KINNELON DERMATOLOGY ASSOCIATES

☐ 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 address: _____

Occupation: _____ Employer: _____ Work Phone: _____

Employer Address: _____

Pharmacy Name: _____ Town: _____Phone#:_____

Primary Doctor Name: _____ Town: _____Phone#:_____

Referring Physician _____ Town: _____ Phone#:_____

New Patients: How did you hear about Kinnelon Dermatology Associates? _____

Primary Insurance Plan:_____ID#_____

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

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 Kinnelon Dermatology does not participate in my plan I am responsible for payment in full at the time of service

I certify that I hereby authorize Kinnelon Dermatology, 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 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 such as surgery, biopsy, or wart destructions. I understand additional written consent may be necessary for these types of procedures and that the legal guardian must be present for such consent.

PATIENT OR LEGAL GUARDIAN SIGNATURE: _____ Date: _____

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APPOINTMENT CANCELLATIONS

If I am unable to keep my scheduled appointment, I will call Kinnelon Dermatology to cancel or re-schedule my appointment. Medical appointments require a 24-business-hour cancellation notice. Cosmetic and surgical appointments require 48 business- hour notice and Mohs surgery requires 72 business-hour notice. If I do not call Kinnelon Dermatology to cancel my appointment, I may be charged the no show fees listed below.

NO SHOWS/ Failure to cancel within time frame outlined above.

Failure to arrive for my scheduled appointment may result in a $25.00 fee for regular appointments and a $100 fee for all surgical appointments (Mohs/ excisions) and loss of my deposit for cosmetic appointments. I understand I will forfeit one treatment if I am in a pre-paid cosmetic package with multiple treatments.

LATE ARRIVALS

Kinnelon Dermatology strives to stay on time as often as possible. There are times surgeries run long or patients present with complicated medical needs which causes providers to run behind. Patients arriving past their scheduled appointment time and being added into the schedule causes significant issues for the practice and other patients. Therefore, I understand should I arrive 10 minutes past my scheduled time will essentially cancel my appointment. Should the provider or their associate have an opening the same day, I may ask to be seen in that time slot and know there may be a wait in doing so. Should the provider or their associate not have any openings for the day, I understand I will have to reschedule my appointment.

CO-PAYMENT POLICY

Copayments are due and collected on the day of my or my family's 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/ REFERRAL POLICY

It is my responsibility to know if my insurance plan requires a referral to see a specialist. If my insurance plan requires a referral, it is my responsibility to obtain an updated referral from my Primary Care Physician and to make sure Kinnelon 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 dates of referrals and will obtain new ones as needed. I understand that should I fail to have a valid referral for my visit, Kinnelon Dermatology is not authorized to see me. I will need to reschedule my appointment. If I fail to reschedule my appointment and chose to be a self-pay patient in lieu of rescheduling and obtaining a referral, I am completely responsible for all charges incurred and must pay at the time of service in full. I understand my insurance company will not reimburse me for this visit.

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 pay in full at the time of the visit and submit my claim to the insurance company for reimbursement or will need to reschedule my appointment. 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 Kinnelon Dermatology of any changes to my insurance or 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.

ACCOUNT BALANCES

All balances are due in full within 30 days of my first billing. If my balance is unpaid after 60 days, I understand I will incur a $25.00 administrative billing fee. Any balance left unpaid after 90 days will be considered for collections. It is my responsibility to contact the office to arrange for an acceptable payment plan should I be unable to pay my balance in full. 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.

MINOR PATIENTS

A legal guardian ***MUST ACCOMPANY*** children under the age of 18 to their initial appointment so that proper forms can be completed and your child can be treated. Children without legal guardian at their initial visit will be rescheduled. Signed forms in lieu of parent/ legal guardian's attendance is not acceptable. Grandparents, babysitters, older siblings etc. are not considered legal guardians without appropriate paperwork presented and the appointment will need to be rescheduled without parental/ legal guardian presence.

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 the balance will become my responsibility to pay.

Patient or Legal Guardian Signature: _____ Date: _____

KINNELON DERMATOLOGY ASSOCIATES

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 Kinnelon Dermatology Associates from discussion 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 you 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.

You may leave a message	**Regarding Appointments**	**Regarding Medical info**
Home Answering Machine	_____	_____
Mobil phone Voice Mail	_____	_____
Mobil 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 or 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.

KINNELON DERMATOLOGY ASSOCIATES

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			FATIGUE			CARPEL TUNNEL	
AIDS			SWEATS			CATARACTS	
ANXIETY			FEVER			ENDOSCOPY	
ATRIAL FLUTTER/FIB			WEIGHT GAIN			HEART BYPASS	
ATYPICAL MOLES			WEIGHT LOSS			HEART VALVE	
BASAL SKIN CANCER			DISCHARGE FROM EYES			HERNIA REPAIR	
BREAST CANCER			DISCHARGE FROM NOSE			JOINT REPLACEMENT	
CANCER: OTHER			DRYNESS IN EYES			PACKEMAKER	
COLD HIVES			BLOODY NOSE			GALLBLADDER	
COLD SORES			DRYNESS IN NOSE			TONSILLECTOMY	
DEPRESSION			DRY SKIN			LUMPECTOMY	
DERMATITIS			ITCHING			MASTECTOMY	
DIABETES			RASH			MOHS SURGERY	
DRY SKIN			HEART ARRYTHMIA			**PERSONAL HABITS**	
ECZEMA			HEART PALPITATIONS			SMOKING:: Current Smoker – Quit – Never Smoked	**Circle one**
GLAUCOMA			ASTHMA			DAILY ASPIRIN USE	
HEART DISEASE			WHEEZING			COUMADIN USE	
HEART MURMUR			ABDOMINAL PAIN			ALCOHOL USE- Never, occasionally, frequently	**Circle one**
HEPATITIS			ARTHRITIS			TATTOOS	
HERPES SIMPLEX			JOINT PAIN			PIERCINGS	
HIGH CHOLESTEROL			SWELLING			USE SUNSCREEN	
HIRSUTISM			KELOID			HISTORY OF SUNBURN	
HIV INFECTION			HAIR LOSS			HISTORY OF BLISTERING SUNBURN	
HYPERTENSION			POOR HEALING OF WOUND			USE TANNING BEDS	
KIDNEY DISEASE			INFLAMED SKIN			ARE YOU PREGNANT	
LUPUS			CHANGES IN SKIN LEISION			ARE YOU NURSING	
MELANOMA			SKIN BRUISING EASILLY			DO YOU PLAN ON BECOMING PREGNANT	
MITRAL VALVE PROLAPSE			SUN SENSITIVITY			**FAMILY HISTORY (mother, father, sibling, grandparent)**	**If yes who?**
PAROXYSMAL COLD HEMONGLOBUNURIA			LUMP/ MASS UNDER SKIN			BASAL CELL CANCER	
PSORIASIS			NUMBNESS/ TINGLING			SQUAMOUS CELL CANCER	
SARCOID			ANEMIA			MELANOMA	
SCABIES			BLEEDING/ CLOTTING DISORDER			MOLES	
SEIZURE/EPILEPSY			ENLARGED LYMPH NODES			ECZEMA	
SQUAMOUS SKIN CANCER			OTHER (PLEASE LIST)			OTHER CANCERS	
STROKE/ TIA						LUPUS	
T-CELL LYMPHOMA						SARCOID	
THYROID DISEASE						OTHER (PLEASE LIST)	
WARTS							

LIST CURRENT MEDICATIONS:

_____

ALLERGIES TO MEDICATIONS: _____