METRODERMATOLOGY

Name: _____ _____ _____
Last **First** **M.I.**

Street Address: _____ **Apt. #:** _____

City: _____ **State:** _____ **Zip:** _____

Date of Birth: _____ /_____ /_____ **Social Security** _____-_____-_____

Marital Status: □**Single** □**Married** □**Other** **Sex:** □ **Male** □ **Female**

Email Address:_____@_____

****Cell Phone #: (** _____) _____ – _____ **Home # : (** _____) _____ – _____

****If you do NOT want to receive text reminders, please inform the Front Desk staff.**

Emergency Contact:_____ **Emergency Phone:(**_____**)**_____

Primary/Referring Doctor: _____**Dr. Phone: (**_____**)** _____ – _____

Preferred Language: □ **English** □ **Español** □ 한국어 □ 國 語 □ 廣東語 □ 日本語 □ **Other:** _____

How did you hear about us?	□ **Doctor Referral**	□ **Family / Friend Referral**
	□ **Insurance Directory**	□ **Online Advertisement**
	□ **Paper Advertisement**	□ **TV / Radio Advertisement**

Preferred Pharmacy

Pharmacy Name:_____ **Pharmacy Phone#** _____

Primary Insurance: _____
Does your insurance require a referral to see a specialist? □ **Yes** □ **No**

Subscriber's Name: _____ _____ _____
Last **First** **M.I.**

Subscriber's DOB: _____ /_____ /_____ **Relationship to Patient:** _____

SIGNATURE: **X**_____ **DATE:** _____/_____/_____

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HIPAA Privacy Authorization

In accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule, we do not disclose Protected Health Information (PHI) without your permission. Please provide the name(s) and phone number(s) of any person(s) other than yourself with whom we can discuss the following;

- Leave message regarding appointments, treatments, and/or test results.
- Discuss your appointments and billing issues.

_____

Names of Authorized Individual(s) (Print) Phone Numbers

Treatment Consent

I hereby authorize and consent to treatment at Metro Dermatology. This may include the administration of medication, diagnostic tests, and procedures as deemed necessary by my physician, or the physician's assistants or designees, for purposes of diagnosis or treatment. **_____ (initial)**

Authorization & Assignment

I authorize Metro Dermatology to release any medical or other information required to process my insurance claim. I also authorize payment of my benefits to Metro Dermatology. I understand that I am financially responsible for any balance not covered by my insurance carrier. _____ **(initial)**

Medicare Claims

We are participating providers in the Medicare program. We will accept assignment for the services we provide. Patients are responsible for meeting their annual deductible and any coinsurance. We will also file with secondary/supplemental carriers if applicable. However, in the event that the secondary carrier does not pay within 60 days, patients will be balance billed._____ **(initial)**

Payment Guarantee

*** Patient Responsibility.** I understand that I am responsible for any amount not covered by insurance. I agree to provide payment within thirty (30) days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether I am covered by an HMO, PPO, or a traditional group health plan. If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. **_____ (initial)**

*** Contracted Insurers.** If we participate (are contracted) with my insurance plan, we file claims as a courtesy to me. I understand that I am responsible for:

- Co-payments - Annual deductibles
- Coinsurances - Non-covered services **_____ (initial)**

*** Non-Covered Services.** Insurers routinely state, "The determination of benefit is made at the time of the claim is received." We often do not know if treatments will be covered until we receive the insurer's EOB (explanation of benefits). After the EOB for your submitted claim has been received at Metro Dermatology, you will be billed for any items not covered by your insurance plan. Services may be denied for coverage because the carrier considers the services: 1) Medically unnecessary 2) for a pre-existing condition 3) cosmetic. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment**.** **_____ (initial)**

*** Transfer of Credit Balance.** A credit balance resulting from payment to Metro Dermatology from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured. **_____ (initial)**

*** Pathology & Laboratory Charges.** Final laboratory charges cannot be anticipated at the time of service and are not within our control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. You will be responsible for any amount not covered by insurance. **_____ (initial**)

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Fees

*** Co-Pay Rebilling Charge.** Our contract with your insurer requires us to collect any co-payments in full at the time of service. If I ask to be billed for the co-payment rather than paying it at the time of service, a $10 service charge will apply for additional billing needed to collect the co-payment. **_____ (initial)**

*** Insurance Charge**. If I do not provide the correct insurance information before my insurer's claim filing deadline, I will become responsible for the full cost of the visit. **_____ (initial)**

*** Returned Checks.** There is a $25 processing fee for returned checks. Returned checks may also be forwarded to our collection agency for further action. **_____ (initial)**

***Transfer of Records**. The administrative charge for processing is as follows:

New York: Seventy-five cents ($.75) per page for paper copies and a reasonable charge for diagnostic images, plus postage.

New Jersey: $1.00 per page for first 100 pages, $.25 per page thereafter to a maximum charge of $200.00 for the entire record **_____ (initial)**

* Appointment Cancellation or 'No Show' Policy:

I will notify Metro Dermatology at least 24 hours in advance if I am not able to keep my appointment. A late cancellation (less than 24 hours notice) is considered to be a "No Show." I understand that "No Shows" may be charged a $50.00 fee. I understand that leaving a message on the answering machine is not an acceptable cancellation. **I understand that this charge is not billable to any insurance carrier. _____ (initial)**

I agree to provide a credit card number, which may be charged $50 for any no-show of a scheduled appointment.[1] I understand that I must cancel or reschedule an appointment at least 24 hours in advance to avoid a potential no-show charge to the credit card provided. **_____ (initial)**

Appointments may be canceled by calling 718-886-9000 when I receive the appointment confirmation link. Metro Dermatology will help me to reschedule the appointment if needed.

Medication Refills

Patients are given enough medication to cover them until their next visit. A follow up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given. **_____ (initial)**

No Insurance Card

All patients MUST present their insurance card(s) and photo ID on their first visit, and whenever there are any changes to their insurance. Due to recent unfortunate insurance fraud incidents, we will not be able to provide services to patients who do not present their insurance card(s) and a photo ID at the time of service. If I do not have my insurance card or photo ID with me, I will need to reschedule my appointment. **_____ (initial)**

If I want to be seen without my insurance card for my first visit, I understand that I will be charged the standard commercial fee.

SIGNATURE: X_____ **DATE:** _____/_____/_____

[1] *We will store your credit card information with a third party vendor, **Stripe.** Stripe stores the information on a separate, secure site. This enables us to run credit card transactions within our system. Office personnel will not have access to your card information. Only the last 4 digits of your card will show in our system.*