Atlantic Dermatology Associates, P.C.

Dermatology and Dermatologic Surgery

PATIENT INFORMATION FORM

Patient Account # _____

Patient Last Name	First	MI	Social Security No.

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Please indicate primary phone ____ Home / ____ Work / ____ Cell		Email Address

Sex M / F	Marital Status S M D W	Birthdate / /	Age	Occupation	Employer Address

Guarantor Name	Birthdate / /	Social Security No.

Address	City	State	Zip Code

Home Phone	Work Phone	Cell Phone

Relationship to Patient	Occupation	Employer

Emergency Contact Name	Emergency Contact Phone	Relationship

HIPAA Acknowledgements: Please check all that apply -

____ I acknowledge that a copy of the Notice Privacy Policy is available upon my request.

____ It is ok to leave a message regarding my health information at ___Home ___Cell ___No Messages

____ May we leave messages with family members? ___Yes / ___No

____ By default, no other persons may have access to my medical records except the following listed below:

Contact Name & Relationship	Phone

Contact Name & Relationship	Phone

Deemed Consent for Treatment – Release of Medical Information

Under Virginia Law, if any employee or agent of the practice is exposed to your blood or other body fluids in a manner which may transmit human immunodeficiency virus (HIV) or Hepatitis B or C viruses, you shall be deemed to have consented to testing for infectious with HIV or Hepatitis B or C viruses. In addition, you shall be deemed to have consented to the release of such test results to the person who was exposed.

Financial Agreement – Insurance Agreement

I hereby authorize treatment to patient by any Atlantic Dermatology Associates provider and/or affiliated medical staff member(s). I further authorize release of any and all medical and/or billing information as is necessary for reimbursement from the insurance carrier, Tricare or Medicare. I authorize direct payment from said insurer(s) to this practice. I accept responsibility for payment of all treatment that payor determines does not constitute as covered services, including denied claims, as well as attorney fees for any related costs or collection should such action become necessary. Atlantic Dermatology Associates, P.C. are participating providers of Medicare and Tricare and are authorized to receive benefits for any services furnished by out group of physicians. This includes all MEDIGAP policies to which your Medicare automatically crosses over.

Signature of Patient/Responsible Party	Relationship to Patient	Date

DEMOGRAPHIC VERIFICATION CHECK SHEET

FOR OFFICE USE ONLY

Dermatology Medical History

Patient: _____ Date of Birth:: ___/___/___ Today's Date: ___/___/___

Reason for today's visit: _____

Are you allergic to any medications? ☐ YES ☐ NO If yes, list below:
1. _____ 2. _____

Have you ever had dental anesthesia (Novocaine)? ☐ YES ☐ NO Any bad reaction? ☐ YES ☐ NO

List all medications you are currently taking (including prescriptions, over-the-counter meds., vitamins, and herbals):
1. _____ 3. _____ 5. _____
2. _____ 4. _____ 6. _____

Do you have now, or have you ever had diseases or conditions of: (Please check YES or NO)

Lungs:	**YES**	**NO**
Bronchitis	☐	☐
Emphysema	☐	☐
Asthma	☐	☐
Chronic Cough	☐	☐
Morning Cough	☐	☐
Shortness of Breath	☐	☐
Wheezing	☐	☐

Cardiovascular:	**YES**	**NO**
High Blood Pressure	☐	☐
Chest Pain	☐	☐
Heart Attack	☐	☐
Heart Murmur	☐	☐
Irregular Heartbeat	☐	☐
Phlebitis	☐	☐
Inflammation of vein	☐	☐
Blood clots	☐	☐
Pacemaker	☐	☐

Other Systemic:	**YES**	**NO**
Diabetes	☐	☐
Excessive thirst/hunger	☐	☐
Amputation	☐	☐
Thyroid	☐	☐
Kidney	☐	☐
Dialysis	☐	☐
Bladder	☐	☐
Frequency/burning	☐	☐
Gastrointestinal		
Stomach absorptive disorder	☐	☐
Nausea, vomiting, diarrhea when taking antibiotics	☐	☐
Yeast infection when taking antibiotics	☐	☐
Arthritis/Joint Deformity	☐	☐
Arthralgia	☐	☐
Limited motion	☐	☐
Artificial joint	☐	☐
Convulsions, Epilepsy or Seizures	☐	☐
Fainting	☐	☐

List any other diseases or conditions: _____

List surgical procedures you have had in the last 6 months: _____

Skin:
Have you ever had skin cancer? ☐ YES ☐ NO
Has anyone in your family had skin cancer? ☐ YES ☐ NO
Do you have a history of any specific skin diseases? ☐ YES ☐ NO If yes, _____
Do you have problems with healing ☐ YES ☐ NO
Do you develop keloids (scars) after surgery ☐ YES ☐ NO
Do you bleed easily? ☐ YES ☐ NO
Do you develop skin rashes in reaction to ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin ☐ Other _____

Social History:
Do you drink alcohol? ☐ YES ☐ NO If YES _____ drinks per day
Do you use IV drugs? ☐ YES ☐ NO If YES, what? _____ How often? _____
Do you smoke? ☐ YES ☐ NO If YES, how much: _____
Have you had or have you been exposed to HIV (AIDS)? ☐ YES ☐ NO

Please answer the following questions:
(Women) Are you pregnant? ☐ YES ☐ NO Due Date: ___/___/___
What is your occupation? _____ Hobbies? _____

Completed by: ☐ Patient ☐ Medical Assistant _____ Initials

_____ Signed by Patient / Parent / Guardian ___/___/___ Date

_____ Reviewed by ___/___/___ Date

Patient Name _____ **Date of Birth** ___ / ___ / ___

Primary Care Physician

Name:	
Address:	
Phone:	**Fax:**

Referring Physician

Name:	
Address:	
Phone:	**Fax:**

Health Insurance Information

Primary Insurance:

Name:		
Subscriber ID:	**Group Number:**	
Subscriber Name:	**DOB:**	**SS#:**

Secondary Insurance:

Name:		
Subscriber ID:	**Group Number:**	
Subscriber Name:	**DOB:**	**SS#:**

Preferred Pharmacy:

Name:	**Phone:**
Address:	

Preferred Lab by Insurance:

Name:

Attention

This notice is to inform you that you may have an **out patient surgery and or treatment deductible** with your insurance carrier. **Any procedure and or treatment performed** by our doctor's or one of the Medical Assistants may be applied to this deductible if it has not been met, and you may be billed for all or part of the allowed amount by your insurance carrier for this procedure. If you have met your deductible you may be billed a co insurance which is a percentage of the allowed amount by your insurance carrier

Below are the most common and/or frequently performed procedures/treatments that you may be billed for after your insurance has processed our claim for you.

Cryo-Surgery (freezing of pre-cancer, wart, molluscum, or anything else the physician deems this treatment for)

Shave or Punch biopsy (removal of all or part of a suspicious lesion, mole, wart)

Excision of any skin tissue for pathology interpretation

Cyst removal or drainage of cyst

Removal of irritated skin tag

Allergy testing of skin by patch test

All light therapy

Laser treatment for skin disorders

Any specimen that has been removed will be sent to an outside laboratory that is in network with your insurance carrier. This lab will file their own separate charges to your insurance carrier. You may receive a bill from this laboratory for their interpretation of the specimen(s). If you do receive a bill from the lab and have any questions regarding the bill please contact the number on the bottom of the statement.

If a pathology report comes back with positive results, and further treatment is needed we will file a claim with your insurance company with our charges. This is not considered a follow up to the previous removal.

By signing this form you are acknowledging you have read and accept the contents within.

Printed Name

_____

Signature

_____

Date

_____

ATLANTIC DERMATOLOGY ASSOCIATES, PC
pd/08/01/2015
Revised 01/07/16

Atlantic Dermatology Associates, PC
Office Financial Policy

Dear Patient,

Atlantic Dermatology Associates, PC would like to share the following policies with you so that you understand your responsibility regarding the charges for the services rendered to you by this office.

1. If we participate (are contracted) with a commercial insurance plan under which you are covered, we will bill the carrier for all charges for services rendered. We will bill both your primary and secondary insurance plans for contracted plans. You will be responsible at the time of service for payment of:

   a. The annual deductibles
   b. Copayments, and/or co-insurance
   c. Charges for non-covered or cosmetic services

   In the event that we are not aware of a procedure or diagnosis that is not covered by your plan, you will be billed for the charges after we obtain a denial from your insurance carrier.

2. We are Medicare participating providers. We will file with Medicare and Medigap Carriers'. You will be responsible at the time of service for payment of:

   a. The annual deductible
   b. Co-payments, and/or co-insurance
   c. Charges for no-covered or cosmetic services.

   You will be asked to sign a Waiver of Liability Form in the event that a service is provided for you which we know is not covered by Medicare.

   If you have Medicare as well as secondary coverage with a commercial plan that is not a Medigap, or is an insurance company with which we have no contract, we will file a claim to your secondary/supplemental carrier. If no payment is received from your secondary/supplemental carrier within 60 days after we file a claim, you will be sent a bill and we will be responsible for the balance.

3. Non-Medicare patients who have insurance coverage with an insurance carrier, with which we do not have a contractual relationship, please note the following:

   a. We will file both your primary and secondary insurance. If no payment is received from your primary carrier within 60 days after we file the claim, you will be billed for the entire amount. Payment is due within 10 days after receipt of statement.
   b. If you only have a primary insurance, we will file a claim with them. If we do not receive payment from your primary carrier within 60 days after we file the claim, we will bill you the entire amount. Payment is due 10 days from receipt of the statement

4. In the event that your account is turned over to our outside collection agency, you agree to reimburse us an automatic collection fee of $5.25. That will be added to the principal balance. If the account goes into intensive collection there will be an additional charge of 30% of the principal balance added to your balance.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

_____ _____/_____/_____

Patient/Parent/Guarantor Signature **Today's Date**

Revised 02/11/2016
pdean