**Financial Policy and Patient Liability**

The physicians and staff are committed to providing you with the finest care possible. It is our feeling the energies and personnel functions of this office must be geared toward patient centered medical care, not financial record keeping. To achieve this goal, it is important you have a clear understanding of our financial policy.

*IT IS IMPORTANT YOU UNDERSTAND THE FOLLOWING*:

Your insurance plan is a legal document between YOU and your insurance company. All fees incurred with this office are your responsibility for payment. Insurance is a means of payment and not a transfer of personal responsibility. We cannot render services on the assumption our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare and submit any necessary claim forms, reports, and itemizations to assist in making collections from insurance companies and will credit such collections to the patient’s account.

In order to better serve you, we have contracts with a number of insurance companies and health plans to provide services at specific reimbursement rates. We also accept Medicare assignment. However, these plans include co-pays, co-insurance and annual deductibles, which are due at time of service. If you disagree with your insurance company’s settlement of your claim you will need to pay the balance due and appeal directly to your carrier. Delays in payment of more than 30 days will result in service charges at the rate of $30.00 per month. Should we reach a point where we must seek the assistance of a collection agency to satisfy your debt, you will be responsible for any collection and attorney fees incurred.

If temporary financial problems affect your ability to pay, and there is no alternative except to set up a payment program, we reserve the right to establish the minimum of payment and the date on which the account is to be paid in full.

We understand your schedule may sometimes change and you will need to cancel or re-schedule your appointment with us. Please call us as soon as possible and we will make every effort to accommodate your schedule. In keeping with our desire to provide quality care to all our patients, you will be charged $75.00 for a “No Show” standard office visit and $150.00 for a “No Show” surgery appointment.

We are always happy to prepare copies of your medical record file. However, this again requires staff time and equipment. Therefore a prepaid fee of $25.00 applies to this task. It is in your best interest to make the written notification of your request as early as possible allowing the staff 7 days to complete your request.

*I have read and understand the financial policy of A. David Gerstein, MD, PC. I realize all medical and surgical charges incurred by me for services rendered are my financial responsibility. I am also aware and may obtain at any time a copy of the Privacy Practice used in relationship to my medical information obtained during my visits*

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Patient Signature Date*

**Confidential Patient Registration**

*Please* ***PRINT ALL*** *information for the patient and the insured*

***We must have the insured information for filing insurance claims***

**Patient Demographics**

Patient First Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Last Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_\_\_\_\_Today’s Date\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient SS #\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: Male Female

Patient Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_

Primary Phone Number ( \_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Alternate Phone Number (\_\_\_\_\_)\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ type of phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status Single Married Divorced Widowed

(Please provide if we may email personal medical and account information to you)

 How did you hear

Student: Y/N Full Time Part Time about our office: Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer Phone Number (\_\_\_\_\_) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party Name** Last\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_First\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_M.I.\_\_\_\_\_\_

(This is the person responsible for receiving and paying statements. If patient is responsible for payment you may write Self and skip down to Emergency Contact. If the patient is younger than 18, this must be the adult bringing the patient to his/her first appointment)

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_SS#\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone Number (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_

Email \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Employer\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(Please provide if we can e-mail personal medical and account information to responsible party)

**Emergency Contact Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number (\_\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Insurance Coverage Information**

**Primary Insurance Carrier** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Subscriber Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (please include middle initial)

**Date of Birth**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Social Security #**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Relationship to Patient**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Address**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Parent or Guardian Signature** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (if patient is under 18)

Initial here if it is acceptable to leave messages regarding your health care on your voice mail or answering machine. This includes, but is not limited to biopsy results. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Initial here if it is acceptable to leave messages regarding your health care with your spouse \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***GENERAL MEDICAL INFORMATION***

Why are you seeing the doctor today? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your general medical health GOOD FAIR POOR

Have you ever been diagnosed with skin cancer NO YES

 Describe \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you diabetic? NO YES

Have you ever had a bleeding problem? NO YES

Do you smoke? NO YES

Have you ever had high blood pressure? NO YES

Have you ever had a stroke? NO YES

Have you ever had trouble with:

 a. Ear, Nose, Throat NO YES

 b. Stomach for digestive tract? NO YES

 c. Heart? NO YES

 d. Circulation? NO YES

 e. Kidney or urinary tract? NO YES

 f. Liver? NO YES

 g. Lungs? NO YES

 h. Teeth or gums? NO YES

 i. Are you allergic to Latex? NO YES

What medicine do you take on a regular schedule? (use back of form for more space)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you allergic to any medication or food? NO YES

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any previous surgery not related

 to your present concern? NO YES

If yes, please list \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List any infection you have had in the last month, such as cold, flu, kidney, skin, dental, etc:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all current medical problems

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of Patient \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Skin Consult Intake Form

 Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Today’s Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Which concerns apply to you? (Please mark all that apply)**

 \_\_\_Uneven skin tone \_\_\_Excessive oiliness \_\_\_Upper lip lines

\_\_\_Enlarged or clogged pores \_\_\_Wrinkles \_\_\_Blackheads/whiteheads

\_\_\_Acne \_\_\_Stretch Marks \_\_\_Dry patches

\_\_\_Hyperpigmentation (brown spots) \_\_\_Scarring

\_\_\_Exposed blood vessels

\_\_\_Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**What is your skin type? (Please Circle)** Normal Dry Oily Combination

**Do you have any of the following chronic skin disorders? (Please mark all that apply)**

\_\_\_Psoriasis \_\_\_Dermatitis \_\_\_Eczema \_\_\_keloid scarring \_\_\_Fever blisters

\_\_\_Cold sores \_\_\_Herpes Simplex/Blisters

**Have you ever undergone any of the following treatments? (Please mark all that apply)**

\_\_\_Microdermabrasion \_\_\_Acid Peel \_\_\_Cosmetic Surgery \_\_\_Accutane \_\_\_Botox

\_\_\_Restylane \_\_\_Juvederm

**Are you currently using any topical creams, lotions, or oral antibiotics for acne, skin cancer, anti-**

**aging or hyperpigmentation?**

Please list:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Additional Comments:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_