neda
SKIN SOLUTIONS

**PLEASE NOTE:**
**IF YOUR INSURANCE REQUIRES A REFERRAL YOU WILL NEED TO CONTACT YOUR PCP PRIOR TO YOUR APPOINTMENT TO REQUEST ONE.**

# NEW PATIENT INFORMATION
## PLEASE PRINT CLEARLY

**Date:** _____

Patient's Name: _____ Parent / Guardian: _____ (if applicable)

Date of Birth: _____ [PLEASE CIRCLE:] Sex: Male Female Single / Married / Divorced / Widowed

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: (  ) _____ Work Phone: (  ) _____ Cell Phone: (  ) _____

Email Address: _____

Primary Care Physician: _____ Practice Name: _____

Primary Care Physician Address: _____

## Insurance Information

Name of Insurance: _____ Employer: _____

Insurance Subscriber Name: _____ Subscriber Date of Birth: _____ Relationship to patient: _____

Subscriber ID Number: _____ Group # _____

Secondary Insurance: _____ Name: _____ ID #: _____

☐ **Were you referred by a medical provider?** **YES** ○ **NO** ○ If ***YES***, Who referred you? _____

## Please read this agreement and sign below:

I hereby authorize the physicians and healthcare professionals of NEDA to examine and treat me for my dermatologic condition.

The physicians and healthcare professionals of NEDA are committed to your health. As such, they are willing to perform a comprehensive (total body) skin screening. These screenings are meant to detect potential serious skin conditions (especially skin cancer), which you might not yet be aware of**.** If this is not the primary reason for your visit today, you can ask the provider or nurse if time will permit them to do this today, if there is not enough time please **make a future appointment for a complete screening before you leave today.** However, should you have any area of particular concern, please ask the doctor to look at it today.

I understand that testing/procedures may be required to diagnose or treat my condition. I will have an opportunity to ask any questions before any test or procedure is performed. I do understand, however, that any procedure involves risks including, but not limited to, bleeding, infection and scarring. I am aware that a scar can result from any procedure and the type or severity of such scarring cannot always be predicted before the procedure. I understand that these tests (biopsies) will be sent to the NEDA dermatopathology laboratory to be processed and to be read by a board certified dermatopathologist. I understand that under certain circumstances some tests may require additional special stains which may incur further charges not collected at my initial visit, but would not be known at the time of your visit.

I authorize that the payment of insurance benefits be made on my behalf to the physicians and mid-level providers of Northeast Dermatology Associates for any services furnished me by a NEDA healthcare professional. I further understand that prior to disbursing payment for services my insurance company may require documentation from my medical record in order to approve payment.

I agree to obtain and be responsible for any necessary referrals and pay required co-payments at the time of service. I further agree to, at the time of service, pay for any unmet deductible or leave my credit card information to charge the amount due after hearing from my insurance company in accordance with the Financial Policy. Patients with Private Insurance agree to assume full responsibility for the balance of services. Patients with no insurance assume full responsibility for balance at the time of service, unless prior arrangements have been made.

I also understand that my insurance may not cover certain procedures and/or medications. (When a procedure is considered to be not medically necessary, your physician will help explain this, but cannot change the rules of your insurance policy. Note that the physician cannot be responsible for knowing the particular level of benefits that your individual plan allows.) I further understand that I may not receive a statement until my insurance company responds to the claim submitted by Northeast Dermatology. In the event that my insurance carrier determines that I was treated for a non-covered service or if I have a coinsurance or deductible, I agree to assume full responsibility for the balance not covered within 30 days of receipt of the 1st statement.

**Signature** ***(Must be 18 or older)*** _____ **Date:** _____

Print Name: _____ Relationship to patient: _____

**PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

With my consent, Northeast Dermatology Associates [NEDA] may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Northeast Dermatology Associates' **Notice of Privacy Practices** for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Northeast Dermatology Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Northeast Dermatology Associates' Chief Privacy Officer at [*280 Merrimack St, #311, Lawrence, MA 01843*].

With my consent, Northeast Dermatology Associates may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Northeast Dermatology Associates may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

**CHECK ONE**

○ With my consent, I hereby give Northeast Dermatology Associates permission to discuss/ share my PHI pertaining to my treatment and/or diagnosis with _____

[Relationship to patient:_____] Contact Phone # _____

Please initial: _____

○ I choose not to give consent to NEDA to discuss/share my PHI pertaining to my treatment and/or diagnosis with anyone other than myself at this time. I understand that I may change this decision in the future by submitting a written authorization to Northeast Dermatology.

By signing this form, I am consenting to Northeast Dermatology Associates use and disclosure of my PHI to carry out TPO and I verify that I have read and accepted Northeast Dermatology's Notice of Privacy Polices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Northeast Dermatology Associates may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Printed Name of Legal Guardian (if applicable)

_____ ____/____/_____ _____

Patient's Name Patient DOB Date Signed

**Emergency Contact Information**

Emergency Contact Name: _____

Phone Number: _____

Relationship to patient: _____

Today's Date: _____

**Patient Financial Policy**

Thank you for choosing us for your healthcare needs. As your healthcare provider, we are committed to providing you with the best possible care. Please read our financial policy and, if you have any questions, please ask one of our associates for assistance or call our billing office at (844) 733-1400.

**You will be asked to show the front office staff your current insurance card at each visit.** Please come prepared. This allows us to verify the information and assist you in collecting the benefits from your insurancecompany to which you are entitled.

**PATIENTS WITH INSURANCE POLICIES**

*For Insurance companies that we participate with:*

We are pleased to bill your insurance on your behalf. If your insurance requires you to make a copay, coinsurance, and/or deductible, we expect this payment at time of service. In addition, you will be responsiblefor any amount the insurance plan deems not covered, up to the entire amount.

*If we do not hear from your insurance company:*

If we have not received payment or rejection from your insurance company in a timely manner, we will transfer the balance to your responsibility. We request your assistance in following up with your insurance company to resolve any non-payment issues.

*For insurance companies that we **DO NOT** participate with:*

If your insurance has an out-of-network benefit clause and we are able to verify coverage and obtain authorization, we will submit a claim to the insurance company on your behalf. PhyNet reserves the right to collect any unmet deductible or coinsurance at the time of service. It is ultimately the patient's responsibility to verify if we are in your network and what the out-of-pocket costs in using an out-of-network provider will be.

**SELF PAY PATIENTS**

If you do not have insurance or are seeking care outside of your insurance plan benefits, payment in full is required prior to the service. For your convenience, we accept cash, check, Visa, Mastercard, Discover, and American Express. A returned check fee of $35 will be assessed on any check returned by the bank. Future services will require payment by cash, money order or credit card.

**COPAYMENTS**

According to the agreement you have made with your insurance company, copayments are due at each visit. If you are not prepared to pay your co-pay, your appointment will be rescheduled.

Signature: _____ DOB: _____

**COINSURANCE**

Coinsurance is based on the pre-determined level of coverage outlined in your insurance policy. For example,you may have an 80/20 plan, meaning the insurance will consider and pay on 80% of the charges and the remaining 20% is your responsibility. It is very important to review your coverage to determine your level of coinsurance.

**NO SHOW FEES**

Patients who fail to keep appointments or cancel without 24 hours advanced notice may be charged a $50 fee for an office visit and a $100 fee for a missed surgical/cosmetic appointment.

**PAST DUE ACCOUNTS**

In the event a balance becomes past due, your account will be considered delinquent. Delinquent accounts are subject to further collection action, including placement with a collection agency. The patient will be responsible for any collection fees associated with collecting the outstanding balance.

**DISABILITY AND OTHER SPECIAL FORMS**

We recognize that special forms are sometimes necessary to provide documentation of medical conditions. Completing forms is time-consuming and generally falls outside of the contractual relationship between youand your insurance company. We will be happy to complete these forms at the following rates:

- FMLA - $25
- Disability/Physician Attestation - $25
- Miscellaneous Forms - $25
- Medical Records - $35

Payment of the form filing fee is due at the time of request and a medical release form must be signed.

We will gladly discuss your proposed treatment and will do our best to answer any questions relative to your insurance. You must realize that: A) your insurance is a contract between you, your employer, and the insurance company. B) not all services are a covered benefit in all contracts. Your insurance plan may elect to not cover certain services for various reasons.

As your medical provider, our relationship and concern is with you and your health, not your insurance company. While the filing of insurance claims is a courtesy, **all charges are your responsibility from the date services are rendered.**

I HAVE READ AND UNDERSTAND THE ABOVE FINANCIAL POLICY.

Signature:_____ Date:_____

Patient Name:_____ DOB: _____