HMGS DERMATOLOGY HEALTH HISTORY INTAKE FORM

Name: _____ **Date of Birth:** _____ **MR#:** _____

Primary Care Provider: _____ Address/Town: _____

Patient Email Address (for communication and online patient portal): _____

Past Medical History (please check all that apply):

☐ Anemia	☐ CHF	☐ Depression	☐ Hayfever	☐ Hypertension	☐ Reflux/GERD
☐ Anxiety	☐ COPD	☐ Diabetes	☐ Heart Disease	☐ Hypothyroidism	☐ Seizures
☐ Arthritis	☐ Cataracts	☐ Eczema	☐ Hepatitis A/B/C	☐ Hyperthyroidism	☐ Stroke
☐ Asthma	☐ Clotting Problems	☐ Glaucoma	☐ High Cholesterol	☐ Lupus	☐ Ulcerative Colitis
☐ Bleeding	☐ Crohn's Disease	☐ HIV	☐ Hives	☐ Psoriasis	☐ Tuberculosis

Other (not listed): _____

Personal history of cancer: _____

Implants/Devices: Do you have (check all that apply): ☐ Artificial joint ☐ Pacemaker ☐ Defibrillator

Past Surgical History (Please list all previous surgeries):

_____

_____

_____

Personal Skin Cancer History: _____Basal Cell _____Squamous Cell _____Melanoma Other_____

Do you wear sunscreen regularly: ☐ YES ☐ NO Have you used tanning beds: ☐ YES ☐ NO

Do you have family history of melanoma: ☐ YES ☐ NO If so, whom: _____

Smoking history: ☐ Never Smoker ☐ Former Smoker ☐ Everyday Smoker ☐ Some Day Smoker

Do you have any **allergies** to medications: ☐ YES ☐ NO If yes, please list: _____

Current Medications (including dose if known, e.g. aspirin 81mg): _____

_____

_____

_____

Preferred Pharmacy: _____ Address/Town/Phone: _____

Occupation: _____

Patient or Guardian Signature: _____ **Today's Date:** _____

Revised 5/6/2020

HEYMANN, MANDERS, GREEN & SOMMER, LLC.

CONSENT, DISCLOSURE, AND AUTHORIZATION FORM

Patient Name:_____ **SSN# :** _____

Address:_____ **DOB:** _____

Email Address:_____ **MR# (office use only):**_____

As used in this form, the words "I," "me," "my" and similar references means the patient whose name appears above, or the parent, legal guardian or other legally responsible person on behalf of the minor or incapacitated patient named above.

General Consent for Examination and Treatment

I hereby consent and authorize Heymann, Manders, Green & Sommer, LLC. ("HMGS") and all physicians, nurses, and other ancillary medical personnel of HMGS, to perform medical examinations and provide routine dermatologic care for all my visits to HMGS. This may include routine diagnostic and laboratory procedures and tests, medication administration, and other routine care for which a specific informed consent form will not be signed by me. This consent includes consent and authorization to photograph or otherwise take images of me and/or parts of my body for purposes of identification, diagnosis, treatment, payment, and healthcare operations of HMGS, as further described below. Any photographs or other images taken will become part of my medical record. HMGS will not use such photographs or images for any other purposes without my specific written consent. I understand that certain procedures will require a specific informed consent, and that HMGS will provide me with information and forms prior to such procedures.

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of the HMGS HIPAA Notice of Privacy Practices, which contains information on the uses and disclosures of my protected health information ("PHI"). I understand that HMGS has the right to change its HIPAA Notice of Privacy Practices from time to time and that whenever an important change is made, HMGS will post a new notice in the office. I may contact HMGS at any time to obtain a current copy of the HIPAA Notice of Privacy Practices. I also may access a copy on its website.

Consent To Use and Disclose Protected Health Information for Treatment, Payment and Health Care Operations

I hereby consent and authorize HMGS to use and disclose my health information, which includes all or any part of my medical records and any other information concerning my diagnosis or treatment, as well as demographic information, by and to its workforce members and to health care professionals, insurance companies, medical facilities, physicians and vendors or suppliers involved, or who may become involved, with my treatment, the payment for my treatment and/or the health care operations of HMGS. I understand that, for example, my health information may be used or disclosed by HMGS to: provide for my care and treatment; communicate among various health care professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by HMGS; provide information to and obtain payment from my health insurance company or plan; assess and review the quality of my care; and conduct its business and health care operations. In addition, I understand HMGS may release my protected health information as required by law or court order.

Patient Name:_____
Date of Birth:_____

Disclosures to Authorized Individuals

I understand that HMGS may release my PHI to a family member, friend, or other person I indicate is involved in my care unless I object. I designate the following person(s) listed below as a person or persons involved with my health care and/or payment for my health care (circle as applicable), to whom the information circled "yes" below may be released:

Name:_____ Relationship: _____
Address:_____ Phone: _____
Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Name:_____ Relationship:_____
Address:_____ Phone: _____
Health Info: ☐ Yes ☐ No Payment Info: ☐ Yes ☐ No

Emergency Contact

In case of an emergency, please contact the below individual. You may provide general information about me, including as necessary to communicate information about the emergency. If this person is also listed above, you may provide information as authorized above.

Name:_____ Relationship: _____
Address:_____ Phone: _____

Contact Information

I wish to be contacted in the following manner (Please check all that apply):

☐ Home Telephone (h) _____	☐ Detailed Message	☐ Call Back Message Only
☐ Work Telephone (w) _____	☐ Detailed Message	☐ Call Back Message Only
☐ Cell Telephone (c) _____	☐ Detailed Message	☐ Call Back Message Only

☐ Mail to Home Address ☐ Mail to Work Address

Mailing address: _____

I understand that if I have checked the box "detailed message," I agree that HMGS may leave any of the following detailed messages at the indicated telephone number: appointment reminders, insurance/financial issues, biopsy or other test results, and any other information regarding care/treatment.

Patient Name:_____
Date of Birth:_____

Use of Consent and Authorization

A copy of this consent and authorization may be used in place of the original.

Consent and Authorization

I have read and understand the terms of this document. I have had an opportunity to ask questions about the use or disclosure of my health information and about the contents of this form. I acknowledge and agree to the terms and conditions of this document:

Patient Name_____Date _____

Patient Signature _____

Authorized Individual (Parent/Guardian) Name _____

Authorized Individual Signature _____

Basis of Authority (e.g., parent, guardian): _____

(Authorized individuals will be required to provide proof of authority)

HEYMANN, MANDERS & GREEN, LLC

FINANCIAL RESPONSIBILITY AND BILLING POLICY

Welcome to Heymann, Manders & Green, LLC, a dermatology practice that strives to provide you with the finest care possible. We are grateful for your decision to choose our practice. Please feel free to ask us any questions about your medical condition, your financial responsibility, or our billing procedures.

Identification and Referrals

At each visit, please bring your identification (e.g., current driver's license or government issued identification card) and your insurance card, if applicable. If a referral form is required, please bring it with you on the day of your visit. If you do not have your referral form, you will have to re-schedule your appointment.

Affiliated Facilities and Participating Insurance Plans

We are affiliated with the facility(ies) listed in **Attachment A**, which information is also available on our website. We participate and are in-network with the insurance plans listed in **Attachment A**, which information is also available on our website. We do not participate and are out-of-network with all other insurance plans. Please note that these lists may be amended from time to time.

Financial Responsibility

Services Covered Under Medicare. If you are a Medicare patient, please note that you will have financial responsibility for the deductible and 20% of the accepted fee that Medicare allows for Medicare covered services.

Services Covered On An In-Network Basis. If your insurance plan is listed in **Attachment A** (as may be amended from time to time) and if our health care services are covered by your insurance plan, we will submit claims for payment to your insurance plan. You will have financial responsibility for any applicable copayment, deductible, or coinsurance under your insurance plan. Even though we are in-network with your insurance plan, you still may have a balance due after we receive reimbursement and an explanation of benefits (EOB) from your insurance plan if you have not yet fulfilled your in-network deductible or have not already paid cost-sharing amounts. We will bill you for any balance due.

Services Covered On An Out-of-Network Basis. If your insurance plan is not listed in **Attachment A**, the following apply to you:

- The amount or estimated amount we will charge for health care services is available upon request. If you request health care services, we will provide to you in writing the amount or estimated amount that we will bill for such services and the Current Procedural Terminology (CPT) codes associated with such services, absent unforeseen medical circumstances that may arise.
- You will have financial responsibility applicable to the health care services provided by an out-of-network professional, in excess of your copayment, deductible, or coinsurance, and you may be responsible for any costs in excess of those allowed by your insurance plan.
- We advise you to contact your insurance plan for further consultation on these costs.
- We will submit claims for payment to your insurance plan. You will have financial responsibility for the entire amount of the balance due. We will bill you for this balance after we receive reimbursement and an explanation of benefits (EOB) from your insurance plan. Please be advised that you may incur additional out-of-network charges for ancillary services (see below).

Non-Covered Services and No Insurance Coverage. If our services are not covered by your insurance plan or if you have no insurance, you agree to be, and shall be, financially responsible for all such services.

Ancillary Services: Certain laboratory, pathology or radiology services may be required in connection with our health care services or as coordinated or referred to by us. These ancillary services may be provided by:

- Quest Diagnostics, 900 Business Center Drive, Horsham PA 19044, 866-697-8378
- LabCorp, 69 First Avenue, Raritan, NJ 08869, 800-762-4522
- Dermpath Diagnostics Institute, 3805 West Chester Pike, Newtown Square, PA 19073, 800-257-0117
- Heymann, Manders & Green, LLC, 10000 Sagemore Drive, Suite 10103, Marlton, NJ 08053, 856-596-3040

We advise you to contact each of these providers and your insurance plan prior to receiving any health care services to determine the plans that each of these providers participates in, and to contact your insurance plan for further consultation on costs.

YOU ARE RESPONSIBLE FOR UNDERSTANDING WHAT YOUR INSURANCE PLAN PROVIDES, INCLUDING YOUR CO-PAYMENT, DEDUCTIBLE, CO-INSURANCE, NON-COVERED SERVICES, OUT-OF-NETWORK BENEFITS, AND FINANCIAL RESPONSIBILITY. MANY INSURANCE PLANS HAVE HIGH DEDUCTIBLES OR CO-INSURANCE. YOU ARE RESPONSIBLE FOR PAYING THESE CHARGES IN FULL. PLEASE CONTACT AND CONSULT WITH YOUR INSURANCE PLAN FOR DETAILS.

Payment

Payment for all health care services is expected on the day that services are rendered. Payment may be made in cash or by check, Visa, MasterCard, Discover, or American Express.

Billing Practices

You will be held responsible for any remaining balance not covered by your insurance plan. Our billing service sends out bills on a monthly basis. Please do not ignore these bills. If the billing cycle is complete and payment is not received, we will then employ the use of a collection agency. You agree to be responsible for all costs of collection, including court costs, collection agency costs, and legal fees.

If you receive a bill that you have questions about, please contact our billing service at 1-888-245-5337.

Cancellation/No-Show Policy

If it is necessary to cancel an appointment, we require that 24-hours' advance notice be given to our office. You will be charged a $50.00 fee if you do not provide 24 hours' notice of cancellation or do not show up for your scheduled appointment. We reserve the right to discharge from our practice patients who miss multiple appointments or fail to give 24-hours' prior notice of cancellation.

Returned Checks for Insufficient Funds

You will be charged a fee of $35.00 for any checks that are not payable by your bank in the event you have insufficient funds.

Assignment of Benefits

By signing below, I hereby authorize Heymann, Manders & Green, LLC, and its physicians and staff (each and collectively, "**HMG**") to release to the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient (identified below) any information, including without limitation protected health information, needed for the processing of claims for payment for services rendered to the patient.

I hereby authorize HMG to submit claims to the applicable payor, insurance plan, intermediary, plan administrator, or third party for all services rendered to the patient and to exercise any appeals and other rights on the patient's behalf.

I hereby authorize HMG the right to file suit, obtain counsel, and enter into legal or other actions on the patient's behalf, including arbitration or dispute resolution processes, for any claims against the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient. This authorization includes assignment of the right to pursue declaratory, equitable, and compensatory relief or other legal remedies.

I hereby authorize HMG to appoint an attorney to represent the patient directly for the collection of all insurance plan or other benefits through the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient. I authorize HMG to obtain an attorney to represent the patient directly in appealing a claim to the applicable payor, insurance plan, intermediary, plan administrator, or third party.

I hereby authorize HMG to act on the patient's behalf and report any suspected violations of proper claims practices to the proper regulatory authorities.

I hereby direct the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient to issue a payment check directly to HMG. If payment will not be made directly to HMG, I hereby authorize and direct the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient to send all checks and copies of Explanation of Benefit forms in connection with the services provided by HMG to Heymann, Manders & Green, LLC, 100 Brick Road, Suite 306, Marlton, NJ 08053.

I understand and agree that, should I, the patient, my dependents, or my beneficiaries receive funds from the applicable payor, insurance plan, intermediary, plan administrator, or third party for services performed by or at HMG, that it is my responsibility to endorse the checks and send them to HMG.

We realize that you have many options for dermatologists. We are thankful to those who make Drs. Heymann, Manders, Green, Halpern, Sommer and Julianna Jarvis, PA-C, their providers of choice. We look forward to meeting with you soon.

Please sign below to confirm that you have read and understand the foregoing financial responsibility and billing policy and that you are signing it of your own free will.

_____ Print Name of Patient	_____ Print Name of Guardian/Responsible Party (if different from Patient)
_____ Signature of Patient/Guardian/Responsible Party Dated:_____	_____ Signature of Witness Dated: _____