DERMATOLOGY PHYSICIANS OF CONNECTICUT

**PATIENT DEMOGRAPHICS**

First Name: _____ Middle Initial: _____ Last Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____ DOB: _____

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

Gender: Male _____ Female _____ Marital Status: S _____ M _____ D _____ W _____

Emergency Contact/ Guardian: _____

Relationship: _____ Phone # _____

Referring Physician's Name: _____ Phone # _____

Primary Care Physician's Name: _____ Phone # _____

Pharmacy: _____ Phone # _____

Address: _____

Responsible Party (if other than patient), Name: _____

Relationship: _____ Phone #: _____

Address: _____

**Primary Insurance Information:**

Insurance Carrier: _____

Primary Subscriber: _____ Relationship to patient: _____

Subscriber Tel #: _____ Subscriber DOB: _____

I hereby authorize Dermatology Physicians of Connecticut, PC to release any of my medical information necessary to process this claim and also authorize payments directly to the provider. A photocopy of this assignment shall be valid as the original.

I hereby voluntarily consent for examination and treatment by the physicians of Dermatology Physicians of Connecticut, PC.

Signature: _____ Date: _____

Relationship if other than patient: _____

DERMATOLOGY PHYSICIANS OF CONNECTICUT

**PATIENT AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION**

Patient Information:

Name: _____ DOB: _____

(Last) (First) (MI)

I authorize the disclosure and use of my protected health information by Dermatology Physicians of Connecticut (Practice) as described below:

1. Who may receive and use this information?
(Print their name, address, phone number and relationship to you.)

_____

_____

2. List any restrictions on the information to be released:

_____

_____

I understand that:

- I may revoke this authorization at any time by notifying, in writing, the Practice at the address below.
- Revoking this authorization does not apply to information that has already been released under this authorization.
- I have the right to inspect or copy the health information to be disclosed.
- If the disclosed information goes to a health care provider or a health plan covered by federal privacy laws, it will be protected by federal privacy laws.
- Information that goes to other persons or entities may not be protected by state or federal privacy laws and may be re-disclosed.
- I do not have to sign this form. Treatment will still be provided to me if I do not sign this form.

Payment for services is not contingent upon signing this form, unless those services are for the sole purpose of creating personal information for a third party, such as life insurance companies.

Signature of Patient or Patient's Representative_____ Date _____

DERMATOLOGY PHYSICIANS OF CONNECTICUT

**CERTIFICATION OF ACTIVE AND VALID INSURANCE & ASSIGNMENT OF BENEFITS**

Patient name: _____

Primary Insurance: _____ Policy #: _____

Secondary Insurance: _____ Policy #: _____

I voluntarily declare that I have the following valid and active health insurance for today's doctor visit. I fully understand that I will be responsible for payment of the services rendered if my insurance is not valid and active at the time of service.

I hereby request and instruct the above insurance company to pay by check made payable and sent directly to:

DERMATOLOGY PHYSICIANS OF CONNECTICUT, PC
4 CORPORATE DRIVE, SUITE 386, SHELTON, CT 06484
148 EAST AVENUE, SUITE 3B, NORWALK, CT 06851
6 BUSINESS PARK DRIVE, SUITE 204, BRANFORD, CT 06405
2416 WHITNEY AVE, HAMDEN, CT 06518
1 BRADLEY RD, SUITE 705, WOODBRIDGE, CT 06525

This is for professional services rendered to me, and as payable under my policy benefits. This is a direct assignment of my rights and benefits under this policy. This payment will not exceed to the above-mentioned assignee, and I have agreed to pay in a current manner, any balance of said professional service charge over and above this insurance payment.

I will assume the cost of any services or procedures not covered by my insurance or deemed as cosmetic in nature. Examples include but are not limited to: skin tags, acne surgery (milia), comedone extraction, paring hyperkeratosis lesions, alopecia.

A photocopy of this assignment shall be considered as effective and valid as the original. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

Patient/ Responsible Party Signature _____ Date _____

DERMATOLOGY PHYSICIANS OF CONNECTICUT

## PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Name: _____
(Last) (First) (Middle)

I understand that the Dermatology Physicians of Connecticut (the "Practice") may use my health information for treatment, payment and health care operations. I have been shown a copy of the Practice's Notice of Privacy Practices that describes how my information is used and disclosed. I understand that the Practice has the right to change this Notice at any time. I may obtain a current copy of the Notice by contacting the Practice's Privacy Officer at (203) 538-5682.

_____ _____
Signature of Client/ Parent/ Legal Guardian or Personal Representative Date

_____ April 1, 2013
If signed by a Personal Representative, relationship to client

## LABORATORY ACKNOWLEDGEMENT

List of laboratories Dermatology Physicians of Connecticut may send specimens to, in case a biopsy or culture is needed. By signing below I acknowledge that if my insurance doesn't participate with one of the listed laboratories, I will be liable for any bills I may incur from the lab. It is patient responsibility to know their insurance plan benefits, coverage and limitations.

Dermatopathology Laboratory of New England

Dermatopathology Laboratory of New York

Yale Dermatopathology Laboratory

Griffin Hospital Laboratory

Corium Diagnostics

LabCorp

Quest

Signature of Patient or Patient's Representative_____ Date _____

# Patient Financial Obligation

We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

As you are probably aware the changes in health care have shifted many of the costs from the insurance company to you, the patient. If we participate with your insurance plan you will be responsible to pay for your co-pay, deductibles and /or co-insurance at time of service. You may also be responsible for payment of services related to conditions that are not covered by your Plan. If you have not met your deductible, you will be responsible for the amount of the deductible and whatever amounts the insurance company does not pay. If your insurance company denies payment or will only pay a portion of your medical bill, you, the patients are responsible for payment of services rendered and will be billed accordingly. Please be aware that your insurance carrier does not guarantee accuracy of its confirmation of coverage and benefits.

**Laboratory Bills**

If you should undergo a biopsy in our office, the Lab will bill your insurance carrier separately. You will receive a separate bill from the Lab for any uncovered charges.

**Payment Methods:**

For your convenience, we accept the following forms of payment: Cash, Check, Visa, MasterCard, American Express, or Discover.

- **It is office policy that a credit card is left on file** as most insurance policies have deductible, co-insurance, and surgical co-insurance in addition to co-pays. Your insurance company determines the exact amount after we have submitted your claim for payment. We will charge your card for the amount, which is your responsibility and your insurance company, will also send you a copy of the explanation of benefits.
- Your signature below provides authorization for our office to process payment(s) to this card for reasons as outlined above.
- Any balances in excess of $300 will receive a call and given the option of a payment plan.
- Once the Explanation of benefits (EOB) from the insurance company has been received, you will not receive a statement from us, only a receipt after the payment has been processed.

***It is our utmost concern that patients' transactions are processed according to the highest security standards. To that end, Dermatology Physicians of CT will safely and securely store your credit card information on Authorize.net, the industry leader in gateway security. This method meets all PCI requirements. All card information will be stored in an Authorize.net "Lock Box" and truncated during the process to prevent unauthorized access to full card information.***

**Failure to Pay:**

**Any unpaid balance that exceeds 90 days will be sent to a collection attorney and will incur any attorney fees and collection costs. The patient/or guarantor will be responsible for all associated costs including interest from the date of service.**

**I, _____ have read the above disclaimer and fully understand my financial responsibilities to Dermatology Physicians of CT.**

**Patient/Guardian Signature: x _____**

**Email: _____**

**Date: ___/ ___/ ___**

**Credit Card: Visa _____ MasterCard _____ American Express _____Discover_____**

**Credit Card # _____Expiration Date: ____ / ____**