

Dermatology Professionals, PA

Account# _____

13359 Isle Drive, Suite 3, Baxter, MN 56425

(This information is necessary for our files and will be considered confidential)

Provider- PBL NTM BRW

PATIENT'S FULL NAME _____ GENDER: __M __F

DATE OF BIRTH _____ MARITAL STATUS: __S __M __W __D

SOCIAL SECURITY #: _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

RACE: __ASIAN __BLACK __CAUCASIAN __HISPANIC __NATIVE AMERICAN __OTHER

ETHNICITY: __NON-HISPANIC __HISPANIC PREFERRED LANGUAGE: _____

HOME PHONE #: _____ CELL PHONE #: _____

PLACE OF EMPLOYMENT: _____ WORK PHONE #: _____

PREFERRED PHONE # TO CONTACT YOU: __HOME __CELL __WORK

EMERGENCY CONTACT:

NAME _____ RELATIONSHIP _____ PHONE NUMBER: _____

I hereby assign payment of authorized medical benefits to include major medical benefits to which I am entitled; to be made on my behalf to Dermatology Professionals, PA for any services furnished me by that practitioner. I authorize release of medical information needed to determine these benefits payable to related services. I understand that I am financially responsible for all charges whether or not paid by said insurance. This facility does not deny any benefits or service because of race, color, national origin, age gender, disability, religious or political beliefs. If you feel you have been discriminated against, you may file a Complaint of Discrimination with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

In addition, I agree to pay any additional charges related to the cost of collection (including but not limited to, collection agency fees, reasonable attorney fees and court costs), in the event that I would fail to pay my bill.

Signature _____ **Date** _____

NAME OF INSURANCE _____

ID # _____ GROUP # _____

POLICY HOLDER

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

NAME OF INSURANCE _____

ID # _____ GROUP # _____

NAME _____ DOB _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

RELATIONSHIP TO PATIENT _____

Dermatology Professionals, PA
13359 Isle Drive, Suite 3, Baxter, MN 56425

**AUTHORIZATION FOR RELEASE OF INFORMATION
AND FINANCIAL RESPONSIBILITY**

RECORD RELEASE: I authorize Dermatology Professionals, PA to release medical information about me to my insurance carriers, the Social Security Administration or its intermediaries/carriers, Centers for Medicare & Medicaid Services (CMS) and its agents for purposes of payment, and to referring physicians and other providers involved in my care.

_____ **Initial**

PHOTOGRAPHS: I hereby give permission to my provider or any assistant designated, to take photographs to enhance the medical record and for diagnostic purposes. I understand that they may show them to other health professionals to help with my skin care and for educational purposes for their patients.

_____ **Initial**

ASSIGNMENT OF BENEFITS: I authorize payment of Medical/Medicare benefits to Dermatology Professionals, PA for any services furnished by this clinic to me. I understand that I am financially responsible for charges not covered by Medicare and/or my insurance carriers. This authorization also covers charges generated by Dermatology Professionals, PA and their physicians for services received at St. Joseph's Medical Center or other medical facilities.

_____ **Initial**

PRIVACY PRACTICE: I hereby acknowledge that I have been offered a copy of the Dermatology Professionals, PA Notice of Privacy Practices.

_____ **Initial**

FINANCIAL POLICY: I hereby acknowledge that I have been offered a copy of the Dermatology Professionals, PA Financial Policy.

_____ **Initial**

I permit a copy of this authorization to be used in place of the original.

SIGNATURE _____ DATE _____

(Relationship if patient is a minor: _____)

Minor Contact Information

Patient Name: _____ DOB: _____

Mother's Name: _____ DOB: _____

Address: _____

Daytime Phone: _____ Cell Phone: _____

Father's Name: _____ DOB: _____

Address: _____

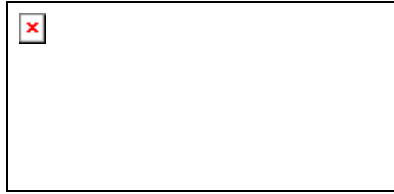
Daytime Phone: _____ Cell Phone: _____

Emergency Contact (other than parent): _____

Relationship to minor: _____ Phone #: _____

Emergency Contact (other than parent): _____

Relationship to minor: _____ Phone #: _____



Health History

PBL NTM BRW Name _____ Account _____

Height _____ Weight _____

Do you drink? Yes or No Do you use any drugs? Yes or No
Do you smoke? Yes or No If yes, how much daily? _____

Have you ever had skin cancer? Yes or No If yes, what kind? _____

Has anyone in your family ever had skin cancer? Yes or No If yes, who had skin cancer and what kind of skin cancer? _____

Who is your primary Doctor? _____

Do you have any history of a skin disease? Yes or No If yes, what kind?

Have you ever been exposed to HIV (AIDS)? Yes or No

Do you have any artificial joints? Yes or No

Have you ever had Novocain? Yes or No

Do you bleed easily? Yes or No

Do you have any allergies to medications? Yes or No If yes, which ones?

Are you married? Yes or No

Do you have any children? Yes or No If yes, how many? _____

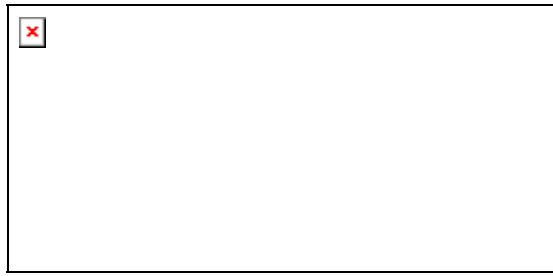
(Women) Are you pregnant? Yes or No

What type of work do you do? _____ Race _____

Have you ever had surgery? Yes or No If yes, for what ?

Are you on any medications? Yes or No If yes, which ones?

Do you have any chronic medical condition (ie diabetes, high blood pressure, thyroid, asthma, hay fever, allergies, pacemaker)? Yes or No If yes, what ?



Financial Policy

This is an agreement between Dermatology Professionals, PA, as creditor, and the patient/debtor named on this form. In this agreement, the words “you,” “your,” and “yours” mean the patient/debtor. The word “account” means the account that has been established in your name to which charges are made and payments credited. The words “we,” “us,” and “our” refer to Dermatology Professionals, PA.

By executing this agreement, you are agreeing to pay for all services that are received.

Benefits:

- It is patient responsibility to verify any and all coverage, eligibility, and benefit levels per their individual insurance policy(s). We are unable to quote any benefits and/or allowed amounts for your visit. Please contact your insurance company directly with any policy concerns.

Policy for patients with contracted insurance companies:

- If we are contracted with your insurance company, we must follow our contract and their requirements.
- Any co-pays required by your insurance company must be paid at the time of service. This is an insurance requirement per your policy.
- It is the insurance company that makes the final determination of your eligibility.
- If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral may result in a lower payment from your insurance company.
- You agree to pay any portion not covered by your insurance.
- We are currently contracted with the following insurance companies: BCBS MN and its affiliates, Cigna, Medica (including Select Care, Labor Care, and United Healthcare), Medicare and Medicare Replacement plans, Minnesota Medical Assistance, Ucare, Preferred One and its affiliates, and Health Partners.

Policy for patients with non-contracted insurance companies:

- Insurance is a contract between you and your insurance company. We are NOT a party to this contract. We will submit your charges as a courtesy to you.
- Any co-pays required by your insurance company must be paid at the time of service. This is an insurance requirement per your policy.
- It is the insurance company that makes the final determination of your eligibility.
- If your insurance company requires a referral, you are responsible for obtaining it. Failure to obtain a referral may result in a lower payment from your insurance company.
- You agree to pay any portion not covered by your insurance.

Policy for Cosmetic Procedures:

- Payment in full is required on the date of service. No same day discount applies as cosmetic procedures are already set at a discounted rate.
- Payment types accepted are: cash, check, Visa, MasterCard, or Discover

Statements:

- You will receive a statement on any remaining balance directly after we receive notification from your insurance company.
- BALANCE IN FULL is due upon receipt of statement.
- Payment options include: cash, check, Visa, MasterCard, Discover.

Returned Checks:

- Any checks returned by your financial institution will be assessed a fee of \$25.00.

Past due accounts:

- If your account becomes past due, we will take any and all necessary steps to collect this debt. If we refer your account to an outside collection agency, all future correspondence regarding that debt will need to be made directly through the collection agency.
- We reserve the right to cancel your privileges to make charges against your account at any time due to delinquent balances.
- If a balance remains unpaid, any future care you may need by our office could be affected.

Waiver of confidentiality:

- You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Effective Date:

- Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Dermatology Professionals, PA
13359 Isle Drive, Suite 3, Baxter, MN 56425

**THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS
INFORMATION. PLEASE REVIEW IT CAREFULLY.**

1. Dermatology Professionals, PA is permitted to make uses and disclosures of **protected health information** (PHI) for treatment, payment, and health care operations, as described in the following examples:
 - a. For treatment – (e.g., to discuss your PHI with other healthcare providers)
 - b. For payment – (e.g., to submit information to your insurance company)
 - c. For health care operations – (e.g., to send the minimum necessary of your PHI to other healthcare providers as appropriate)
2. Dermatology Professionals, PA is permitted or required, under specific circumstances, to use or disclose protected health information without the individual's written authorization. Minnesota state law, when more stringent than federal law, will be followed.
3. Other uses and disclosures will be made only with the individual's written authorization, and the individual may revoke such authorization.
4. Dermatology Professionals, PA may contact the individual to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual or patient.
5. The individual has the following rights regarding protected health information:
 - a. The right to request restrictions on certain uses and disclosures of protected health information. Dermatology Professionals, PA is not required to agree to a requested restriction, however.
 - b. The right to receive confidential communications of protected health information, as applicable.
 - c. The right to inspect and copy protected health information, as provided in the Privacy Regulation.
 - d. The right to amend protected health information, as provided in the Privacy Regulation.
 - e. The right to receive an accounting of disclosures of protected health information.
 - f. The right to obtain a paper copy of the Notice from the covered entity upon request. This right extends to an individual who has agreed to receive the Notice electronically.

6. Dermatology Professionals, PA is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information.
7. Dermatology Professionals, PA is required to abide by the terms of the Notice currently in effect.
8. Dermatology Professionals, PA reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains.
9. Dermatology Professionals, PA will provide individuals or patients with a revised Notice on request in person or by mail after an official public notification in the Brainerd Daily Dispatch.
10. Individuals may complain to Dermatology Professionals, PA and to the Secretary of the Department of Health and Human Services, without fear of retaliation by the organization, if they believe their privacy rights have been violated by calling or writing and requesting a complaint form.
11. Dermatology Professionals, PA contact person for matters relating to complaints is:

Call:

Privacy Officer @ 218-454-7546

Or **Write** to:

Dermatology Professionals, PA
13359 Isle Drive, Suite 3
Baxter, MN 56425

12. This Notice is first in effect on 12/1/2007.