ADVANCED DERMATOLOGY ASSSOCIATES OF SUSSEX COUNTY, P.C.

PLEASE PRINT CLEARLY

PATIENT INFORMATION:

Full Name: _____

Address: _____ City, State: _____ Zip Code: _____

Primary Phone Number: _____ Secondary Phone Number: _____

SSN: _____ - _____ - _____ Date of Birth: _____ Age: _____ Sex: M F

Marital Status: Minor Married Single Divorced Widowed

Primary Care Physician's Name, Address & Phone: _____

_____

Pharmacy Name & Number: _____

Preferred Lab: LabCorp Quest Atlantic Health Other: _____

Employment Status: Full Time Part Time Retired Disabled Unemployed Student

Patient Employer: _____ Work Phone: _____

Employer Address: _____

Occupation: _____

Insurance Information

Primary Insurance: _____

Policy Holder Name: _____ Date of Birth: _____

SSN: _____ Relationship to Patient: _____

Insurance Address: _____

Policy ID #: _____ Group #: _____

Secondary Insurance: _____ Policy ID: _____

Name of Insured: _____ Date of Birth: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

ADVANCED DERMATOLOGY ASSOCIATES OF SUSSEX COUNTY, P.C.

Medical History

Patient Name: _____ Age: _____ Date of Birth: _____

Allergies:

Current Medications:

Medical Problems:

Reason for today's visit: (chief complaint)

_____

_____

Current or past problems with: (Review of systems)

	YES	NO	(If YES, explain)
General Health (Fever, Weight Loss)	□	□	_____
Eyes	□	□	_____
Ears/Nose/Throat/Mouth	□	□	_____
Heart	□	□	_____
Lungs	□	□	_____
Stomach/Bowel	□	□	_____
Kidney	□	□	_____
Arthritis/Muscles/Joints	□	□	_____
Headaches/Seizures	□	□	_____
Psychological Disorders	□	□	_____
Thyroid/Diabetes	□	□	_____
Blood/Bleeding Disorders	□	□	_____
Allergic/Immunologic	□	□	_____
Blood Transfusions	□	□	_____
HIV	□	□	_____
Hepatitis B/C	□	□	_____

Skin:

Have you ever had skin cancer?	□ YES	□ NO	
Has anyone in your family had skin cancer?	□ YES	□ NO	_____
Do you have a history of any specific skin disease?	□ YES	□ NO	_____
Do you have problems with healing?	□ YES	□ NO	
Do you develop keloids (scars) after surgery?	□ YES	□ NO	
Do you bleed easily?	□ YES	□ NO	

Do you develop skin rashes in reaction to: □ Medications □ Food □ Environment □ Bandages □ Topical Neosporin □ Other _____

_____ _____/____/_____

Physician Signature Date

OVER

ADVANCED DERMATOLOGY ASSOCIATES OF SUSSEX COUNTY, P.C.

Family History:

Mother: Living/Deceased Age: _____ Father: Living/Deceased Age: _____

Medical Problems (Mother): Medical Problems (Father):

_____ _____

_____ _____

How many children do you have? _____ Age(s): _____

Women: Are you pregnant? □ YES □ NO Due Date: _____/_____/_____

Social History:

Do you drink alcohol?	□ YES	□ NO	If YES, _____ drinks per day
Do you smoke or use tobacco?	□ YES	□ NO	If YES, what? _____ How much? _____
Do you use IV drugs or recreational drugs?	□ YES	□ NO	If YES, what? _____ How often? _____

What is your occupation: _____

Completed by:

□Patient _____ Date _____/_____/_____
Patient/Guardian Signature

□Medical Assistant _____

_____ Date: _____/_____/_____
Reviewed by

Advanced Dermatology Associates of Sussex County, PC
1 Centre St
Sparta, NJ 07871
P: 973-729-3945 F: 973-729-7441

OFFICE & FINANCIAL POLICIES

Welcome to our office. In order to provide you with the best care possible, your understanding of our policies is essential. To ensure smooth operation of the practice, our office, patient and financial policies are outlined below:

INSURANCE: We participate in several insurance plans and will be happy to bill on your behalf whenever medically applicable, if we are a contracted provider with your insurance company. It is your responsibility to provide this office with accurate insurance information and to notify us of any changes in health insurance coverage. Please note that insurance coverage is a contract BETWEEN YOU and YOUR INSURANCE COMPANY—NOT between the doctor and your insurance company. The insurance companies are increasingly reminding us that they have NO obligation to pay the provider for services. Verification of benefits is not a guarantee of payment. If your insurance carrier denies payment for services rendered, you will be financially responsible. **If your insurance plan requires a referral it is your responsibility to obtain the referral and have it sent prior to your appointment. Please bring your current insurance card to every appointment.** Please consult the office staff before treatment is rendered if you have any questions.

KNOW YOUR BENEFITS: Each insurance company, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurance company, you should understand what services are covered under your specific plan. Your insurer can assist you with any questions you have related to your own benefits with them.

COPAYMENTS: All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. If you arrive for your visit without your co-pay, you may be asked to reschedule.

NON-COVERED SERVICES: Advanced Dermatology may provide services that may not be covered as a benefit of your specific insurance plan. Patients or Guarantors are financially responsible for any and all services provided that are not covered. **It is your responsibility to know and understand your specific insurance plan and what benefits are provided**.

PRIVATE PAY/SELF PAY/COSMETIC: Payment in full is due at the time of visit for all cosmetic services and for patients without medical insurance.

PATIENT BALANCES: Most insurance companies have a deductible or co-pay/co-insurance which YOU are responsible for. **Any balance must be paid before or at the time of your next appointment unless otherwise arranged in advance by our billing staff.**

RETURNED CHECKS: There is a $25 fee for returned checks. If your check is returned from the bank, we may not accept an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

NONPAYMENT: Any outstanding account not paid after **60 days** will be assessed a 12% finance charge. If there is still a balance on your account after three billing cycles, the unpaid balance may be turned over to a collection agency. Patients sent to collections may be discharged from the practice unless their balance is paid in full.

NO SHOW, CANCELLATION AND LATENESS POLICY: If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of 24-hour notice. There will be a $25 fee for missed appointments. If you arrive more than 20 minutes late you may be asked to reschedule.

OUTSIDE PATHOLOGY, LAB FEES: Biopsy, pathology and lab samples are sent out to the appropriate lab according to your insurance to the best of our knowledge. These services are billed independently of Advanced Dermatology. You may receive a bill from the outside lab and will be responsible for payment to that facility.

MINOR PATIENTS: Patients under the age of 18 must be accompanied by a parent or guardian at the time of service. Please understand that it is not our position to get in the middle of family struggles over which party is responsible for the doctor's fees. Responsibility for payment of minors' fees rests with the parent/guardian who seeks treatment. Any court ordered responsibility judgment must be determined between the individuals involved without the inclusion of Advanced Dermatology

By signing below, I acknowledge that I have read, understand and agree to abide by the policies of this practice.

Patient or Responsible Party's Signature: _____ Date Signed: _____
Patient's Printed Name:_____
Responsible Party's Printed Name (only if applicable): _____

This shall remain in effect for this visit and all future visits to this office and will be updated every three years.
Advanced Dermatology Associates of Sussex County, PC

1 Centre Street
Sparta, NJ 07871
P: 973-729-3945 F: 973-729-7441

AUTHORIZATION FOR TREATMENT

By my signature below, I authorize evaluation and/or treatment by the providers at Advanced Dermatology.
I understand that many dermatological conditions are chronic and require ongoing care which may result in multiple visits.
I understand that all medications may have side effects and there are risks to any medication prescribed.
Dermatologists frequently diagnose skin growths by performing a biopsy and may treat skin growths by freezing, cauterizing, and/or injection.
I understand that there are risks to any procedure and these risks include but are not limited to: temporary or permanent discoloration, blistering, pain, bleeding, infection, and scarring.
I consent to having these procedures done as part of my care and treatment.

Patient or Responsible Party's Signature: _____ Date: _____
Patient or Responsible Party's Printed Name: _____

PATIENT CONSENT FOR THE USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing below, I acknowledge that I have been provided with an opportunity to review the Notice of Privacy Practices.

I give my permission to the staff and physicians to communicate my lab, biopsy results, treatment, payment and/or follow-up messages as described below:

I can be reached at the following phone number: _____

or a message may be left as described below (please check all that apply)

___ Home phone
___ Cell phone
___Work phone
___ Other _____

If I am not there, you may share the information with:

Name: _____

Relationship: _____

Phone Number: _____

I understand that I must write to Advanced Dermatology Associates of Sussex County to change or revoke any of my preferences indicated above. No verbal instructions will be accepted.

_____

Signature of Patient/Guardian Date

This authorization and consent shall remain in effect for this visit and all future visits to this office and will be updated every three years

NOTICE OF PRIVACY PRACTICES

This notice is yours to keep; please review it carefully.

Effective Date: March 19, 2007
Updated: May 23, 2019
Privacy Officer: Anthony J. Papadopoulos, MD

Advanced Dermatology Associates of Sussex County, PC
1 Centre Street, Sparta, NJ 07871
Phone: 973-729-3945 Fax: 973-729-7441

This Notice applies to individuals receiving services from Advanced Dermatology and does not require your response.

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

YOUR RIGHTS

•**Right to** see and copy your records. In most cases, you have a right to view or get copies of your records. We will provide a response to your request within thirty (30) days. You may be charged a fee for the cost of copying your records.

•**Right to** correct or update your records. You may ask us to correct your health information if you think there is a mistake. You must make your request and provide a reason for your need to correct the information.

•**Right to** choose how we communicate with you. You may ask us to share information with you in a certain way. For example, you can ask us to send information to your work address instead of your home address. You don't have to explain a reason for the request. We may deny unreasonable requests.

•**Right to** get a list of disclosures. You have a right to ask us for a list of disclosures made after April 14, 2003. This will not include information shared for treatment, payment or health operation purposes.

• **Right to** get notice of a breach. You have a right to be notified upon a breach of any of your protected health information

.•**Right to** request restrictions on uses or disclosures. You have a right to ask us to limit how your information is used or shared with others. You must make the request in writing and indicate what information should be limited. We are not required to agree to a requested restriction. If you paid out-of-pocket expenses in full for a specific item or service, you have a right to ask that your information with respect to that item or service not be disclosed. We will always honor that request.

•**Right to** revoke authorization. If we ask you to sign an authorization to use or disclose your information, you can cancel that authorization at any time. You must make that request in writing. Your request will not affect information that has already been shared.

•**Right to** get a copy of this notice. You have a right to ask for a paper copy of this notice at any time

•**Right to** file a complaint. You have a right to file a complaint if you don't agree with how we have used or disclosed your information.

•**Right to** choose someone to act for you. If someone has been legally designated as your personal representative, that person can exercise your rights and make choices about your health.

OUR DUTIES

Advanced Dermatology functions as a health care provider for you and your family. Consequently, we must collect information about you to provide these services. We are required to protect your information according to federal and state law and will abide by the terms of this notice. We may use and disclose information without your authorization for the following purposes:

•Treatment Purposes. We may use or disclose your information to health care providers who are involved in your health care.

•Payment. We may use or disclose your information to get payment or pay for health care services you received or will receive.

•Health Care Operations. We may use or disclose your information in order to manage our business, improve your care and contact you when necessary.

•As Required by Law. We will disclose information to a public health agency that maintains vital records, such as births, deaths and some diseases.

•Abuse and Neglect Investigations. We may disclose your information to report all potential cases of abuse and/or neglect.

•Health Oversight Activities. We may use or disclose your information to respond to an inspection or investigation by state officials.

•Government Programs. We may use and disclose your information for the management and coordination of public benefits under government programs.

•To Avoid Harm. We may use and disclose information to law enforcement in order to avoid a serious threat to the health and safety of a person or the public.

•For Research. We may use and disclose your information for studies and to develop reports. These reports will not specifically identify you or another person.

•Business Associates. We may use and disclose your information to our business associates that perform functions on our behalf, if necessary, to complete those functions.

•Organ and Tissue Donation. If you are an organ donor, we may use and disclose your information to organizations engaged in procuring, banking or the transportation of organs, eyes, or other tissues to facilitate organ transplantation.

•Military and Veterans. If you are a member of the armed forces, we may disclose your information to the appropriate military authority.

•Workers Compensation. We may use or disclose your information for workers compensation or similar programs providing benefits for work-related injuries or illnesses.

•Data Breach Notification Purposes. We may use or disclose your information to provide legally required notices of unauthorized access or disclosure of your health information.

•Lawsuits and Disputes. We may use or disclose your information in response to a Court or Administrative Order, subpoena, discovery request or other lawful process.

•Law Enforcement. We may disclose your information to law enforcement if the information: 1) is in response to a court order, subpoena, warrant or similar process; 2) limited to identify or locate a suspect, fugitive, material witness or missing person; 3) about a victim of a crime under very limited circumstances; 4) about a death potentially resulting from a crime; 5) is needed in an emergency to report a crime or facts surrounding a crime.

•Coroner, Medical Examiners and Funeral Directors. We may disclose your information to a Coroner or Medical Examiner to identify a deceased person or determine the cause of death. We may release your information to a Funeral Director as necessary for their duties.

•National Security and Intelligence. We may disclose your information to authorized federal officials for intelligence, counter-intelligence and other national security activities authorized by law.

•Inmates or Individuals in Custody. If you are an inmate, we may release your information to a correctional institution if that information would be necessary for the institution to: 1) provide you with health care; 2) protect your health and safety or the health and safety of others or: 3) for the safety and security of the correctional institutions.

•Disclosure to Family, Friends and Others. We may disclose your information to your family members, friends or other persons who are involved in your medical care. You may object to the sharing of this information. We may also share your information with someone legally designated as your personal representative.

•Hospital Directory. Unless you notify us that you object, we may include certain information about you in the hospital directory in order to respond to inquiries from friends, family, clergy and others who inquire about you when you are a patient in the hospital.

Other Uses and Disclosures that Require Your Written Authorization

•For All Other Situations. We will ask for your written authorization before using or disclosing information for any other purpose than what is mentioned above. Special circumstances that require an authorization include most uses and disclosures of your health information If you give us authorization, you can withdraw this written authorization at any time. If you revoke your authorization, we will no longer use or disclose your health information as allowed by your written authorization, except to the extent that we have already relied on your authorization.

•As Required by Other Laws. We will ask for your written authorization to comply with other laws protecting the use and disclosure of your information.

FILING A COMPLAINT

You may use the contact information below if you want to file a complaint or to report a problem regarding the use or disclosure of your health information. Treatment or services being provided to you will not be affected by any complaints you make. DHS opposes any retaliatory acts resulting from participation in a HIPAA investigation.

State of New Jersey Department of Human Services Office of Legal and Regulatory Affairs P.O. Box 700Trenton, NJ 08625888-347-5345 DHS or its appropriate Division will respond to your communication within thirty (30) days.

CHANGES TO THIS NOTICE

In the future, Advanced Dermatology may change its Notice of Privacy Practices. Any change could apply to medical information we already have about you, as well as information we receive in the future. A copy of a new notice will be provided to you as required by law.