

Center for Dermatology & Skin Care of Maryland

Lisa C. Kates, M.D.

OFFICE POLICIES

Office Hours - Our office hours are Monday – Friday from 9:00am to 5:00pm. General questions, appointments and prescription refills are addressed during office hours.

Missed Appointments - If you need to cancel an appointment, it must be done 24 hours prior to the appointment time. **If you miss your appointment without canceling, a \$25 no show fee will be assessed to your patient account.**

Prescription Refills – Please call your pharmacy at least 24 hours in advance of when you need a prescription refilled. This will allow sufficient time for the pharmacy to contact our practice for authorization. Prescriptions will not be refilled if you have not returned for appropriate/required follow-up visits. Prescription refills and questions regarding medications and are addressed during office hours.

Payments – All co-payments and any outstanding patient balances are due on the day of your visit. Payments for cosmetic services are due on the day the procedure is performed. Cosmetic procedure fees are final and non-refundable. Prices and fees are subject to change without notification. We accept cash, checks, Visa and MasterCard. You are welcome to discuss any money related issues with the practice manager.

Patient Fees – A \$5.00 fee, per month, will be assessed to any patient balance that is 60 days or older. We gladly accept personal checks. If any check is returned or declined, you will be charged a \$35.00 return check fee, in addition to any fees from your banking institution. You will be responsible for any interest and/or collection fees assessed in attempt for Lisa C. Kates, MD, LLC to collect bad debt.

Products – All product sales are final and non-refundable.

Forms – Dr. Lisa Kates will fill out insurance forms (i.e. life insurance documents, disability documents, worker's compensation forms) for a fee of \$30.00per form, which must be pre-paid prior to Dr. Kates filling out the form(s).

Medical Records – Medical records can be requested upon completing an authorizing form. A processing fee of \$22.18 plus a \$0.72 per page photocopying fee, and the standard postage rate must be paid prior to releasing the records. There is no charge to forward records to another physician.

Privacy Practices – We are committed to safeguarding your privacy. Federal Privacy Policies (HIPPA) prohibits your medical and/or financial information from being discussed with anyone without your permission.

The Center for Dermatology & Skin Care of Maryland strives to provide you with efficient service. We value you as a patient and appreciate your cooperation regarding our office policies.

Revised 5/23/11

Signature: _____ Date: _____

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PATIENT INFORMATION FORM

Please print: Date: _____

Name: _____ Sex: M F
Last First Middle Initial

Home Address: _____
(Street)

(City) (State) (Zip)

Birth Date: _____ Age: _____ Patient SS#: _____

Home #: _____ Work #: _____ Cell #: _____

Preferred number to call regarding lab results and appointments: _____

May we leave a message if we are unable to reach you? _____ Yes _____ No

Email Address: _____

Would you like to receive information and special promotions via email? _____

Employer: _____ Occupation: _____

Referring Physician: _____ Phone#: _____

Primary Care Physician: _____ Phone#: _____

How did you hear about us (Please check)?

Insurance Plan ___ Yellow Pages ___ Internet/Website ___ Friend/ Family _____

Publication/Advertisement (Please specify): _____

Other (Please specify): _____

Person financially responsible for account: Self Spouse Parent Legal Guardian

Name: _____ SS#: _____

Birth Date: _____ Relationship to Patient: _____

Billing Address: _____

Home Phone #: _____ Work #: _____ Cell # _____

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INSURANCE INFORMATION

	<u>Primary Insurance</u>	<u>Secondary Insurance</u>
Insurance Co. Name:	_____	_____
Address:	_____	_____
Phone #:	_____	_____
I.D. #:	_____	_____
Group #:	_____	_____
Policy Holder Name:	_____	_____
Policy Holder's DOB:	_____	_____
Policy Holder's SS#:	_____	_____
Relationship to Patient:	_____	_____
Policy Holder's Employer:	_____	_____

IN THE EVENT OF AN EMERGENCY, PLEASE CONTACT

Name: _____ Relationship to patient: _____
Home Phone #: _____ Work #: _____ Cell #: _____

Assignment of Benefits: I hereby authorize Lisa C. Kates, M.D., LLC, and her staff to render treatment to me/my dependents. I further give Lisa C. Kates, M.D., LLC permission to release my personal health information for purposes of treatment, payment or operations by phone, mail or fax. I assign and authorize payment of medical/surgical benefits directly to Lisa C. Kates, M.D., LLC

Financial Policies: I understand that any unpaid balances or non-covered services will be my responsibility. I understand that if I provide incorrect or expired insurance information I will assume full financial responsibility for all charges incurred. I understand I will be charged a missed appointment fee of \$25.00 per visit should I fail to provide 24 hours notice of cancellation or rescheduling. I also understand I will be charged a \$30.00 collections fee should my account be referred to a collections company for non-payment and a \$35.00 fee for any and all returned checks. We accept cash, checks, MasterCard, Visa and as forms of payment. By my signature, I certify that the information I have reported with regard to my insurance coverage is correct and acknowledge that I have read and understand the above financial policies (if patient is a minor, signature of responsible party):

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.
- Authorize third party to verify insurance benefits and eligibility.

I have been offered a copy of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____ Signature: _____

Relationship to patient _____

Do we have your permission to discuss your medical information with a member of your family/significant other? _____ Yes _____ No

If yes, with whom? _____

Relationship to patient: _____

By signing below, I am giving Lisa C. Kates, M.D. and/or her staff my permission to discuss any/all of my medical information to the person/persons listed above.

Signature: _____ Date: _____

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Patient History Intake Form

Name: _____ Date: _____ DOB: _____

Are you allergic to any medications? No Yes (List) _____

List all medications, including topical and over the counter, that you are currently taking:

1.) _____ 2.) _____
3.) _____ 4.) _____

Personal Medical History:

1.) _____ 2.) _____
3.) _____ 4.) _____

If female, are you pregnant at this time? No Yes N/A Are you nursing at this time? No Yes N/A

Main reason for today's visit: _____

How long has it been present? _____

Severity/How bad is it? Circle: Mild 1 2 3 4 5 Severe

Family History: Check the box if your blood relatives/family members have had:

skin cancer (other than melanoma) eczema/hay fever/asthma psoriasis baldness/thinning hair
abnormal moles/large number of moles melanoma lupus diabetes or thyroid problems

Social History: Race/Ancestry _____ Occupation: _____

Tobacco use? Frequency? _____ # of peeling sunburns in lifetime? _____

Tanning bed use? How often? _____ Alcohol Drug use, frequency? _____

Do you currently have or have had any of these conditions:

Table with 3 columns: Abnormal moles, Psoriasis, Keloid or abnormal scarring; New or changing moles or lesions, Actinic keratoses (pre-cancers), Other skin conditions; Seborrheic Dermatitis, Skin cancer (BCC / SCC), Hair disorders; Eczema/Atopic dermatitis, Melanoma cancer, Cancer; Prior surgery, Nail disorder, Liver problems or hepatitis; Kidney or urinary problems, HIV/AIDS, Sinus or lung disease (asthma / COPD); Bleeding problems, Endocrine disease, Frequent infections; Heart disease, Neurologic disease, Rheumatologic disease (arthritis, lupus); seasonal or food allergies, mouth or intestinal problems, Constitutional symptoms (fatigue, fever)

I understand the information above is an important part of my medical history/care and have answered all of the above questions truthfully and to the best of my ability. Revised 3/17/11

Patient Signature: _____ Date: _____