HMGS DERMATOLOGY

PEDIATRIC PATIENT INTAKE FORM

Patient Name:	**Date of Birth:**
Home Address:	**City/State/Zip**
Referring Physician Name:	**City/State**
Primary Care Physician Name:	**City/State**

PAST MEDICAL HISTORY

(Please check all boxes that apply)

Anemia	☐	Depression	☐	Hyperthyroidism	☐
Anxiety	☐	Diabetes	☐	Lupus	☐
Arthritis	☐	Eczema	☐	Psoriasis	☐
Asthma	☐	Glaucoma	☐	GERD/Reflux	☐
Bleeding	☐	Herpes Simplex	☐	Seizures	☐
Chronic Heart Failure	☐	HIV	☐	Stroke	☐
Cold Sores	☐	Heart Disease	☐	Ulcerative Colitis	☐
COPD	☐	Hepatitis A/B/C	☐	Tuberculosis	☐
Cataracts	☐	High Cholesterol	☐	Prematurity	☐
Clotting Problems	☐	Hypertension	☐	Other:	
Crohn's Disease	☐	Hypothyroidism	☐	Other:	

Race	Ethnicity	Sexual Orientation	Gender Identity
☐ American Indian or Alaska Native	☐ Hispanic or Latina/o	☐ Lesbian, gay or homosexual	☐ Male
☐ Asian	☐ Non-Hispanic or Non-Latin	☐ Straight or heterosexual	☐ Female
☐ Black or African American	☐ Other	☐ Bisexual	☐ Female-Male (FTM) Transgender
☐ NativeHawaiian or Other Pacific Islander	☐ Asked but unknown	☐ Something else, please specify:	☐ Male-Female (MTF) Transgender
☐ White	☐ Choose not to disclose	☐ Don't Know	☐ Genderqueer, neither exclusively male or female
☐ Other, please specify:		☐ Choose not to disclose	☐ Additional gender category or other, please specify:
☐ Asked but unknown			☐ Choose not to disclose
☐ Choose not to disclose			

Personal Cancer History	**Type:**	**Month/Year**
Family Skin Cancer History	☐ YES Whom? ☐ NO	**Type:**

Do you have any allergies to medications?

☐ Yes

List Medication and the reaction you had:

☐ No

Have you had a Flu Vaccine recently?	☐ YES, MO/YR ☐ NO
Have you had a Pneumonia Vaccine?	☐ YES, MO/YR ☐ NO
Have you been screened for Hepatitis C?	☐ YES, MO/YR ☐ NO

If you are being seen for <u>ECZEMA</u> please list the following products you use:	**If you are being seen for <u>ACNE</u> please list the following products you use:**
Soap in shower/bath:	Face wash:
Shampoo/Conditioner:	Face lotion/moisturizer:
Moisturizer(s):	All over-the-counter products including toners, wipes, pads, etc:
Laundry Detergent:	

Implants/Devices	Month/Year	Past Surgical History (list below)	Month/Year
☐ Artificial Joint ☐ Pacemaker ☐ Defibrillator			

CURRENT MEDICATIONS

Name of Medication	Dose

Preferred Pharmacy:	Pharmacy City/State	Pharmacy Phone Number:

Patient or Guardian Signature: _____ Date: _____

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CONSENT, DISCLOSURE AND AUTHORIZATION FORMS

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

1. General consent for examination and treatment

I hereby consent and authorize **Heymann, Manders, Green & Sommer, LLC (HMGS)** and all physicians, physician assistants, 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 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.

2. Acknowledgement of receipt of Notice of Privacy Practices

I have reviewed 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.

3. Consent to use and Disclosure of Protected Health Information for Treatment, Payment, and Healthcare 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 healthcare 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 Healthcare professionals who are involved in my care or treatment; bill for and obtain payment for care and treatment provided by HMGS; provide information to obtain payment from my health insurance company or plan; access and review the quality of care; and conduct its business and healthcare operations. In addition, I understand HMGS may release my protected health information as required by law or court order.

4. 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 healthcare and/or payment for my healthcare.

NAME	PHONE NUMBER	RELATIONSHIP	DOB	HEALTH INFORMATION	PAYMENT INFORMATION
				YES ☐ NO ☐	YES ☐ NO ☐
				YES ☐ NO ☐	YES ☐ NO ☐
				YES ☐ NO ☐	YES ☐ NO ☐
				YES ☐ NO ☐	YES ☐ NO ☐

5. Emergency

In case of emergency, please contact the below individual/s. 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	PHONE NUMBER	RELATIONSHIP

6. Contact Information

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

TYPE	DETAILED MESSAGE	CALL BACK MESSAGE ONLY	PHONE NUMBER/EMAIL ADDRESS
Home	YES ☐ NO ☐	YES ☐ NO ☐	
Work	YES ☐ NO ☐	YES ☐ NO ☐	
Cell Phone	YES ☐ NO ☐	YES ☐ NO ☐	
Text Message	YES ☐ NO ☐	YES ☐ NO ☐	
Email	YES ☐ NO ☐	YES ☐ NO ☐	

7. My Preferred mailing address is:

☐ **Home Address**

☐ **Work Address**

_____

☐ **Other Address**

_____

I understand that I have checked the box "detailed message", and 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.

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 of the disclosure of my health information and about the consent of this form. I acknowledge and agree to the terms and conditions of this document:

Patient Signature: _____ Date: _____

Authorized Individual (Parent/Guardian Name): _____

Basis of Authority (e.g. Parent, guardian) _____

Authorized Individual Signature _____ Date: _____

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

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FINANCIAL RESPONSIBILITY AND BILLING POLICY

1. **Identification and referrals:** At each visit, you must bring identification (e.g. current driver's license or government-issued ID) and a copy of your insurance card. If a referral is required by your insurance company, it is the patient's responsibility to obtain it from their primary care provider and bring it with you to your visit to avoid having your appointment rescheduled.
2. **Participating insurance plans:** Please be advised we do not participate with all insurance plans at our facilities. Please call your insurance to make sure your provider is participating at the location you are being seen.
3. **Financial Responsibility:**
   a. **Medicare:** Patient is responsible for the annual deductible and/or 20% of the Medicare allowance for all covered services.
   b. **In-Network Insurance:** If HMGS participates with your insurance plan, the patient is responsible for paying all copayments at the time of service. Annual deductibles and coinsurances will be billed to the patient in accordance with the explanation of benefits (EOB) from your insurance. Patient will dispute claims not processed or processed incorrectly according to their plan, directly with their insurance company.
   c. **Out-of-Network Insurance:** If HMGS does not participate in your insurance plan, the following applies:
      i. Patient will be responsible for contacting their insurance to ensure they have out-of-network benefits and to understand what their out-of-network benefits cover and the out-of-pocket costs.
      ii. Patients are financially responsible for all services more than the allowable amount of your insurance plan.
      iii. As a courtesy we will submit a claim to your insurance plan. You will be responsible for the entire amount due.
      iv. A deposit may be required to schedule appointments and/or treatments.
      v. You may incur additional out-of-network charges for ancillary services (see ancillary services below)
   d. **Non-Covered Services and Self-pay:** If our services are not covered by your insurance plan or if you have insurance, you agree you will be financially responsible.
   e. **Ancillary Services:** Certain laboratory, pathology, or radiology services may be required in connection with our healthcare 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
      Lab Corp-69 First Avenue, Raritan, NJ 08869: 800-762-4522
      DermPath Diagnostics Institute, 3805 West Chester Pike, Newtown Sq PA 19073: 800-257-0117
      Heymann, Manders, Green & Sommer, LLC-1000 Sagemore Drive, Suite 10103, Marlton, NJ 08053:856-596-3040

      We advise that patients contact each of these providers and your insurance plan prior to receiving any health services to determine if these providers participate with your insurance plan for further consultation on costs.

The Patient is responsible for understanding their insurance benefit plan and what is covered, including copayments, deductibles, coinsurance, non-covered services, out-of-network benefits, and financial responsibilities. Many patients now have high deductible plans. Please contact your insurance prior to coming so you have a clear understanding of your responsibilities.

Payment: Payment for all services not covered by insurance, copayments, and patient balances are expected the day the services are rendered. Payment may be made in cash or check, Visa, Mastercard, Discover, or American Express.

Billing Practices: Once we have received payment from your insurance company and there are unpaid fees that are the patient's responsibility, you will begin to receive a monthly bill. Please contact our billing department if you will not be paying your balance in full. You will receive 3 statements before your account is referred to a collection agency. You agree to be responsible for all costs of collection, including court costs, collection agency costs, and legal fees.

Cancellations/No-Show Policy: If it is necessary to cancel, we require that a 24-hour notice is given. You will be charged a $50 fee for the first offense and a $75 fee for the second offense; If you do not provide a 24-hour notice of cancellation or do not show up on the day of your scheduled appointment. We reserve the right to ask for a non-refundable deposit for future appointments or discharge patients after multiple offensives.

Returned checks for insufficient funds: You will be charged a fee of **$45** for any checks that are not payable by your bank in the event you have insufficient funds.

By Signing below, I hereby authorize HEYMANN, MANDERS, GREEN & SOMMER, LLC (hereafter HMGS) and its providers and staff to release to the applicable payor, insurance plan, intermediary, plan administrator or third party covering the patient (identified below) any information, including without limitation, including without limitation protected health information needed for the processing of claims for payment for services rendered to the patient.

I hereby authorize HMGS:

- To submit claims to the applicable payor, insurance plan, intermediary plan administrator, or third party for all services rendered the patient and to exercise any appeals and other rights on the patient's behalf
- The right to file suit, obtain counsel and enter 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 alignment of the right to pursue declaratory, equitable, and compensatory relief or other legal remedies.
- To appoint an attorney to represent the patient directly for the collection of all insurance plans or other benefits through the applicable payor, insurance plan, intermediary, plan administrator, or third party covering the patient.
- To appoint an attorney to represent the patient to appeal a claim to the applicable payor, insurance plan, intermediary plan administrator, or third party.
- 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 HMGS. If payment will not be made directly to HMGS, I hereby authorize and direct the payor, insurance plan, intermediatory, plan administrator, or third party covering the patient to send all checks and copies of EOB forms in connection with services provided by HMGS.
- 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 HMGS, that it is my responsibility to endorse the checks and send them to HMGS.
- I understand and agree that, should I, the patient, my dependents, or my beneficiary's funds from the applicable payor, insurance plan, intermediary, plan administrator, or third party for services performed by or at HMGS, that it is my responsibility to endorse the checks and send them to HMGS.

Please sign below to confirm that you have read and understand the foregoing financial responsibility and billing policy.

Print Name of the Patient

Print Name of the Guardian/Responsible Party
If different from the patient

Signature of patient/Guardian/Resp Party

Witness Signature

Date