

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.

PATIENT PAYMENT OBLIGATIONS
&
FINANCIAL POLICY

WELCOME TO IMAGE DERMATOLOGY P.C.®

All patients must complete our patient information sheet before having their procedure.

IMAGE DERMATOLOGY REQUIRES THAT PAYMENT IS DUE AT THE TIME OF SERVICE:

WE DO NOT BILL FOR SERVICES. We accept all major credit cards (and debit cards), checks and cash. We use electronic telecheck for the processing of checks, and it accesses funds in your account while you are checking out after receiving treatment, so sufficient funds must be available immediately in your account. Therefore, if you plan to pay by check, the funds must be in the account and checks cannot be post-dated. Also, if you have starter checks, telecheck cannot process those, so you must pay by another method.

REGARDING MANAGED CARE INSURANCE WE PARTICIPATE WITH:

You are responsible to supply our staff with your ID cards. We will automatically file the claim for you, however, you are responsible for any deductible or co-pay due at the time of service as described in your insurance handbook. If any of the procedures performed here are not covered item under your plan, you will be financially responsible for payment in full.

REGARDING NON-PARTICIPATING INSURANCE:

It is your responsibility to understand which insurance plans image Dermatology participates with. The bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not a part of that contract. We are happy to give you a copy of your bill so you can file directly with your insurance company, however the ultimate responsibility for payment remains yours.

REGARDING MEDICARE AND SUPPLEMENTARY INSURANCE:

We will automatically file your claim directly with Medicare and any other supplementary insurance if applicable. However, you remain responsible for your yearly deductible as well as any remaining co-payment.

REGARDING LABORATORIES:

It is your responsibility to understand which laboratory your insurance company affiliates with. Our center will not be held liable for any services rendered to you by a non-participating laboratory.

PAYMENTS:

We accept cash, check, money order, Visa American Express, and Master Card and Discover. There is a \$50.00 fee for any returned check. **WE DO NOT BILL.**

PLEASE NOTE: We do not accept checks for any new patients, and there will be no exceptions.

Thank you for understanding our Financial Policy.
Please feel free to let our billing office know if you have any questions or concerns
(888)-382-3327.

I have read the above Financial Policy; I agree and understand its term.

Signature of Patient or Responsible Party

Date

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, it 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

IMAGE DERMATOLOGY, P.C. ®

Patient Name :

Date :

Are you planning to attend a special event (wedding, reunion, other) ?

If so, when ?

What are your primary cosmetic goals/concerns today?

Other than the services we have already provided for you, what additional services would you like to learn about?

Please check all that apply

<input type="checkbox"/> Skin care advice <input type="checkbox"/> Skin care products <input type="checkbox"/> Tired looking skin <input type="checkbox"/> Uneven skin tone <input type="checkbox"/> Skin discoloration <input type="checkbox"/> Blotchy skin <input type="checkbox"/> Rough skin texture <input type="checkbox"/> Facial redness <input type="checkbox"/> Brown spots or freckles <input type="checkbox"/> Age spots <input type="checkbox"/> Red spots <input type="checkbox"/> Chemical peels <input type="checkbox"/> Double Chin (Submental Fullness) <input type="checkbox"/> Weak Chin <input type="checkbox"/> Loss of jaw definition <input type="checkbox"/> Kybella	<input type="checkbox"/> BOTOX® Cosmetic <input type="checkbox"/> Latisse <input type="checkbox"/> Juvederm /Restylane /Fillers <input type="checkbox"/> Facial fine lines/wrinkles <input type="checkbox"/> Thin lips <input type="checkbox"/> Frown lines between brows <input type="checkbox"/> Lines around nose & mouth <input type="checkbox"/> Dark circles/ puffiness in eyes <input type="checkbox"/> Facial veins/Facial redness <input type="checkbox"/> Drooping brow <input type="checkbox"/> Intracel microneedling for acne scars, stretchmarks an large pores <input type="checkbox"/> Fraxel Laser Resurfacing for acne scars, brown spots, photo-damage, and stretchmarks	<input type="checkbox"/> Scars (Acne or Surgical) <input type="checkbox"/> Sagging skin <input type="checkbox"/> Blue/ Red/ Spider leg veins <input type="checkbox"/> Neck wrinkles <input type="checkbox"/> Collagen therapy <input type="checkbox"/> Excessive sweating <input type="checkbox"/> Laser Treatments <input type="checkbox"/> Ear lobe repair <input type="checkbox"/> Scar and Keloid Removal <input type="checkbox"/> Unwanted Hair Removal <input type="checkbox"/> Longer, thicker, darker lashes, <input type="checkbox"/> Acne and Dark Spots <input type="checkbox"/> Mole Removal <input type="checkbox"/> Under Eye Hollows
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Approval to contact you.

Best phone number to reach you:

Approval to send you information on products and services (including special offers)

Email address:

I'm not interested in any additional services provided at this time

↓ For Staff Use Only ↓

Physician / provider:

Dr. Downie

Megan

Initial Inquiry/Information Given

Contact in future – give date

Products

Free consultation

IMAGE DERMATOLOGY, P.C. ®

Patient Name: _____

Pharmacy Name: _____

Pharmacy Number: _____

Pharmacy FULL address: _____

Name: of current MEDICATIONS:

What are you taking this for?

Medication Allergies: _____

Have you ever had a bad reaction to dental anesthesia? If yes what reaction?

SEX: Male Female Age: _____ HT: _____ WT: _____ Marital Status: Single Married Widow Divorced Separated

Have you had any of the following conditions in the past?

Skin cancer	Y	N	Hepatitis/Liver disease	Y	N
Melanoma	Y	N	Lupus	Y	N
Atypical moles (dysplastic nevus)	Y	N	Herpes simplex	Y	N
Basal cell carcinoma	Y	N	Bleeding disorders	Y	N
Squamous cell carcinoma	Y	N	Crohn's/Colitis disease	Y	N
Actinic keratoses	Y	N	Heart valve replacement	Y	N
T-cell lymphoma	Y	N	Pacemaker	Y	N
Other cancer	Y	N	Hip replacement	Y	N
Diabetes	Y	N	Cataracts	Y	N
Sarcoid	Y	N	Glaucoma	Y	N
Heart disease	Y	N	Kidney/Renal disease	Y	N
Stroke/TIA	Y	N	GYN problems	Y	N
Seizures/Epilepsy	Y	N	HIV	Y	N
Thyroid disease	Y	N	AIDS	Y	N
Scar/Keloid	Y	N	Other/specify:	Y	N
Hypertension	Y	N			

Do you have any of the following?

Itchiness	Y	N	Nose bleeds	Y	N
Dry skin	Y	N	Swelling in hands/feet	Y	N
Oily skin	Y	N	Wheezing	Y	N
Irritated lesions	Y	N	Abdominal pain	Y	N
Changing lesions	Y	N	Joint pain	Y	N
Fever	Y	N	Headache	Y	N
Fatigue	Y	N	Depression	Y	N
Excessive sweat	Y	N	Recent weight gain	Y	N
Dry eyes	Y	N	Recent weight loss	Y	N
Itchy eyes	Y	N	Swollen glands	Y	N

Please identify any of the following that a family member may have had:

Skin cancer	Y	N	Lupus	Y	N
Melanoma	Y	N	Other cancer	Y	N
Atypical moles	Y	N	Diabetes	Y	N
Acne	Y	N	Sarcoid	Y	N
Eczema	Y	N	HIV	Y	N
Psoriasis	Y	N	AIDS	Y	N

Do you spend long hours in the sun? Y N

Have you ever had a blistering sunburn? Y N

Do you smoke? Y N Packs per day: _____

Females: Pregnant or nursing: Y/ N

Do you drink alcohol? Y N Drinks per day: _____

Trying to get pregnant: Y/ N

Do you use illegal drugs? Y N Which drugs: _____

Medical Assistant _____

M.D. _____

Revised: 9/2021