

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 _____

Emergency Contact Name _____
(Last) _____ (First) _____

Relationship _____ Phone # _____

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)** _____



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:** _____