image Dermatology P.C (Rev. 9/2021)

PATIENT INFORMATION: **Date: _____**

Driver License Number: (REQUIRED)_____

Name: Last_____First_____Middle_____

Address_____ Apt #_____ **City, State, _____**

Zip_____ **Sex**: ☐M ☐F **Martial Status**: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Primary Number: _____ Work _____ Ext_____

Cell Phone_____ **Email**_____

Social Security# (REQUIRED)_____Birthdate_____ /_____ /_____

Occupation _____ **Employer**_____

Referred by _____

Your Physician _____ **Phone #_( ) _____-_____**

Your Pharmacy _____ Phone # ( ) _____-_____

PRIMARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: _____ ID# _____Group _____

Policy Holder's Name:_____ **Birth date of Subscriber:** _____ /_____ /_____

Claim Mailing Address _____ Relation to patient: ☐ SELF, ☐ SPOUSE, ☐ DEPENDENT, ☐ PARENT

SECONDARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: _____ID#_____Group _____

Policy Holder's Name:_____ **Birth date of Subscriber:** _____ /_____ /_____

Claim Mailing Address _____**Relation to patient**: ☐ SELF, ☐ SPOUSE, ☐ DEPENDENT, ☐ PARENT

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian:

I certify that the information that I have provided is correct. I hereby assign to image Dermatology, PC, any insurance or third party payments for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Patient Signature:_____ Date:_____

Person Responsible for Payment:

First Name: _____Initial:_____ Last Name:_____

Address:_____ Apt:_____ City:_____

State:_____ Zip: _____Home Phone: (_____)_____ -_____ Cell Phone: (_____) _____-_____

Relationship to patient: _____Date of Birth: _____ /____ /_____ SS#:_____

I authorize the release my records to any referring physician or appropriate insurance company and medical information acquired in the course of my examination or treatment. If this account is referred to a collection agency for nonpayment, there will be an additional 30% fee added to the outstanding balance**. (I agree to pay a $50.00 cancellation fee if I cancel or do not show up for my appointment with less than 48 hours notice.)**

Signature of Patient or Responsible Party:_____

image Dermatology PC ®
51 Park Street
Montclair, NJ 07042

CREDIT CARD AUTHORIZATION
THIS FORM IS MANDATORY

To our patients,

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card to pay your bill. This is an advantage for everyone because it makes checkout easier and faster, and more efficient.

We have implemented a similar policy. You will be asked for your credit card information. Once the claim is process through your insurance. If any balances are due for example copayments/copay difference, co-insurance, deductibles. You will receive one statement. If no payments or correspondence from you, then we will charge your credit card on file. A copy of the charge will be mailed to your address. Additionally, in the event you are delinquent in timely paying an overdue balance, we reserve the right to charge that amount on your credit card as well. We also request that you provide us with updated credit card information anytime that is warranted (card expires etc.).

Handling small balances in this manner is advantageous for both patients and our practice.

This in no way will compromise your ability to dispute a charge or question your insurance company's payment determination. Co-pays remain due at the time of the visit. If you have a question for us, you may call the office or our billers at 888-382-3327.

Same Day/Cancellations of appointments/no-show

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 48 hours in advance to cancel your appointment. If for any reason, you need to cancel an appointment, please notify our office as a soon as possible. On any no-show occurrence, except emergencies and snow there will be a $50 charge to your account. Similarly, should you be scheduled for surgery your fees for a no-show will exceed $100. Depending on time allotted.

For a NO/SHOW MISSED SURGERY appointment there will be a $100 or more charged to your account.

I accept and agree that Image Dermatology P.C. can charge outstanding balances on my account to the credit card below. I acknowledge that I have had an opportunity to ask questions about this process.

Circle Credit Card Type: ☐ Amex ☐ Mastercard ☐ Visa ☐ Discover

Other HSA (Health Spending Account)/ Flex Spending: _____

Credit Card#_____ **Exp. Date**:_____

Security code_____ **NOTE: AMEX IS A 4 DIGIT CODE ON THE FRONT OF THE CARD.**

Name on card (please print):_____

Signature of cardholder:_____

Date: _____

If the above information of the card holder is different from the patient, please include billing address.

Revised: 9/2021

image Dermatology P.C.®

Patient Name: _____ Date of Birth: _____

_____
Initials

Co-payments/Deductibles/Co-insurance: Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances owing that are past due and you hereby authorize the release of necessary information for us to initiate collections proceedings. I further acknowledge that I am responsible for the coinsurance and/or deductible under my health plan's agreement and should image Dermatology P.C. be required to send me to a collection agency, I shall be responsible for the greater of a 30% collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy. I hereby guarantee payment in full to image Dermatology P.C. for all charges for services rendered and/or charges exceeding third-party payments (except when prohibited by law or under contract). I also authorize image Dermatology P.C. to release to government agencies, insurance carriers and others (including independent utilization review organizations), who may be financially liable for the services, all information necessary to pre-authorize services, determine medical necessity and/or the extent or amount of liability and to challenge denials of medical necessity. I hereby assign all amounts payable for services rendered to image dermatology P.C. I understand that this constitutes a waiver of confidentiality and that this authorization is revocable except to the extent that action has been taken in reliance thereon and will otherwise remain in force indefinitely in order to effectuate the purposes for which it is given. I understand that image Dermatology routinely collects credit card information so that any insurance balance can be paid for immediately.

_____
Initials

Referrals: If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, image Dermatology P.C. will reschedule my appointment. If we accept your insurance, and a referral is required, the referral must be presented prior to your being seen as a patient. If you elect to be seen without having the required referral, then you are required to pay for the treatment in full at the end of the treatment visit. It is also important to note that health insurance does not pay for any cosmetic procedures.

_____
Initials

Insurance Cards: All patients new and returning are required to present their insurance card(s) at every visit. **I** understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

_____
Initials

Cancellation Policy: Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact our office within 48 hours of the appointment will result in a $50.00 no-show fee. This fee is not reimbursable by your insurance company. We will process credit card on file.

_____
Initials

HIPAA Policy: All patients are protected under the Federal **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct. This federal law prohibits any staff member of image Dermatology P.C.® from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient, except as provided above. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition, obtain results or make appointments for you, please list their name(s) below.

Only individual names listed below will be provided with information. Should you wish to update the names provided, please ask the patient service representative at the front desk for a new HIPAA form.

Please name the person you authorize to inquire about your medical records

_____	_____	_____
Person you authorize (please print)	Relationship to Patient	Phone number

Acknowledgement: I acknowledge that a copy of image Dermatology P.C.'s Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 is available for review upon request. I may ask a front desk representative for a copy if I wish to review it in detail.

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian:
I certify that the information that I have provided is correct. I hereby assign to image Dermatology PC, any insurance or third-party payments for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Patient Signature: _____Date:_____ (Rev. 9/2021)

image Dermatology PC ®
51 Park Street
Montclair, NJ 07042

WELCOME TO image Dermatology P.C.®

This form is designed to acquaint you with our office policies. You have an opportunity to question, at this time and prior to service, the office policy and procedures. Once you have read the policies, please initial each item and sign the bottom of the form.

1._____ **Keep Us Accurately Informed:** You have a responsibility to provide, to the best of your knowledge, accurate and complete information about present complaints, past illness, hospitalizations, procedures, medications, and other matters relating to your health, including unexpected changes in your condition. You must also notify the office of any change of insurance, addresses, phone number, credit card or other contact information.

2._____**Follow Your Treatment Plan:** You are responsible for following the treatment plan recommended by the physician, physician assistant or her designee. If you cannot follow through with the prescribed treatment plan, is your responsibility to communicate this with the physician/physician assistant.

3. _____Keep Your Appointments: You are responsible for keeping scheduled appointments. Text message reminders are a courtesy that do not work all the time. When unable to do so for any reason, please notify the practice at least three business days prior to the appointment in order to avoid a late fee cancellation penalty.

4. **_____Conduct Yourself Properly:** Physician, staff and patient relationships are built upon mutual respect. Our staff will always treat you with respect, and we expect the same courtesy from you. It is your responsibility to respect practice property and property of other persons visiting the practice.

5._____**Phone Calls:** All patient phone calls are triaged to the medical staff.

6. _____**Cell Phone Policy:** Please silence your cell phone when in the office. You may use it for calls, texts and emails. Please refrain from answering your phone while the medical staff is attending to you.

7. **_____**To protect the privacy of our patients in the office, use of **recording devices of any kind audio or video are strictly prohibited.**

8. **_____**There is a mandatory **$50.00** missed appointment fee, please keep your scheduled appointments.

9. **_____Billing, Diagnostic** and **Treatment codes** will not be altered for billing purposes.

10. **_____Medication Refills:** are provided at the discretion of the medical staff and maybe the client based on potential side effects, fellow to print that for follow visit our extended absence from the practice. No refills will be provided if you have not been seen in six months or more.

11. **_____**Yearly skin cancer screenings prevent and decrease skin cancers. This may or may not be covered under your health insurance policy, however they are recommended by your physician.

12. **_____Emergencies-** only if you have a true medical emergency and are on your way to the hospital should you page us. Cosmetic filler patients if you notice skin changes you should also page us.

My initials above and signature below signify that I have read and understand the above office policies.

_____ _____

Printed Name Signature

Date Witness