medications require mandatory laboratory testing before they can be refilled. If you do not have up-to-date laboratory testing, this may delay your request until the appropriate testing is completed.
- We will not refill any medications that were prescribed by other physicians. Refills on medications will only be authorized for medications prescribed by our providers in our office.

Policy for oral, certain topical, injectable, or monitored medications:
A follow-up visit will be required at minimum every 6 months to verify medication efficacy

Policy for other topical medications:
A follow-up visit will be required at minimum every 12 months to verify medication efficacy

Please keep your follow-up appointments. It is our office policy not to authorize refills if you have missed your appointments or fail to keep your scheduled recommended visits.

I have read and understand the DSCI document "Important Information to understand regarding Insurance Policies."
I have had an opportunity to read the office's Notice of Privacy Practices. I acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice at each appointment.
I am aware that copies of this document available upon request or can be downloaded from our website: www.361derm.com

______________________________	______________________________	______________
Signature of patient or responsible party	Printed name if other than patient	Date