Eastern Connecticut Dermatology

Patient name_____Age_____Today's date___/___/___

Referring doctor _____ Referring doctor's town_____

Reason for today's visit_____

_____

Medications_____

_____

_____

Drug allergies_____

Do you have, or have members of your family ever had diseases or conditions of any of the following (please explain)?		
	YOU	FAMILY MEMBERS (WHO, WHAT?)
Eyes		
Ears/Nose/Throat		
Heart		
Liver		
Lungs		
Stomach/Bowels		
Kidneys		
Arthritis/Muscles/Joints		
Blood pressure		
Headaches/Seizures		
Psychological problems		
Thyroid/Diabetes		
Blood/bleeding disorders		
Allergic/Immunologic		
Cancer		
Melanoma		
Psoriasis		
Eczema		

Females only: are you pregnant, breast feeding or trying to get pregnant? (yes / no)
Do you have an artificial heart valve, joint pacemaker? Yes / No
Number of children ____ ages _____
Occupation_____Hobbies_____

In case of emergency, please notify _____Phone_____

PHARMACY OF CHOICE _____TOWN_____

Reviewed by_____(physician)

Eastern Connecticut Dermatology *(This information is confidential)* Today's Date___/___/___

Patient name: First_____Middle_____Last_____

Street Address_____Town_____Zip_____

Preferred phone_____(is this cell, home or work?)

Secondary phone_____(is this cell, home or work?)

Email _____ SS#_____

Birth date_____Marital status_____Name of spouse (or parent)_____

Employer_____Address (city)_____

(For minor) parent or guardian name:_____Relationship_____

Address_____Town_____

	Yes	No
May we leave a message on your answering machine?		
May we speak with or leave a message with your spouse / parents? (if so, please list names)		
May we contact you by cell phone?		

Primary insurance company name_____

Insured name_____Relationship to patient_____

Insured birth date (if different from above)___/___/_____Insured employer_____

ID#_____Group number_____Social Security #_____

Secondary insurance company name_____

Insured name_____Relationship to patient_____

Insured birth date (if different from above)___/___/_____Insured employer_____

ID#_____Group number_____Social Security #_____

I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of insurance benefits. I authorize payment for medical services rendered and authorize release of any medical information necessary to process this claim.

Signed_____Date____/____/_____

PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: _____ Date: _____

PAYMENT POLICY:

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We file with secondary/supplemental carriers. Medicare does not cover cosmetic procedures.

HMO, PPO or other managed care patients: You will responsible for paying your annual deductible, copayment and charges for any non-covered or cosmetic procedures.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay the bill at the time of service. The office may agree to bill insurance first in the case of expensive surgical procedures. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient, legal guardian, or responsible party signature _____ **Date:** _____

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original , and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card _____ **Date:** _____

If you have a supplemental policy and it is MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP card _____ **Date:** _____

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

AMENDED 2013

Eastern Connecticut Dermatology
491 Gold Star Highway, Suite 310
Groton, CT 06340
(860)445-8020

Patient Name_____

I hereby acknowledge that I have been offered a summary or full copy (my Preference) of the Eastern Connecticut Dermatology Notice of Privacy Practices. I understand that I may request a copy of any amended Notice of Privacy Practices at any time.

Signed_____Date_____

Printed name_____Phone_____

If not signed by the patient, please indicate your relationship to the patient: _____

_____

For office use only:

Signed form received from_____

Refused to sign:

Reason for refusal:_____

Efforts to obtain: _____

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For patient with high deductible plans or health savings accounts (Lumenos, Pequot Plus, United Healthcare)

Due to the increased popularity of HSA/high deductible insurance policies, we have initiated a policy to cover these deductibles. Much like a hotel asks for a credit card which is later used to pay your bill, we have a similar policy.

You will be asked for a credit card number at the time of check in. Your information will be held securely until your insurance(s) have paid their portion and notified us of the amount of your share. At that time, you will be sent a statement which you have 30 days to pay. If the bill remains unpaid after 30 days, we will bill your card.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays due at the time of service will continue to be due at the time of service.

If you have any questions, do not hesitate to ask.

Sincerely,
Eastern Connecticut Dermatology

I understand I am responsible for the balance of my bill after processing by my insurance. I authorize Eastern Connecticut Dermatology to charge the outstanding balance on my account to the following credit card:

Visa Mastercard Discover

Account Number_____ Expiration Date_____

Name on card (please print)_____

Address_____

Signature_____ Date_____

-or-

Please bill my credit card immediately for any balances due after processing my insurance.

Signature_____Date_____