CATSKILL DERMATOLOGY, PC

110 Bridgeville Road
Monticello, New York 12701
(845) 794-3030

1997 Route 17M
Goshen, NY 10924
(845) 294-6123

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____ Sex _____

Patient SS # _____ Marital status _____

PERMANENT ADDRESS:
Street / PO Box _____
City _____
State _____ Zip Code _____
Home Phone _____
Cell Phone _____

LOCAL / SEASONAL ADDRESS: (If applicable)
Street / PO Box _____
City _____
State _____ Zip Code _____
Local Phone _____

Employer Name & Phone # _____

I AM THE INSURANCE POLICY HOLDER? (circle one) YES No, IF NO:

Policy Holder Name _____ **Date of Birth** _____ **Relationship to patient** _____

****

PATIENTS SPOUSE or PARENT INFORMATION:

Name _____ Date of Birth _____ SSN _____

Relationship to patient _____ Address (if different than above) _____

Work Phone# _____ Employer Name & Phone # _____

PRIMARY PHYSICIAN: Please Note: If your insurance company requires a referral for specialists, you must present a referral from your Primary Doctor at the time of your visit.

Name: _____ Phone _____

Address _____

INSURANCE INFORMATION: Please Present ALL insurance cards at the front desk at the time of your visit.

Primary Insurance _____ Secondary Insurance _____

Prescription Insurance _____ Pharmacy _____

Catskill Dermatology, PC does not participate with all insurance plans. If Catskill Dermatology, PC does not accept my insurance or I have no insurance coverage, I understand that I am expected to pay in full on the day that professional services are rendered, unless other arrangements have been made in advance. If Catskill Dermatology, PC does accept my insurance, I understand that I am responsible for any amount not covered by my insurance, including deductibles and co-payments.

I hereby authorize treatment of my/my dependants medical condition by Catskill Dermatology, PC.

I hereby authorize Catskill Dermatology, PC to furnish information to my insurance plan(s) concerning my illness and treatment, and assign to the physician all payments for medical services rendered to myself and my dependants. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signed _____ **Dated** _____

PATIENT'S NAME:_____

Are you allergic to any medications? (Please list) _____

_____

Are you currently taking any medications, including over the counter medications? (Please list)

_____

_____

Have you ever been treated for any of the following? (Please circle)

Heart disease or pacemaker	yes	no	Emotional / Physical Problems	yes	no
High blood pressure	yes	no	Venereal Disease	yes	no

Have you or any blood relative had any of the following: (please circle and list family member if other than yourself)

Asthma	yes	no	_____	Diabetes	yes	no	_____
Hay Fever	yes	no	_____	Psoriasis	yes	no	_____
Hives	yes	no	_____	Skin Cancer	yes	no	_____
Eczema	yes	no	_____	Melanoma	yes	no	_____

In the last 6 months have you had an accident or operation? Yes No (If yes, please list)

_____

Have you ever been treated for a skin disorder before? Yes No (If yes, please list)

_____

Have you ever had a treatment for the skin called GRENZ RAY treatments? Yes No Don't know

I use sunscreen:	always	sometimes	never	What moisturizer do you use? _____
I smoke:	always	sometimes	never	What soap do you use? _____
I drink alcohol	always	sometimes	never	Do you take birth control pills? Yes No N/A

Are you pregnant or planning a pregnancy? Yes No N/A

In order to ensure your privacy Catskill Dermatology, PC will only discuss your medical records with you, unless written consent is granted to do otherwise. If you wish to permit other person (s) i.e.; husband, wife, parent, child, doctor, etc. to discuss your medical condition with us or to have access to your medical records, those person (s) must be listed below.

NOTE: This consent will remain in effect until changed in writing by the patient or guardian.

1._____

2._____

3._____

4._____

To the best of my knowledge, the medical information provided is correct.

Signature_____ Date_____

PATIENT BILLING & FINANCIAL INFORMATION

Health Insurance Policies (full or partial coverage)

We offer the following information to help you understand our financial policies and encourage you to ask us any questions relating to the services you may receive. Any members of our billing department will be glad to discuss payment arrangements with you or your responsible party.

Catskill Dermatology, PC participates with many insurance companies, including HMO, PPO, POS, and several local plans. It is your responsibility to make sure that we are participating with your health plan or that you have out-of network benefits. If we do not participate in your plan, payment in full is expected at each visit. We make every effort to verify your insurance coverage prior to your appointment, in order to notify you of your financial responsibility at the time of your appointment. In the event that your coverage cannot be verified prior to your appointment you will be responsible to pay for any services administered at the time you are seen.

Catskill Dermatology, PC will file your insurance claim for you. Therefore, at the time you check in, you will be asked to present your health insurance card so we may retain a copy for our records. If your policy requires, it will be your responsibility to make sure a referral from your primary care physician is obtained prior to your appointment. If you do not have a referral you may reschedule your appointment or contact your doctor from our office. However, you will not be seen until your referral has been received in our office.

If your insurance company declines to cover the services provided or pays less than the actual cost, you will be responsible for any remaining balance that your coverage deems your responsibility. All co-payments and deductibles are due at the time services are rendered. A $25 surcharge will be added to your account if your co-payment is not paid at the time of your appointment. If you pay by check and your bank returns your check you will be charged a $25 fee and/or a $35 fee for any payments written on a closed account.

Summary: You may be responsible for a bill if:

- You have a deductible that has not been met at the time services are rendered. Please keep in mind that some insurance plans have a separate surgical and/or pathology deductible which is not included in your annual medical deductible.
- The service is not a covered service under your plan
- Your insurance company deems the services to be not medically necessary
- Your plan requires you to pay a co-insurance on any services rendered

By signing this document you acknowledge that you have read the above information regarding our billing policies.

_____ _____

Patient Signature Date

PAYMENT METHOD FOR DEDUCTIBLES AND CO INSURANCE

To Our Patients:

If you choose to give a credit card number. This information will be held securely according to privacy laws, until your insurances have paid their portion and notified us of the amount you are responsible for. At that time, any remaining balance owed, that you did not pay at the time of service, will be charged to your credit card, and a copy of the charge will be mailed to you.

This will be an advantage to you, since you will no longer have to write out and pay postage to mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of healthcare down. This will no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you would rather not pay the deductible, co insurance or Medicare's 20% fees until after we bill your insurance company, we will be happy to bill your credit card, after your insurance company has paid its share, as stated above.

****Co-pays are always due at the time of the visit.** ***

According to your Insurance Co., your plan has a deductible of $_____. As of today's date, you have met $_____. Your plan also has a coinsurance of_____. .

***If you choose not to give us a credit card number, we will in fact then expect you to pay deductibles, etc at the time of your visit. If your responsibility differs after the claim is processed, you may get a refund or be billed the additional fees.**

We will gladly accept cash, check, or credit/debit cards.

****PLEASE FILL IN CREDIT CARD INFO* "OR" *CHECK LINE BELOW ****

_____ **I understand that if I do not wish to provide a credit card number, and my insurance requires me to pay towards deductibles or co insurance that I will be responsible to pay on the date service is rendered. (Please sign below)** ****OR****

I authorize Catskill Dermatology, PC to charge outstanding balances on my account to the following credit card:

. Visa MasterCard Discover

Account Number_____ExpirationDate_____

Name on card(please print)_____Security code_____

_____ I would like a courtesy phone call stating the amount that will be charged to my card on the day it is charged.

Signature_____**Date**_____

(SIGNATURE IS REQUIRED ON BOTH SIDES OF THIS FORM)