ADVANCED DERMATOLOGY ASSOCIATES 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

E-Mail: _____

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

_____

Pharmacy Name & Number: _____

Preferred Lab: LabCorp Quest Atlantic Health Other: _____

Emergency Contact Information

Name: _____ Relationship: _____ Phone: _____

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: _____

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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**

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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. 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 with many insurance plans and will be happy to bill on your behalf if we are a contracted provider with your insurance company. It is your responsibility to provide this office with accurate and up to date insurance information and to notify us of any changes in your coverage. Please note that insurance coverage is a contract BETWEEN YOU and YOUR INSURANCE COMPANY—NOT between the doctor and your insurance company. **Verification of benefits is not a guarantee of payment**. It is always the patients responsibility to know if our office is participating with their plan. If your insurance carrier denies payment for services rendered, you will be financially responsible.

REFERRALS: **If your insurance plan requires a referral, it is your responsibility to obtain the referral and have it sent prior to your appointment.**

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. 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 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: Any balance must be paid before your next appointment unless otherwise arranged in advance by our billing staff.

RETURNED CHECKS: There will be a $35 fee for returned checks. You may be placed on a cash only basis following any returned check.

NONPAYMENT: Any outstanding balance not paid after **60 days** will be assessed a 12% monthly finance charge and after **90 days** may be turned over to a collection agency. Patients sent to collections will incur a $30 collection fee and 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 $75 fee for missed appointments and $150 fee for missed surgical procedures**. If you arrive more than 15 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. 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. **Any minor accompanied by an adult other than the parent/legal guardian stated in their chart will need a signed note of consent from the parent/legal guardian for each visit.**

PATIENT CONDUCT: We feel strongly that our staff should be able to work in an environment free from verbal and physical abuse. Angry outbursts or inappropriate language or behavior towards our clinical, billing or office staff will not be tolerated and will result in a patient's discharge from the practice.

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 or as the office sees fit

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