

Center for Dermatology & Skin Care of Maryland

Lisa C. Kates, M.D.

OFFICE POLICIES

- Our office hours are Monday – Friday from 9:00am to 5:00pm.
- General questions, appointments and prescription refills are addressed during office hours only.
- If you need to cancel an appointment, it must be done 24 hours prior to the appointment time. If you miss an appointment without canceling it, a \$25.00 no show fee will be assessed to your patient account.
- All co-payments are due on the day of your visit. We accept cash, checks, Visa and MasterCard.
- Due to Federal Privacy Policies (HIPPA) your medical and financial information can't be discussed with anyone without your permission.
- Fees for cosmetic services are due on the day the service is performed. All product sales and cosmetic procedure fees are final and non-refundable. Prices and fees are subject to change without notification.
- Dr. Lisa Kates will fill out forms (i.e. insurance documents, disability documents, Worker's compensation forms) for a fee of \$30.00 per form, which must be pre-paid prior to Dr. Kates filling out the forms.
- Medical records can be requested upon completing an authorization form. There is a \$22.18 processing fee, \$0.72 per page photocopying fee, and the standard rate for postage. There is no charge to forward records to another physician/medical practice.
- 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 are responsible for any interest and/or collection fees assessed in attempt to collect bad debt.

Our goal is to provide you with efficient service. The Center for Dermatology & Skin Care of Maryland values you as a patient and appreciates your cooperation regarding our office policies.

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: _____ 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 _____ Date: _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:
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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.) _____

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

Personal Medical History: _____

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.

Patient Signature: _____ Date: _____