INSTRUCTIONS FOR FILLING OUT OUR FORMS FOR NEW PATIENTS

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance in filling out our forms.

Welcome to Advanced Dermatology and Skin Care, where our goal is to respond to all of our patients' needs and to provide the highest quality care.

In anticipation of your first visit to our office, we have provided you with five forms to fill out:

1. **ADSC Patient Registration Form**
2. **ADSC Patient Confidentiality**
3. **ADSC Financial Policy**
4. **ADSC Medical Racial and Ethnic Background Questionnaire**
5. **ADSC Receipt of Notice of Privacy Practices**

In order to be seen by one of our physicians we require the forms be filled out completely and signed either by you, or if you have a guardian, then by your guardian; from time to time we may ask you to update these forms.

If you have downloaded the forms, you may either:

- ✓ **Fill them out on your PC, Mac, iPad or other device, print them out, and sign them or**
- ✓ **Print the forms out, fill them out by hand, and then sign them.**

In either case, please either bring the completed forms to our office at the time of your appointment and hand the signed originals to the reception desk or fax them to us at the number below. We apologize for not being able to take the forms electronically at this time.

We look forward to seeing you.

Deborah R. Spey, MD and the doctors of
Advanced Dermatology and Skin Care
"Creating a more beautiful you"

101 Old Short Hills Road, Suite 410, West Orange, NJ 07052
Phone Number: (973) 731-9600 FAX: (973) 731-1635

PATIENT REGISTRATION FORM

LAST NAME ______________________ **FIRST NAME** ______________________ **MI** _______ **DATE** ______________

STREET ADDRESS __ ____ **EMAIL** ____________________

CITY ______________________________ **STATE** ______ **ZIP CODE** ____________ **DOB** ________________________

AGE ______________ **SEX: M F** **MARITAL STATUS: S M P D W SEP** **SS#** ___________________________

HOME PHONE ____________________ **WORK PHONE** _____________________ **CELL PHONE** ____________________

OCCUPATION __________________________________ **REFERRED BY** ____

EMERGENCY CONTACT NAME ____ **PHONE** ____________________

PRIMARY INSURANCE ____ **POLICY #** ____________________________

POLICY HOLDERS NAME _____________________________________ **RELATIONSHIP** __________________________

STREET ADDRESS ____

CITY _____________________________ **STATE** _________ **ZIP CODE** __________ **SS #** __________________________

HOME PHONE _______________________ **SEX: M F** **DOB** ___________________________________

POLICY HOLDER'S EMPLOYER ____ **PHONE** _________________________

EMPLOYER ADDRESS ____

SECONDARY INSURANCE ____ **POLICY #** ____________________________

POLICY HOLDERS NAME ____ **RELATIONSHIP** _________________________

STREET ADDRESS ____

CITY _____________________________ **STATE** _________ **ZIP CODE** __________ **SS #** __________________________

HOME PHONE __________________________ **SEX: M F** **DOB:** _____________________________________

POLICY HOLDER'S EMPLOYER ____ **PHONE** _________________________

EMPLOYER ADDRESS ____

PRIMARY CARE PHYSICIAN NAME ______________________________________ **PHONE** __________________________

PHARMACY NAME ____ **PHONE** __________________________

I HAVE BEEN ADVISED THAT <u>NONE</u> OF THE PHYSICIANS IN THIS PRACTICE PARTICIPATE WITH MEDICAID _
(please initial)

I ALSO ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES FOR ADVANCED DERMATOLOGY & SKIN CARE.

____ ______________________________
Signature of Patient or Guardian **Date**

PATIENT CONFIDENTIALITY

In this office, **Patient Confidentiality** is a prime concern.

Please indicate below with whom our office can or cannot leave a message by checking where appropriate:

CONTACT	YES	NO	DOES NOT APPLY
Spouse/Significant Other			
Parent			
Children			
Home			
Work			
Answering Machine			
Cell Phone			

Are you able to receive phone calls at your workplace? **Y** **N**

May we call you at your workplace and state who is calling? **Y** **N**

Due to confidentiality regulations, should a family member, friend or relative contact our office, we are not at liberty to discuss your situation unless we have permission from you, the patient, or your guardian.

Please check with whom we may discuss your situation:

CONTACT	YES	NO	DOES NOT APPLY
Spouse/Significant Other			
Parent			
Children			

Spouse/Significant Other, Parent, Children approved for contact

Name		Name	
Relationship		Relationship	
Phone		Phone	
Name		Name	
Relationship		Relationship	
Phone		Phone	

_______________________________________ _______________

Signature of Patient or Guardian Date

FINANCIAL POLICY

We are committed to providing you with the best possible care. In order to achieve this goal, we need your assistance and your understanding of our payment policy.

If we do not have a contractual agreement with your insurance company, payment for services is due at the time services are rendered. We accept cash, check, and credit card payments.

PLEASE NOTE THAT THIS OFFICE DOES NOT PARTICIPATE WITH MEDICAID AND INITIAL HERE:

Returned checks, and balances older than 90 days may be subject to additional collection fees. **Skin care products must be returned within 90 days of purchase for reimbursement.**

Appointments must be cancelled with 24 hours advance notice. Failure to do so will result in a no-show fee as follows: $50.00 for every 15 minutes of general dermatology time and $100.00 for every 15 minutes of cosmetic time scheduled.

We will gladly discuss proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. If you have an indemnity plan, your insurance is a contract between you, your employer (if applicable), and the insurance company.
2. Our fees are generally considered to fall within acceptable range by most companies; they are covered up to the maximum allowances determined by each carrier. Thus, our fees are considered to be usual and customary by most companies. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard and cost of care in this area.
3. Not all services are covered benefits in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. All co-payments are to be made at the time of service.
5. If your insurance is an HMO/POS, you are responsible to supply this office with the referral and/or authorization forms PRIOR to being examined. **YOU CANNOT BE SEEN WITHOUT A REFERRAL.**
6. You are responsible for informing us of any changes in your insurance plan or policy. Failure to do so may result in denial of coverage, and you will be held responsible for the fees.

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable, to which I am entitled, including Medicare, Private Insurance, and any other health plans to the above named providers.

We must emphasize that as health care providers we are dedicated to providing the best treatment for our patients. We will do our best in the filing of insurance claims; however**, all charges are your responsibility from the date services are rendered.**

Thank you for understanding our Office Financial Policy. If you have any questions, please call and our billing staff will be happy to assist you.

I (**please print name**) ____ have read the Office Financial Policy of Advanced Dermatology & Skin Care, and I understand and agree to abide by this policy.

____ ______________________

Signature of Patient or Guardian **Date**

MEDICAL RACIAL AND ETHNIC BACKGROUND QUESTIONNAIRE

As part of the Federal Government's "Meaningful Use" initiative for electronic health records, we are required to request the following information. You may choose not to report some or all of this information by selecting "Choose not to report". Please note that the selections have been placed in the order they appear in our electronic medical records system.

RACE

AMERICAN INDIAN OR ALASKA NATIVE

ASIAN

NATIVE HAWAIIN OR OTHER PACIFIC

BLACK OR AFRICAN AMERICAN

WHITE

HISPANIC

OTHER RACE

OTHER PACIFIC ISLANDER

CHOOSE NOT TO REPORT

ETHNICITY

HISPANIC OR LATINO

NOT HISPANIC OR LATINO

CHOOSE NOT TO REPORT

LANGUAGE

OTHER

INDIAN AND OTHER SOUTH ASIAN

SPANISH

RUSSIAN

ENGLISH

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I am a patient of ______________________________. I hereby acknowledge receipt of Advanced Dermatology and Skin Care's Notice of Privacy Practices.

Name [please print]: ___________________________________

Signature: ____

Date: ____

OR

I am a parent or legal guardian of ___________________________[patient name].
I hereby acknowledge receipt of Advanced Dermatology and Skin Care's Notice of Privacy Practices with respect to the patient.

Name [please print]: ___________________________________

Relationship to Patient: ☐ Parent ☐ Legal Guardian

Signature: ____

Date: ____

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, in addition to other fundraising communications, that may be of interest to you. You do have the right to "opt out" with respect to receiving fundraising communications from us.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;
- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;

- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI:

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice if effective as of October 1, 2013 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer (Nancy Violette, RN, at 973-731-9600) for more information, in person or in writing.