Dermatology and Skin Cancer Institute Registration Form (Revised 03/08/2022)

Patient Name: _____ Marital Status: □ single □ divorced □ married □ widow

Date of birth: _____ Age: _____ Sex (Circle one): Male - Female - Other _____

Language Preference: □ English □ Spanish □ Other: _____ **Race**: □ White □ American Indian/Alaskan Native
□ Asian or Asian American □ Black / African American □ Hawaiian or Pacific Islander □ Other: _____
Ethnicity: □ Hispanic or Latino □ NOT Hispanic or Latino

Home Phone: _____ Cell Phone: _____ Work:_____

Emergency contact: _____

Emergency contact's phone #: _____ Emergency Person (Circle One): Friend - Spouse - Child

Preferred Contact Method? Circle One: Home Phone or Mobile Phone

Is it okay to leave a detailed message on your voicemail? Yes or No

Email Address: _____

Address: _____

Release my PHI Authorization Information to: _____ Relationship: _____

Insurance Subscriber's Name _____ **Subscriber's date of birth**_____(required)
Relationship to Patient: Circle one: Self Spouse Child Other _____

Pharmacy Information Pharmacy Name: _____ Phone Number: _____

Pharmacy Address: (Be sure it is correct address) _____

Receipt of Notice of Privacy Practices Written Acknowledgement

I acknowledge that a copy of the current notice is posted in the reception area at front desk for me to review any time.

How did you hear about us? Circle One: Friend Colleague Facebook Internet

Primary Care Doctor Name: _____ ****FAX:** _____

Surgery Patients: Referring Dermatologist or Other Doctor to whom you would like surgical records sent:

Doctor Name_____ ****FAX:** _____

Signature for Office Policies/Financial Policy/Authorization to Pay

I have read the document regarding DSCI Office Policies, Financial Policy and Authorization to Pay / Release Medical records in cooperation with my insurance company. I am aware that copies of this document available upon request or can be downloaded from the DSCI website: www.361derm.com

_____ _____ _____

Signature of Patient or Responsible Party **Printed Name if other than Patient** **Date**

Dermatology and Skin Cancer Institute

455 W. Pennsylvania Avenue, Ste 127
Fort Washington, PA 19034
P: 215.793.9755

1240 S. Broad Street, Ste 200
Lansdale, PA 19446
P: 215.361.3376

Financial and Other Office Policies (rev 06/10/2021)

Patient Name: _____ Date: _____

Thank you for choosing The Dermatology and Skin Cancer Institute for your skin care needs. We are committed to providing you with the best possible care. In an effort to ensure your visit and the billing process goes as smoothly as possible it is important that you understand our office policies. We are happy to discuss any questions you may have.

Dermatology and Skin Cancer Institute Office Financial Policy

All patients are required to complete our patient information registration form. ***At each visit, please let us know if you have any changes to your address, phone, driver's license, insurance information, and/or credit card information. It is your responsibility to alert our staff should your coverage change from your last visit or be discontinued. If we do not participate with your insurance, you will be billed at self-pay rates.*** If you cannot provide current health insurance information at the time of your visit you will be responsible for payment in full at the time of the visit. As a courtesy, insurance claim forms will be prepared and sent to your insurance company on your behalf. Please be advised that the contract between you and your insurance company is a separate contract from that between you and our clinic.

If you are uncertain if a procedure is covered, please contact your carrier prior to your appointment to find out. As hard as we try, it is impossible for us to know every detail and nuance about each insurance company, about each insurance plan's coverage, benefits, and/or eligibility, and about the changes in coverage the insurance companies make daily. As such, we apologize, but we are not able to waive charges that your insurance company does not cover or payments that they retract later. ***It is your responsibility to be knowledgeable about your own insurance coverage/benefits/eligibility.***

Co-pays are required at the time of each visit prior to being seen. Some HMOs require referrals. You are responsible for obtaining your own referral prior to your appointment with us. We can retrieve electronic referrals, but if your insurance requires a paper referral, you are responsible for picking the referral up from your doctor and bringing it with you to your appointment. ***If you are seen in the office without a referral, you will be billed at self-pay rates which you will be responsible for in full.***

For any reason if your insurance company does not pay for any or all of your visit, or if your insurance company retracts the payment at any time, you will be responsible for payment in full.

DSCI requires our patients to provide a valid credit card to be stored by our credit card processor under secure (SSL) protocol. With your authorization below, **we will charge your credit card for any balance due, per the Summary Statement below, once your insurance company has paid their portion of your covered charges. This includes your deductible, co-insurance, additional co-pay, and/or any non-covered charges. A receipt of this payment will be emailed to you. Please be aware that the balance on your account is your responsibility.** If you do not have insurance or your insurance does not cover the services rendered, payment is expected in full at the time of service. Payment will be due **prior** to procedure. If this is a financial hardship, payment arrangements can be made. Credit Cards are accepted by our practice as a convenience to you. As part of the Fair Credit Billing Act, patients of the practice agree to not submit dispute charge requests with their credit card company or banking facility without making a good-faith effort to resolve a problem with the practice. Personal checks are accepted as well; **personal checks that are returned for non-sufficient funds are subject to an administrative fee of $35.**

All sales are final. We do not offer refunds or exchanges for products or services. Rewards points have no cash value and may not be transferred or combined. Performance of any cosmetic treatments or procedures is at the sole discretion of our medical staff. If you are not an appropriate candidate for a procedure you have purchased, the purchase amount may be applied towards another treatment or products that are available on our store.

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DSCI does not provide outpatient services for Medicaid patients. Services to Medicaid patients are available on a limited inpatient basis at Abington Hospital Clinic only.

Appointment Cancellation / "No-Show" Policy

We kindly request at least 24 hours' notice when cancelling or rescheduling your appointment. Due to the Covid-19 Pandemic, the volume of patients we can see has steeply declined to maintain safe social distancing and cleaning protocols. Appointment availability is very limited, and a no-show for your appointment takes away from a patient desperately waiting to see us. As such, we have made the decision to implement a no-show fee of $50 for ANY missed appointment to our office with less than 24 hours notice.

Medication Refill Requests (rev 06/04/2021)

Refills may be called in during regular office hours. Please have the following information available when you call one in: patient's name, date of birth, phone number, name of medication, strength and dosage, and the pharmacy you want it called in to. Please make sure we have your complete pharmacy information including name, complete address and telephone number.

Please allow 48 business hours for medication to be called in to your pharmacy.
DSCI does not refill prescriptions after business hours, weekends, or on holidays.

- Plan ahead: You should contact our office three (3) days before your medication is due to run out. However, if you are using a mail order company; please contact us fourteen (14) days before your medication is due to run out.
- Be patient: some medications require prior authorizations. The extra paperwork required from your insurance company may take days to process and may delay your needed medication. Please anticipate a 7-to-10-day approval process.
- Any refill request will require a review of your medical records, etc. Certain medications require mandatory laboratory testing before they can be refilled. If you do not have up-to-date laboratory testing, this may delay your request until the appropriate testing is completed.
- We will not refill any medications that were prescribed by other physicians. Refills on medications will only be authorized for medications prescribed by our providers in our office.
- **Please keep your follow-up appointments. It is our office policy not to authorize refills if you have missed your appointments or fail to keep your scheduled recommended visits.**

Policy for oral, certain topical, injectable, or monitored medications:
A follow-up visit will be required at minimum every 3-6 months to verify medication efficacy

Policy for other topical medications:
A follow-up visit will be required at minimum every 12 months to verify medication efficacy

We appreciate positive reviews online!
We kindly request that our patients direct any concerns or constructive feedback to the attention of our office manager via phone or email patientservices@361derm.com. We make every effort to ensure the finest delivery of care and customer service.

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FINANCIAL and OTHER OFFICE POLICIES - SUMMARY STATEMENT FOR SIGNATURE (6/10/2021)

I have read and understand the DSCI Office Policies including the Financial Policy and agree to be bound by its terms.

I understand I will be charged a $50 non-refundable admin fee if I no-show or cancel with less than 24 hours' notice.

I have read and understand the DSCI document "Important Information to understand regarding Insurance Policies."

I have read and understand the Medication Refill Request Policy

I have had an opportunity to read the office's Notice of Privacy Practices. I acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice at each appointment. I am aware that copies of this document available upon request or can be downloaded from our website: www.361derm.com

I understand that accounts with unpaid balances after 60 days may be forwarded to a collection agency or District Court.

I accept responsibility for any co-pay due. I understand the co-pay is NOT-REFUNDABLE once I have been evaluated by a provider.

I accept responsibility for any deductibles, co-insurance amounts, and the full cost of non-covered services.

I understand if my insurance company does not pay for any or all of my visit, or if my insurance company retracts the payment at any time, I will be responsible for payment in full.

I understand that I am required to keep a credit card on file with the practice.

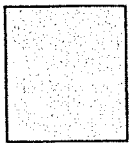
***If my responsibility amount, as determined by my insurance carrier after they have processed the claim, is less than $75, I hereby give permission to DSCI to automatically charge my credit card on file and email me a copy of the processed claim information and a receipt.**

***I understand DSCI will send at least (1) one statement for any balance over $75 prior to charging my credit card. Thereafter, I authorize DSCI to charge my credit card on file for the amount owed up to $500. Should the amount owed exceed $500, the card will be charged for the remainder the following month.**

Authorization to Pay / Authorization to release medical records: I request that payment of authorized Medicare and/or Insurance benefits be paid directly to Dermatology & Cosmetic Surgery Institute, PC. I permit a copy of this authorization to be used in place of the original. I authorize the release to the Social Security Administration, Centers for Medicare and Medicaid Services or its intermediaries, or to my medical insurance carriers any information regarding this or related claims. Additionally, if I have "Medigap" / Secondary Insurance coverage, I request benefits be paid on my behalf for any services furnished. I authorize the Dermatology and Skin Cancer Institute to release to my "Medigap" carrier information needed to determine my benefits.

Signature of patient or responsible party	Printed name if other than patient	Date

DSCI ADMINSTRATOR SECTION ONLY



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DSCI - Important Information to understand regarding Insurance Policies (rev 06/10/2021

What is a referral?
A referral is an important process in your medical care. When you join an HMO, the primary care physician (PCP) you select will coordinate ("refer") your care to a specialist (Dermatologist) to ensure you get the most appropriate care. Your insurance carrier mandates that you get this referral from your PCP. Please contact your PCP within three (3) business days of your appointment in our office to determine if they issued you the referral. Without a referral, we will have to reschedule the appointment.

What is a co-pay and co-insurance?
A ***co-pay*** is the amount you have to pay to access medical care according to your insurance contract. In some cases, it might be $10-$80 but with some insurances, it would be a percentage of your bill (10-20% is common). **Once you have been evaluated by a provider in the practice, your co-pay is NOT REFUNDABLE.** ***Co-insurance*** is the remaining balance after the insurance company has paid their portion. With the new Medicare products being offered by commercial insurance companies, some Medicare patients do have a co-pay as well as their co-insurance to pay.

What is a deductible?
A deductible is the amount of money that a patient must pay out of pocket before the insurance company is responsible for any charges. The average deductible ranges from $100 to $3000 and once this is met by patient the insurance company will begin to pay for covered charges. **There is no way for us to know how much your deductible is since there are so many different insurance plans in existence.** Every medical service in this office will generate a charge, so if you are concerned that you will have to pay out of pocket, please contact your insurance company prior to having a procedure done. Medicare patients are responsible for their deductible at the beginning of each year.

Why do I have to pay my co-pay and/or deductible?
When you sign up with an insurance carrier, you sign a contract which stipulates that you are obligated under the conditions of that contract to pay your co-pay, co-insurance, and/or deductibles. This means you are required to pay a co-pay, co-insurance, and/or deductible for all office visits, including follow-up examinations and outpatient surgical procedures done in our office. If you do not meet this obligation, your insurance company has the right to deny the charges which would leave you responsible for the entire cost of the services rendered during your visit.

Please note: Depending on your insurance, you may receive bills from outside laboratory companies (i.e. Quest laboratory, pathology companies, etc...). If you receive a bill from an outside company, please call that company's phone number and speak to their representative regarding the matter.

Why can't you just "write off" my co-pay and/or deductible?
Since your insurance contract stipulates that you must pay a co-pay and/or deductible, waiving this fee would violate your contract. When we signed up with your insurance company our contract states we will collect co-pays and/or deductibles owed by the patient. If the doctor gives you a "discount" by waiving your co-pay and/or deductible and then bills the insurance company without giving them the same "discount", it is considered insurance fraud.

Why do you collect the co-pay instead of billing me like my last doctor?
It is much more efficient to collect the co-pay at the time of service. Otherwise, it becomes more difficult and expensive to deal with administratively. This policy is non-negotiable.

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Advance Beneficiary Notice of Noncoverage (ABN) (rev 9/5/19)

If Medicare or your personal insurance doesn't pay for the treatment listed in box D. you will have to pay in full. Medicare and many commercial insurance companies do not pay for everything, even some treatments that you or your health provider have good reason to think you need. We expect Medicare and many commercial insurance companies may not pay for the treatment listed in box D. below:

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost (Circle One)
Destruction of the following BENIGN lesions: o Irritated Seborrheic Keratoses o Seborrheic Keratoses o Irritated Skin Tags o Skin Tags o Sebaceous Hyperplasia o Cherry Angiomas o Lentigos o Dermatofibroma o Other: _____	The lesions are benign, not malignant, so Medicare or any commercial insurance company may not deem the procedure medically necessary, and thus, may not pay for the procedure	$125 (up to 15 lesions) $150 (16-20 lesions, includes first 15)

What you need to do now:

- Read this notice and ask any questions you may have so you can make an informed decision about your care.
- Choose an option below about whether to receive the treatment listed in box D. above.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the treatment in box D. listed above. I understand I am required to pay the office fee today, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles. This option only pertains to Medicare patients.

☐ **OPTION 2.** I want the treatment in box D. listed above, but do not bill Medicare / my insurance. I understand I am required to pay the office fee today as I am now responsible for payment. **I cannot appeal this payment since Medicare/ my insurance is NOT billed.**

☐ **OPTION 3.** I don't want the treatment in box D. listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare or my insurance would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare/insurance decision. If you have other questions on this notice or to request this publication in an alternate format, call **1-800-MEDICARE** (1-800-633-4227/TTY: 1-877-486-2048). Signing below means that you have received and understand this notice. You can also receive a copy upon request.

I. Signature:	J. Date:

Dermatology and Skin Cancer Institute Intake Form (rev 5/27/20)

PATIENT NAME: _____ DOB: _____ DATE: _____

Past Medical History: (please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial Fibrillation
BPH (Large Prostate)
Bone Marrow Transplant
Breast Cancer
Crohns Disease
Colon Cancer
COPD
Coronary Artery Heart Disease
Depression
Diabetes (Type I, Type II, Gest, Pre-)
Diverticulitis
End Stage Kidney Disease
Endometriosis
Epilepsy
GERD(Reflux)
Hearing Loss
Heart Attack
Hepatitis A B C
High Blood Pressure
HIV/Aids
High Cholesterol
Hyperthyroidism
Hypothyroidism
Leukemia
Low Blood Pressure
Low Cholesterol
Lung Cancer
Lupus
Lymphoma
Malignant Tumor/location:_____
Multiple Sclerosis
Prostate Cancer
Radiation Treatment
Seizures
Stroke/mini-stroke/TIA/MI
Blood Clots
Pulmonary Embolism
Tuberculosis

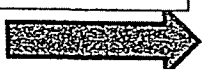
Past Surgical History: (please circle all that apply)

Appendix Removed
Bladder Removed
Breast Biopsy
Breast Mastectomy (Right/Left)
Breast Lumpectomy (Right Left)
Breast Reduction/Implants
Colon Removal
Gallbladder Removed
Coronary Artery Bypass Heart Surgery
PTCA/Heart Stents
Valve Replacement (Biological/Mechanical)
Ovaries Removed
Portosystemic Shunts (PSS)
Prostate Removed
Testicles Removed (Right/Left)
Heart Transplant
Hysterectomy
Joint Replacement Knee(Right/Left)
Joint Replacement Hip(Right/Left)
Joint Replacement with last 2 years
Joint Surgery(Non-Replacement)
Kidney Removed(Right/Left)
Kidney Stone Removed
Kidney Transplant
Liver Transplant
Low Anterior Resection (LAR)
Pancreas Removed
Prostate Biopsy
Spleen Removed
Tubal Ligation

Skin: Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma

Skin Disease History: (circle all that apply)

Acne
Actinic Keratoses (pre-cancer)
Asthma
Basal Cell Skin Cancer
Blistering Sunburns
Dry Skin
Eczema
Flaking or Itchy Scalp
Hay Fever / Allergies
Melanoma
Poison Ivy
Precancerous Moles
Psoriasis
Rosacea
Squamous Cell Skin Cancer
Fever Blisters / Cold Sores
Other:_____



Dermatology and Skin Cancer Institute Intake Form (rev 5/27/20)

PATIENT NAME: _____ DOB: _____ DATE: _____

Medications – Include Aspirin, Herbal Supplements, and Vitamins (If you have a list, we will copy it)

Name	Dose	Frequency	Notes

Allergies to Medications: _____

_____

Circle your response:

Do you wear Sunscreen: Yes No If Yes, what SPF are you using? _____

Do you tan in a tanning salon: Yes No

Do you have a family history of Melanoma? Yes No If Yes, which relative(s)_____

Do you smoke? Daily Occasional Never Former Smoker Quit _____

Alcohol: None # drinks per day_____ Recreational Drug Use: Yes No

Occupation: _____ Retired: Yes No

Family History of Other Skin Cancer? Yes No If Yes, which relative(s)_____

Do you currently have? Or, do you have a history of the following: Circle Yes or No

Changing mole(s) Yes No	Problems w bleeding Yes No	Allergy to adhesive Yes No
Rash Yes No	Pacemaker Yes No	Allery to latex Yes No
Fever or Chills Yes No	Defibrillator Yes No	Allergy to lidocaine Yes No
Problems with healing Yes No	Organ Transplantation Yes No	Allergy to Clindamycin Yes No
Yeast infections with antibiotics Yes No	Pre-medicate for dental procedures Yes No	Allergy to topical antibiotics Yes No
GI/stomach problems with antibiotics Yes No	Immunosuppression Yes No	Pregnant or Planning pregnancy Yes No
History of fainting Yes No	Aspirin, Fish Oil, Vit E Yes No	Blood Thinners Yes No
Problems with scarring (hypertrophic or keloid) Yes No	Breastfeeding/Nursing Yes No	Rapid Heartbeat with Epinephrine Yes No
History of Melanoma In-Situ Yes No	History of Squamous Cell Carcinoma Yes No	
History of Melanoma Yes No	History of Basal Cell Yes No	