SPYGLASS DERMATOLOGY

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

***PLEASE PROVIDE CURRENT INSURANCE INFORMATION. IF YOU ARE NOT OVER 18, OR NOT THE LEGAL GUARDIAN OF THE PATIENT, PLEASE SEE THE RECEPTIONIST.**

Patient Information: 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: _____ Soc. Security#:_____

Home Phone: _____ Cell: _____ Email address_____

Pharmacy Name: _____ Town: _____Phone#:_____

Primary Doctor Name: _____ Town: _____Phone#:_____

Referring Physician _____Town: _____ Phone#:_____

New Patients: How did you hear about SPYGLASS Dermatology?

_____

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 Ins Plan:_____ID#_____

Secondary Ins. 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 Spyglass 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 Spyglass 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 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: _____

Patient Name: _____ **DOB:** _____

SPYGLASS DERMATOLOGY

Past Medical History

- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Aids
- ☐ Anxiety
- ☐ Atrial Fibrillation
- ☐ Atypical Moles
- ☐ Cold Sores
- ☐ Dermatitis
- ☐ Diabetes
- ☐ Depression
- ☐ Dry Skin
- ☐ Eczema
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV
- ☐ Hypertension
- ☐ Kidney Disease
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Psoriasis
- ☐ Sarcoid
- ☐ Scabies
- ☐ Seizure
- ☐ Stroke
- ☐ T-Cell Lymphoma
- ☐ Thyroid Disease
- ☐ Warts

History of Cancers

- ☐ Basal Cell Skin Cancer
- ☐ Squamous Skin Cancer
- ☐ Pre- Cancerous Skin Lesion
- ☐ Melanoma Skin Cancer
- ☐ Other Cancers:

_____

Surgical History

- ☐ Appendectomy
- ☐ Cataracts
- ☐ Defibrillator
- ☐ Endoscopy
- ☐ Heath Bypass
- ☐ Heart Valve
- ☐ Pacemaker
- ☐ Defibrillator
- ☐ Lumpectomy
- ☐ Mastectomy
- ☐ Mohs Surgery
- ☐ Organ transplant

Current Problems

- ☐ Acne
- ☐ Bruising Easily
- ☐ Changes in Skin Lesion
- ☐ Discharge from Eyes
- ☐ Discharge from Nose
- ☐ Dryness of Eyes
- ☐ Dry Skin
- ☐ Excessive Sweating
- ☐ Hair Loss
- ☐ Inflamed Skin
- ☐ Itching
- ☐ Keloid- Raised Scar
- ☐ Lump/ mass under skin
- ☐ Moles Changing
- ☐ Poor Wound Healing
- ☐ Rash
- ☐ Scabies
- ☐ Sun Sensitivity
- ☐ Warts Hair Loss
- ☐ Weight Loss- no dieting
- ☐ Weight Gain

Social History

- ☐ Smoking
- ☐ Alcohol
- ☐ Tattoos
- ☐ Piercings
- ☐ Use of Sunscreen
- ☐ History of Sunburn
- ☐ History of Blistering Sunburn
- ☐ Use of Tanning Beds
- ☐ Are you currently pregnant?
- ☐ Are you currently nursing?
- ☐ Do you plan to become pregnant?

Family History

	Mother	Father	Sibling	Grandparent
Basal Skin Cancer				
Squamous Skin Cancer				
Melanoma				
Moles				

Patient Name: _____

SPYGLASS DERMATOLOGY

NAME OF MEDICATION	DOSAGE/ FREQUENCY

Immunizations

Pneumococcal: Date given_____ Administered By? _____

Influenza: Date given_____ Administered By? _____

Covid: Date's given 1st dose _____ 2nd Dose _____ Administered By? _____

Allergies to Medication: _____

Patient Name (Please Print) _____

Signature: _____ Date: _____

SPYGLASS DERMATOLOGY

Our goal is to provide you and your family with the 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 medical appointment will result in a charge of $100 and $300 for a surgical appointment. Failure to provide 48-hours' notice for a cosmetic procedure may result in forfeit of my cosmetic deposit or a treatment in my laser package.
- These charges cannot be billed to my insurance company.

Late Arrivals for Appointments

- I understand Spyglass Dermatology 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 60 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 $35.00 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 it is my responsibility to obtain initial referrals track usage, obtain additional referrals as needed and verify* Spyglass Dermatology *has these referrals in their office prior to my visit.*
- I understand that should I fail to have a valid referral for my visit, Spyglass Dermatology 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 Spyglass Dermatology will not allow enough time to maintain my scheduled appointment and doing so will forfeit my scheduled time at Spyglass Dermatology.

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 or will be responsible for all charges.
- 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 or considered an uncovered benefit; and separate co-insurances, deductibles or co-payments or payments in full 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 SPYGLASS 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.

SPYGLASS DERMATOLOGY

Minor Patients

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, stepparents 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 request from my insurance company requesting information about my coverage that will require me to contact my insurance company.
- I understand that claims will not be paid without my providing this information
- I will reply to all insurance inquiries within 10 days of receipt or will be responsible for the entire balance.

Credit Card on File

- We have implemented a policy requiring a credit card held on file for touchless transactions.
- 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, your credit card will be run for the amount indicated. I understand I will not receive a statement from SPYGLASS Dermatology and my EOB will determine my financial responsibility.
- This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.
- Additional information will be explained with our Credit Card on File policy form

Cosmetic Deposits

A significant amount of time is reserved for our patient's cosmetic appointments, and therefore a deposit of $250 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: _____

SPYGLASS DERMATOLOGY

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 SPYGLASS 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/ Phone Number**
_____	_____
_____	_____
_____	_____

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.

SPYGLASS DERMATOLOGY

CREDIT CARD ON FILE

Like many medical practices, Spyglass Dermatology has implemented a credit card on file for all transactions. With the changing environment in healthcare, 90% of our patients now have deductibles and/ or co-insurances in addition to their copayments. Simply put, this means their insurance companies are placing more responsibility of payment on our patients. Covid-19 has reinforced our plan with providing for contactless transactions.

How it Works

- Similar to hotels and car rental agencies, you will be asked for a credit card at the time you check-in.
- The information will be held securely in an encrypted system; No one will be able to see your full credit card number and it will be accessed by your name and Spyglass Dermatology account number.
- I understand I will receive an Explanation of Benefits (EOB) from my insurance company after my claim has processed. The EOB will outline any financial responsibilities such as deductibles or coinsurance
- ***I understand I will not receive a separate statement from SPYGLASS Dermatology*** and my EOB will be used to determine my financial responsibilities. I will receive a message/ call before my card is processed. I do not need to confirm processing, as this is a courtesy call. My receipt will be emailed.
- I understand I may also request this card be used for copayments, products or cosmetic treatments,
- In signing below, I authorize and request Spyglass Dermatology to charge my credit card for balances due for services rendered that my insurance company identifies as my financial responsibility.
- This authorization relates to all payments not covered by my insurance company for services provided to me/ my child/ spouse for whom I provide this credit card.
- This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to Spyglass Dermatology in writing and with no open or pending balances.
- I agree to provide an alternate card prior to the expiration date and will provide an alternate method of payment within 5 days should my card not contain enough credit/ monies to cover my balance.
- I understand failure to provide alternate payment methods as outlined above may result in my account being sent to collections and discharge from the practice.

Patient Name: _____

Card Holder Signature: _____ ***Date:*** _____

Credit Card Holder Name: _____ ***Relationship:*** _____

Card type:_____Visa _____MC _____Discover_____AMEX_____HSA

Card # _____ Exp Date: _____ Sec Code: _____

Mailing Address for Card: _____

Email Address of Card Holder: _____ Phone # of Card Holder: _____

SPYGLASS DERMATOLOGY

Rapid Payment Program

Patient Name: _____ DOB: _____

You have elected *not* to participate in our Credit Card on File program. We understand and respect your decision and will therefore, be enrolled in our Rapid Payment Program.

- Patients in the Rapid Payment Program will receive both an Explanation of Benefits from your insurance company as well as ONE Statement of Balance from our practice.
- You may call the office to make your payment in person, over the phone, mail a check to the office.
- Balances are due in full within 30-days of the date on the statement.
- If the balance is not paid in full within 30 days, your account will be placed in pre-collections.
- We will make 1 additional attempt to contact you via telephone to obtain payment in full.
- Should we be unsuccessful in receiving payment in full by day 60, your account will be sent to collections.
- All families in the same household with accounts in collection with our practice are discharged and collections through legal means will be pursued.

Payment plans

- We understand there are times when large balances occur and may require you to enroll in a payment plan with our practice.
- This is a separate formal agreement, with an understanding of dates for payments to be made.
- ALL payment plans require, with no exception, to have a credit card on file with the practice.
- You may select the date for payments to be run with the agreed-to amount in order to pay off the balance.
- The maximum amount allowed in payment plans is $1000 per family.
- The minimum payment each month for payment plans is $100.
- The maximum length of payment plan is 6 months. i.e. if a balance is $1000, it must be paid over 6 months making the monthly payment $166.66.

Subsequent visits may create additional patient responsibilities.

- New balances will not be automatically enrolled in the payment plan system and will be subject to the same 30-day statement process as outlined above.
- If you wish to enroll a new balance into an active payment plan, it will be your responsibility to notify us and a new agreement must be activated.
- Payment plans are maxed at $1000 per family and each balance added must be cleared within 6 months of the activation.

Patient or Legal Guardian Signature: _____ Date: _____

Name of Legal Guardian: _____ Relationship: _____