

# Patient Information

Name \_\_\_\_\_  
(Last) (First) (MI)

Male  Female Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Marital Status \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Preferred Pharmacy/Location/Phone # \_\_\_\_\_

Driver's License # & State \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State) (Zip Code)

Home # \_\_\_\_\_ Work # \_\_\_\_\_ Cell # \_\_\_\_\_

Fax # \_\_\_\_\_ Email Address \_\_\_\_\_

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Emergency Contact Name \_\_\_\_\_  
(Last) (First)

Relationship \_\_\_\_\_ Phone # \_\_\_\_\_

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Primary Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Start Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ CoPay \_\_\_\_\_ Referral Required?  Yes  No

Policyholder Name \_\_\_\_\_ Relation \_\_\_\_\_  
(Last) (First)

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

Secondary Insurance Company \_\_\_\_\_

Policy # \_\_\_\_\_ Group # \_\_\_\_\_

Policy Start Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ CoPay \_\_\_\_\_ Referral Required?  Yes  No

Policyholder Name \_\_\_\_\_ Relation \_\_\_\_\_  
(Last) (First)

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Address \_\_\_\_\_ Phone # \_\_\_\_\_

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for the payment of your bill.

You are responsible for payment of any co-payment at the time of service and on receipt of a bill for any deductible/ coinsurance as determined by your contract with your insurance carrier. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and your physician elect to continue treatment past your approved period, you will be responsible for your account balance in full.

I hereby authorize Englert Dermatology LLC to release any information necessary for my course of treatment.

I have read the above policy regarding my financial responsibility to Englert Dermatology LLC for providing Dermatology service to the above named patient or me. I certify that the information provided is so, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Englert Dermatology LLC. I agree to pay Englert Dermatology LLC the full and entire amount of all bills incurred by me or the above named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Signature \_\_\_\_\_ Date \_\_\_\_\_

Patient Name \_\_\_\_\_ D.O.B. \_\_\_\_\_

Primary Care Physician \_\_\_\_\_

Medication Allergies? \_\_\_\_\_

**List of Current Medications (OTC and Prescription) Reason of Medication**


**Medical Conditions Know to the Patient:**

1.
2.
3.

**Have you ever been hospitalized? If Yes, please list dates and problems**

Year	Problem / Surgery	Hospital	Physician

Do you have a History of:	Yes	No
Asthma		
Dermatitis		
Eczema		
Hepatitis C		
Herpes		
HIV / AIDS		
Hyperthyroid		
Hypothyroid		
Liver Disease		
Lupus		
Melanoma		
Murmur		
Psoriasis		
Skin Cancer		
Tinea (skin/foot fungus)		
Warts		

Do you have:	Yes	No
Adhesive Allergy		
Advanced Directive (Health Care Proxy)		
Bowel or Urination Changes		
Changing moles (color, size, bleeding)		
Chills		
Cough		
Depression		
Difficulty Sleeping		
Difficulty Hearing		
Fevers		
Hair loss or nail changes		
Headaches		
Immunizations up to date?		
Latex Allergies		
Muscle or joint aches		
Recent Stress		
Sensitive skin		
Unexplained weight gain or loss		
Vision Problems		

Does Anyone in Your Family have a History of:	Yes	No
Allergies		
Asthma		
Cancer		
Cancer of the Skin		
Dermatitis		
Eczema		
Melanoma		
Psoriasis		

Provider Reviewed: \_\_\_\_\_

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

***Personal Habits*****Alcohol** (amount per day / week) \_\_\_\_\_**Coffee, Cola** (amount per day) \_\_\_\_\_**Laundry Detergent Brand** \_\_\_\_\_**Dryer Sheets?** \_\_\_\_\_**Pets (what kind?)** \_\_\_\_\_**Soap (brand)** \_\_\_\_\_**Suntan Parlors (frequency)** \_\_\_\_\_**Smoking (amount per day, how many years)** \_\_\_\_\_

## Medicare Patient Information

Patient Name: \_\_\_\_\_ SS#: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex:  Female  Male

Address: \_\_\_\_\_  
Street

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

( ) \_\_\_\_\_ ( ) \_\_\_\_\_  
HomePhone WorkPhone

**Please print your name as it Appears on Your Medicare Card**

**Medicare Health Insurance Claim Number as it appears on your card. This is usually your Social Security number. Be sure to include the letter after the nine-digit number. It is important that we have both the numbers and letter)**

### Referring Physician

Name: \_\_\_\_\_ Phone# ( ) \_\_\_\_\_

### Emergency Contact

Name of Spouse or Close Relative or Friend: \_\_\_\_\_  
(In Case of Emergency)

Phone# ( ) \_\_\_\_\_

### Please Sign So We May Have Your Medicare Authorization On File

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Signature: \_\_\_\_\_

### Payment Policy

**Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual \$110.00 deductible and paying for the 20% copayment. We do file with secondary /supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**

**Note:** If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers.

-Continued on Back-

Please read each of the following and answer as they apply to you. If it does apply to you, please check YES. If it does NOT apply to you, please check NO

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?                        |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by a HMO/ PPO which makes Medicare secondary?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office for an illness or accident that has been covered or is authorized for coverage from the VA (Veteran's Administration)? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work and have coverage through the insurance at your job?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you eligible for any benefits under the Federal Black Lung Program?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office for an illness; accident or injury that is the result of an automobile accident?                                       |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you coming to this office due to Medicare disability coverage?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by the Federal End Stage Renal Disease Program?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you presently receiving Workers' Compensation?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Is the illness or injury you are coming to this office for the result of work-related causes?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have medical assistance through Welfare or state-aid?   |

If you answered YES to ANY of the above questions: \_\_\_\_\_  
Explain

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name Policy Holder (Insured): \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Policy Holder (Insured) SS# \_\_\_\_\_

**Supplemental (MEDIGAP) Insurance**

In the event of a major procedure or hospitalization, we request secondary insurance information for our records (supplemental Medicare insurance information). Please fill out below if you are covered by a plan which covers the 20% NOT covered by Medicare. (MEDIGAP Coverage)

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Name Policy Holder (Insured): \_\_\_\_\_  Male  Female

Date of Birth: \_\_\_/\_\_\_/\_\_\_ Policy Holder (Insured) SS# \_\_\_\_\_

**Please Sign So We May Have Your Supplemental Authorization On File:**

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: \_\_\_/\_\_\_/\_\_\_ Signature: \_\_\_\_\_



Patient Name : \_\_\_\_\_ D.O.B . - \_\_\_\_\_

### Office and Financial Policies

***Welcome and thank you for choosing Advanced Dermatology, Bel Air, and North Baltimore Dermatology for your dermatology care. We hope that providing you with the policies of this office will prevent any misunderstandings or frustrations at the time of your visit.***

**Initial: \_\_\_\_\_ Insurance** – When making an appointment with your provider, it is your responsibility to confirm with your insurance company that the physician is currently under contract with the plan. If your plan requires that you have a referral prior to seeing a specialist, please contact your primary care physician so that you have the referral in hand at the time of your appointment. We will accept a faxed referral at 410-569-1131 for Bel Air, and 410-472-0900 for the North Baltimore Dermatology office. If you do not bring your referral with you to your appointment, you will need to reschedule your appointment, or choose to be seen without the insurance benefits and pay for your visit in full.

**Initial: \_\_\_\_\_ The patient is responsible for knowing their insurance benefit coverage and whether a referral is needed for a specialist visit.** We will gladly file your insurance claim on your behalf. We allow 45 days from the date the claim is filed for the insurance company to pay. If the insurance company does NOT pay within this time, you will be responsible for the entire balance. We will not become involved in disputes between you and your insurance company regarding coverage and or policy benefit criteria, i.e. deductibles, non-covered services, co-insurance, coordination of benefits, pre-existing conditions or “reasonable and customary charges. You are responsible for all co-payments and deductibles.

**Initial: \_\_\_\_\_ Check – In:** New Patients, please arrive for your appointment 15 minutes prior to your appointment time so that all paperwork may be completed before you are scheduled to be seen by your provider. Please bring your current insurance card with you to EACH visit. Without the insurance card, we will be unable to file your insurance, and you will be responsible for all charges for that visit. On follow-up visits you will be asked to verify all demographic and insurance information so that our records remain up-to-date.

**Initial: \_\_\_\_\_ Check-Out** – Please be prepared to pay for the current visit as well as any past balances on your account. Payment of co-payments, deductibles or fees for non-covered services will be required at the time of service. For your convenience we take cash, check, and all major credit cards.

**Initial: \_\_\_\_\_ Late Arrivals** – We do our best to keep to a schedule. When a patient is late, it is impossible to stay on schedule. If you arrive more than 15 minutes past your scheduled appointment time, you will be rescheduled so that other patients are not inconvenienced.

**Initial: \_\_\_\_\_ No Shows and Cancellations** – We require a 24 hour notice if you must cancel an appointment. For your convenience we offer an automated confirmation reminder system that will call you 48 hours prior to your appointment. If you cancel the same day as your appointment, you will be considered a NO SHOW for that visit. Each patient is allowed one NO-SHOW without penalty. The second NO SHOW will result in a \$50.00 charge to your account. Once you have two no show appointments in your file, you may also be required to secure subsequent appointments with a credit card and subsequent appointments may be charged \$125.00

**Initial: \_\_\_\_\_ Non-Covered Services:** An “Insurance Waiver may be required to acknowledge understanding of your responsibility for paying for non-covered services. In dermatology, there are many procedures that are considered by Medicare and private insurers as non-covered, including removal of skin tags and seborrheic keratoses, cosmetic treatment of facial spider veins, removal of whiteheads, as well as others. If you are coming in for a non-covered service, please be prepared to pay for the service in full.



Patient Name : \_\_\_\_\_ D.O.B . - \_\_\_\_\_

**Initial: \_\_\_\_\_ Collection Fees & Return Check Fees** – Delinquent accounts are referred to an outside collection agency. Those accounts will be assessed a \$35.00 collection fee. The Guarantor is responsible for any statutory interest and finance charges associated with the collection. Any returned check from the bank for non-payment shall result in the patients or Guarantors account being assessed a \$35.00 fee per check.

**Initial: \_\_\_\_\_ Billing Agency:** The billing agency our office uses is Dermatology Billing Associates. All billing questions should be referred to them by calling 1-888-Bill-Derm.

**Initial: \_\_\_\_\_ Minors:** The parent(s) or Guardian(s) accompanying minor are responsible for providing current insurance information for the minor and/or payment in full for services provided. Unaccompanied minors must have written authorization for medical treatment signed by the parent before treatment can be rendered. An authorization to charge services must be in file for any co-payments, deductibles or non-covered services.

**Initial: \_\_\_\_\_ Pathology Fees:** We send tissue to an outside reference lab of our choice for slide processing and interpretation. Patients and their insurance companies may receive a bill from the outside laboratory. Any billings you receive should be handled with the insurance company and the laboratory directly.

**Initial: \_\_\_\_\_ Biopsy Results:** Our office requires that you ***return for all biopsy results.*** We check the site where the biopsy was done to make sure it is healing properly, discuss the results, and make sure the results correlate with our Pathology Consultation. This is the standards set by this practice and exceptions will not be made.

I have read, understand and agree to all the above office and financial policies. I hereby attest that I have given and agreed to provide current demographic and insurance information and authorize the release of information necessary for insurance filing and pre-certification by signing this statement.

**Patient Name:** \_\_\_\_\_ **D.O.B:** \_\_\_\_\_

**Responsible Person’s Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Notice to Patient**

Assignment of Benefits: I hereby authorize the physicians and staff of North Baltimore Dermatology / Advanced Dermatology Bel Air to render treatment to me/my dependents. I further authorize North Baltimore Dermatology / Advanced Dermatology Bel Air to release my personal health information for purposes of treatment, payment or operations by phone, mail or fax. I assign and authorize payment of medical/surgical benefits directly to North Baltimore Dermatology / Advanced Dermatology Bel Air. I understand that any unpaid balances or non-covered services will be my responsibility. I understand I will be charged a missed appointment fee of \$25.00 per visit should I fail to provide 24 hours notice of cancellation or rescheduling. I also understand I will be charged a \$30.00 collections fee should my account be referred to a collections company utilized by this practice and a \$35.00 fee for any and all returned checks. We accept cash, checks, MasterCard, Visa, American Express, and Discover as forms of payment.

**Biopsy Results** will not be given over the phone. We require you to come back to obtain all results. Why do we do this? We want to make sure that they biopsy site has healed properly. We want to make sure that the pathology report matches what we actually see, we want to discuss the findings with you in person, and go over the plan of treatment with you. This is an office policy and no exceptions will be made.

**Skin Tags** are considered cosmetic therefore they are a non-covered service and will not be submitted to the insurance company. There will be a fee associated with the removal of skin tags. It is the provider's discretion to determine if they can submit the removal on a skin tag to the insurance company for a medical reason.

By my signature, I acknowledge that I have read and understand the above information (if patient is a minor, signature of responsible party):

Signature \_\_\_\_\_ Date \_\_\_\_\_