

PATIENT INFORMATION FORM

PLEASE PRINT CLEARLY

DATE ____/____/____

NAME _____ SOC. SEC # _____

AGE _____ DATE OF BIRTH ____/____/____ SEX: MALE FEMALE

STATUS: SINGLE MARRIED PARTNERED WIDOWED

HOME MAILING ADDRESS: _____

PHONE; HOME: _____ WORK: _____ CELL: _____

EMERGENCY CONTACT NAME & RELATIONSHIP: _____

EMERGENCY CONTACT PHONE: _____

WERE YOU REFERRED BY A PHYSICIAN? YES NO

SELF PAY? YES NO

PRIMARY MD: _____ REFERRING MD: _____

ADDRESS: _____

PATIENT'S EMPLOYER: _____ OCCUPATION: _____

PHARMACY NAME, LOCATION, AND PHONE NUMBER: _____

CANCELLATION PROTOCOL

We all have busy lives. Our commitment to you is that our office staff will make every effort to contact you prior to your scheduled appointment. This is to let you know that we have reserved time especially for you. We do want you to know, however, that you are ultimately responsible for your scheduled appointment.

There is a nationwide shortage of dermatologists. When we schedule an appointment for you, we reserve a specific time in our day just for you. If you do not show up for your reserved appointment time it leaves us with an opening in our schedule that we are unable to recover. Ultimately it affects everyone. Not only do we have an opening in our schedule but it also prevents us from calling patients that are in need of immediate treatment. In an effort to prevent this from happening we need your help. **IF YOU ARE UNABLE TO KEEP YOUR APPOINTMENT OR NEED TO MAKE A CHANGE WE REQUIRE A 24 HOUR NOTICE.** This will allow another patient who is in need of treatment to be called in.

FOR THOSE PATIENTS WHO FAIL TO PROVIDE A 24 HOUR NOTICE, THE FOLLOWING WILL PERTAIN:

MISSED APPOINTMENT: A broken appointment fee of \$25.00 will be charged to your account for a regular visit and \$100.00 for a surgery visit. You may be asked to reserve future appointments with a credit card. **Each case will be handled according to your individual situation.**

REPEATED MISSED APPOINTMENTS: This may result in dismissal from our practice.

We are pleased that you have chosen our office for your dermatology care and we look forward to serving you.

I have read Dr. Kircher's cancellation protocol. I understand the protocol and will abide by the requirements.

PATIENT SIGNATURE _____ DATE _____

INCLEMENT WEATHER POLICY

If the **KINGSTON CITY SCHOOLS** are **CLOSED** due to inclement weather **OUR OFFICE WILL BE CLOSED** for that day. If there is any kind of delay due to the weather our office will be open, but please call before coming in for your appointment.

PATIENT'S INITIAL _____

WITNESS'S INITIAL _____

HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose health information about you. The Notice contains a Patient Rights Section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office. You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment, and health care operations. You have the right to revoke the Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior consent. The Practice provides this form to comply with the Health Insurance Portability of Accountability Act of 1996 (HIPAA).

The patient understands that: Protected Health Information may be disclosed or used for treatment, payment, or health care operations. The Practice has a Notice of Privacy and that the patient has the opportunity to review this Notice. The Practice reserves the right to restrict the uses of their information but the Practice does not have to agree to those restrictions. The patient may revoke this Consent in writing at any time and all future disclosures will then cease. The Practice may condition receipt of treatment upon execution of this Consent.

This consent was signed by: _____
PRINTED NAME – PATIENT OR REPRESENTATIVE

SIGNATURE **DATE** _____

RELATIONSHIP TO PATIENT IF OTHER THAN PATIENT **DATE** _____

INSURANCE AUTHORIZATION & ASSIGNMENT

I hereby authorize Kenneth T. Kircher, D.O., Advanced Dermatology, PLLC, to release medical information concerning my condition & treatment to my insurance carrier and/or the Health Care Financing Administration. I hereby request that payment of authorized insurance and/or Medicare benefits be made on my behalf to the above Physician for services rendered by them. I understand that I am responsible for any amount not covered.

PATIENT SIGNATURE **DATE** _____

LIFETIME BENEFICIARY CLAIM AUTHORIZATION (MEDICARE PATIENTS ONLY)

PATIENT NAME _____

MEDICARE NUMBER _____

I request that payment of authorized Medicare Benefits be made either to me or on my behalf to Kenneth T. Kircher, D.O., for any services furnished me by Kenneth T. Kircher, D.O. I authorize any holder of medical information about me to release to the Centers for Medicare & Medicaid Services (CMS) and its agents any information needed to determine these benefits or the benefits payable to related services.

I understand my signature requests that payment be made and authorized release of medical information necessary to pay the claim. If item 9 of the CMS 1500 claim form is completed, my signature authorized releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

PATIENT SIGNATURE **DATE** _____

PRINT CLEARLY NAME _____ DATE ____/____/____

ARE YOU **CURRENTLY** HAVING PROBLEMS WITH ANY OF THE FOLLOWING? IF YES, PLEASE EXPLAIN.

	YES	NO		YES	NO		YES	NO
GENERAL HEALTH	<input type="checkbox"/>	<input type="checkbox"/>	WEAKNESS	<input type="checkbox"/>	<input type="checkbox"/>	FEVER	<input type="checkbox"/>	<input type="checkbox"/>
EYES	<input type="checkbox"/>	<input type="checkbox"/>	UNEXPLAINED WEIGHT LOSS	<input type="checkbox"/>	<input type="checkbox"/>	HEART	<input type="checkbox"/>	<input type="checkbox"/>
LUNGS	<input type="checkbox"/>	<input type="checkbox"/>	EARS, NOSE, MOUTH, THROAT	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEYS/URINARY SYSTEM	<input type="checkbox"/>	<input type="checkbox"/>
ARTHRITIS	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH/BOWELS	<input type="checkbox"/>	<input type="checkbox"/>			

EXPLANATION _____

DO YOU SMOKE? YES IF YES, NUMBER OF PACKS PER DAY _____ NO

DO YOU DRINK ALCOHOL? YES IF YES, NUMBER OF DRINKS DAILY _____ NO

DO YOU HAVE OR EVER HAD A HISTORY OF SUBSTANCE ABUSE? YES IF YES, TYPE _____ NO

HAVE YOU HAD ANY SEVERE OR BLISTERING SUNBURNS? YES IF YES, HOW MANY _____ NO

DO YOU NOW OR HAVE YOU IN THE PAST FREQUENTED TANNING SALONS OR TANNING BEDS? YES NO

IF FEMALE: ARE YOU PREGNANT? YES NO NURSING NOW? YES NO

DO YOU PLAN TO BECOME PREGNANT IN THE NEXT YEAR? YES NO

FAMILY HISTORY

INCLUDING MOTHER, FATHER, SIBLINGS, GRANDPARENTS, CHILDREN.

<input type="checkbox"/> SKIN CANCER-TYPE: _____	<input type="checkbox"/> LUPUS	<input type="checkbox"/> ECZEMA
<input type="checkbox"/> MELANOMA; WHO: _____	<input type="checkbox"/> HEART DISEASE	<input type="checkbox"/> KELOIDS
<input type="checkbox"/> PSORIASIS	<input type="checkbox"/> HIGH BLOOD PRESSURE	<input type="checkbox"/> SEASONAL ALLERGIES
<input type="checkbox"/> CYSTIC ACNE	<input type="checkbox"/> DIABETES	<input type="checkbox"/> ASTHMA
<input type="checkbox"/> TUBERCULOSIS	<input type="checkbox"/> NOT KNOWN	
<input type="checkbox"/> OTHER SERIOUS ILLNESS: _____		

PATIENT HEALTH INFORMATION

PLEASE PRINT CLEARLY

DATE ____/____/____

NAME _____ AGE _____ DATE OF BIRTH ____/____/____

SEX: MALE FEMALE

PLEASE STATE NATURE, LOCATION,
AND DURATION OF YOUR SKIN PROBLEM: _____

PREVIOUS TREATMENTS: _____

PAST MEDICAL HISTORY

PLEASE CHECK ALL THAT APPLY;

- | | | |
|---|--|---|
| <input type="checkbox"/> SKIN CANCER (Please circle one): BCC SCC | <input type="checkbox"/> ECZEMA | <input type="checkbox"/> CANCER-TYPE: _____ |
| <input type="checkbox"/> MELANOMA DATE: _____ | <input type="checkbox"/> PSORIASIS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> DIABETES |
| <input type="checkbox"/> HEART PROBLEM-TYPE: _____ | <input type="checkbox"/> SEASONAL ALLERGIES | <input type="checkbox"/> STOMACH DISORDERS |
| <input type="checkbox"/> DEFIBRILLATOR | <input type="checkbox"/> HEPATITIS-TYPE: _____ | <input type="checkbox"/> EPILEPSY |
| <input type="checkbox"/> ARTIFICIAL HEART VALVE | <input type="checkbox"/> ARTIFICIAL JOINTS | <input type="checkbox"/> HIGH CHOLESTEROL |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> POSITIVE HIV TEST | <input type="checkbox"/> KELOID |
| <input type="checkbox"/> HEART ATTACK | <input type="checkbox"/> BLOOD TRANSFUSIONS | <input type="checkbox"/> HYPOTHYROID |

OTHER? _____

LIST ANY SURGERY OR HOSPITALIZATIONS (WITH APPROXIMATE DATES): _____

IF YOU REQUIRE ANTIBIOTICS PRIOR TO SURGERY/DENTAL PROCEDURES, PLEASE EXPLAIN _____

LIST PRESENT MEDICATIONS (INCLUDING NON-PRESCRIPTION & BIRTH CONTROL PILLS):

MEDICATION ALLERGIES? YES NO

IF YES, GIVE NAME & REACTION _____

PATIENT INSURANCE INFORMATION

Please bring your insurance cards to your appointment **at every visit** so copies and updates to this information can be made as needed. **You must have a referral, if required, for your visit or you will be asked to reschedule your appointment**

PRIMARY Insurance Information:

NAME OF INSURANCE CARRIER: _____

Please **print your name exactly** as it appears on your insurance card (even if incorrectly spelled on your card)

FIRST: _____ M.I.: _____ LAST: _____

DATE OF BIRTH: _____

IDENTIFICATION #: _____ GROUP #: _____

If you are not the policyholder, please **print the name of the policyholder**

FIRST: _____ M.I.: _____ LAST: _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER DATE OF BIRTH: _____

NAME OF POLICY HOLDER'S EMPLOYER (COMPANY NAME): _____

SECONDARY Insurance Information:

NAME OF INSURANCE CARRIER: _____

Please **print your name exactly** as it appears on your insurance card (even if incorrectly spelled on your card)

FIRST: _____ M.I.: _____ LAST: _____

DATE OF BIRTH: _____

IDENTIFICATION #: _____ GROUP #: _____

If you are not the policyholder, please **print the name of the policyholder**

FIRST: _____ M.I.: _____ LAST: _____

RELATIONSHIP TO PATIENT: _____ POLICY HOLDER DATE OF BIRTH: _____

NAME OF POLICY HOLDER'S EMPLOYER (COMPANY NAME): _____

MVP & CDPHP Patients:

PRIMARY CARE PHYSICIAN: _____

PHYSICIAN ADDRESS: _____

REFERRAL REQUIRED: YES NO

REFERRAL NUMBER: _____

OF VISITS AUTHORIZED: _____

SPECIALTY OFFICE COPAY \$ _____

IN-OFFICE PROCEDURE COPAY \$ _____

Advanced Dermatology, PLLC
301 Hurley Avenue
Kingston, NY 12401

OFFICE FINANCIAL POLICY

Patient Name _____

Date of Birth _____

We would like to share the following policies with you so that you can understand your responsibility regarding the charges for the services rendered to you by this office:

We are Medicare participating providers. We will bill Medicare. You will be responsible at the time of service for payment of the annual deductible, copayments, and charges for non covered or cosmetic services. You may be asked to sign an Advanced Notice of Liability form in the event that a service, cosmetic or otherwise, is provided which we know is not a covered service by Medicare. If you have a secondary insurance which is part of the Medicare Medigap, Medicare is responsible for submission of your claim. If payment from your Medigap is not received within 30 days of Medicare payment, you will be billed and will be responsible for payment of that balance. Since we do not participate with all secondary insurance carriers, it may be necessary for you to submit your Medicare Explanation of Benefits to your secondary insurance.

We currently participate with the following insurance plans: MVP Healthcare, Capital District Physicians Health Plan, National Health Administrators, Empire Blue Cross/Blue Shield. We will bill the carrier for all charges that are covered, medically necessary services. We do not participate with United Health Care or NYSHIP plans. You will be responsible **at the time of service** for any deductibles, copayments, or charges that are non-covered or cosmetic services. If you have a secondary insurance which we participate with, we will file your secondary insurance claim for you. Please note that copayments and deductibles are determined by your insurance carrier. We may not know at the time of service exactly what your responsibility will be and will balance bill upon receipt of your explanation of benefits. Any question regarding that balance or the policy by which it is determined should be directed to your carrier since we may not be able to provide that information to you accurately.

If you have an insurance which requires prior authorization for your visit it is your responsibility to obtain that referral prior to your visit. Any amount denied by your insurance for lack of appropriate authorization will be billed to you directly and will be your responsibility to pay.

For non-Medicare patients and patients with an insurance carrier with which we do not have a contractual relationship, payment is expected at the time of visit. Please understand that since we do not have a contract with your plan, we are not obligated to adjust our charges based on your plan's coverage or benefits. We will provide you with a claim form to submit to your insurance carrier upon request.

Payment is expected in full at the time of visit for any patient presenting without insurance. Please express any concerns regarding this policy before services are rendered as you will be held responsible for your balance in full at the time of the visit.

Cosmetic services will not be billed to any insurance carrier for any reason. Payment is expected in advance or at the time of service at the discretion of our office.

Our billing is completed on a monthly basis. All statements are payable within 30 days of receipt. We reserve the right to turn any unpaid balance over to the proper facility (legal, collection, and/or credit bureau) for collection purposes.

Your signature below signifies that you understand our financial policy and your responsibility regarding charges incurred in this office.

Patient Signature

Date