Dermatology

CONNECTICUT SKIN HEALTH

PATIENT DEMOGRAPHICS

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

Address: _____

City: _____ State: _____ Zip Code:_____

Email: _____ DOB: _____

Primary phone #: _____ C H W Secondary phone #: _____ C H W

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: _____

I hereby authorize Connecticut Skin Health 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 Connecticut Skin Health.

Signature: _____ Date: _____

Relationship if other than patient: _____

Dermatology

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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 Connecticut Skin Health (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

CONNECTICUT SKIN HEALTH

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:

CONNECTICUT SKIN HEALTH LLP
4 CORPORATE DRIVE, SUITE 386, SHELTON, CT 06484

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

CONNECTICUT SKIN HEALTH

LABORATORY ACKNOWLEDGEMENT

I understand that if a specimen is taken and sent to a laboratory, 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. It is my responsibility to let the medical staff know if there is a specific laboratory I would like to use.

Signature of Patient or Patient's Representative_____ Date _____

PRIVACY NOTICE WRITTEN ACKNOWLEDGEMENT

Name: _____

(Last) (First) (Middle)

I understand that the Connecticut Skin Health (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

Dermatology

CONNECTICUT SKIN HEALTH

Please read and initial

_____ **Insurance Information:** Insurance card(s) must be presented at time of visit. Cards will be copied for my file. It is my responsibility to provide any updated information or changes regarding my insurance at the time of service. If insurance information is not provided at the time of visit, the charges are my responsibility.

_____ **Referrals:** In the case that my insurance requires a referral, I am responsible for obtaining the referral from my primary care physician prior to my scheduled appointment. If I chose to be seen without a referral, I may be responsible for the charges. CTSH has the right to postpone my visit until referral is provided.

_____ **Co-Payments:** Co-pays are expected to be paid at the time of visit.

_____ **Self-Pay:** In the case that I do not have any insurance or have insurance that CTSH does not participate with, I will be fully responsible for all charges due at the time of service. Any procedures deemed cosmetic and not medically necessary are also expected to be paid at the time of service.

_____ **Account Balances:** I understand that I am responsible for payment of any balances on my account for services declined by my insurance company or applied to my deductible. If my account will stay delinquent for more than 60 days, I will not be able to schedule any future appointments and could be subject to collections.

_____ **No shows:** There is a $50 no show fee for any missed appointments other than cosmetic consults and $100 no show fee for alopecia patients. If my credit card is on file, it will be charged for any no-show fees.

_____ **Cosmetic Consults:** I am aware that there is $150 fee for a cosmetic consultation due at the time of scheduling an appointment. The fee will be applied towards any procedure discussed during the consultation. The fee will be refunded if the appointment is canceled at least 24 hours prior to the appointment. The fee is non-refundable for missed appointments.

_____ **Divorce or Custody Situations:** The parent/guardian bringing the child in for the visit is responsible for any co-pays or balances that are due at time of service. Any issues are to be resolved between parents.

Signature of Patient or Patient's Representative_____ Date _____

4 CORPORATE DRIVE, SUITE 386, SHELTON, CT 06484 P: 203-538-5682 F: 203-538-5685 • 148 EAST AVENUE, SUITE 3B, NORWALK, CT 06851 P: 203-538-5682 F: 203-538-5685

6 BUSINESS PARK DRIVE, SUITE 204, BRANFORD, CT 06405 P: 203-208-4082 F: 203-208-4952 • 1 BRADLEY ROAD, SUITE 705, WOODBRIDGE, CT 06525 P: 203-389-1185 F: 203-389-1427

1952 WHITNEY AVE, 2nd FL, HAMDEN, CT 06518 P: 203-288-1142 F: 203-288-5086 • 425 POST ROAD, 2nd FL, FAIRFIELD CT 06824 P: 203-292-9490 F: 203-760-0172

1 LONG WHARF DRIVE, SUITE 103, NEW HAVEN, CT 06511 P: 203-787-4171 F: 203-865-3344 • 6 SHAWS COVE, SUITE 204, NEW LONDON, CT 06320 P: 860-440-3744 F: 860-440-3718

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.

Failure to Pay:

Any unpaid balance that exceeds 60 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.

Payment Methods:

For your convenience, we accept the following forms of payment: 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, Connecticut Skin Health will safely and securely store your credit card information in a PCI compliant system and all card information will be encrypted. ** Please hand your credit card to the receptionist to be entered into our system.*

I, _____ have read the above disclaimer and fully understand my financial responsibilities to Connecticut Skin Health.

Credit Card: Visa _____ MasterCard _____ American Express _____Discover_____

Last 4 digits of Credit Card # _____ Expiration Date: ____ / ____ CVV: _____

Patient/Guardian Signature: x _____

Date: ___/ ___/ ____

As of January 1st, 2020, we will be requiring patients to leave a credit card on file with our office.

Why the change?

We need to ensure that we have a guarantee of payment on file in our office. Things are changing in healthcare, and we need to be sure that patient responsible balances are paid in a timely manner.

But I always pay my bill, why me?

We have to be fair and apply the policy to all patients. We have wonderful patients and we know that most of you pay your balances. Unfortunately, this is not the case for everyone.

How will I know how much you are going to charge me?

You will receive a letter from your insurance carrier that explains how much of your office visit they pay and how much you pay. This is called an Explanation of Benefits or an EOB. This letter tells you exactly, according to your health insurance coverage, what portion of your health care bill is your responsibility and what portion was paid to your health care provider by your insurance company. Any portion of the medical expense not covered by the insurance company, such as a deductible or co-pay, will be the patient's responsibility.

Then what?

We receive the same letter after you do. It arrives about 20-30 business days after your appointment. We look at each Explanation of Benefits (EOB) carefully, and determine what your insurance has determined to be the patient's responsibility. This is the same way we determine the amount of the bill you receive in the mail. However, instead of sending you a bill, we will charge the credit card we have on file if your patient responsibility is under $300. Please note that if you choose to provide us with your debit/ credit /HAS card as your method of payment, you will not be notified of the charge if it is under $300.

But wait, I'm nervous about leaving you my credit card information.

We do not store your sensitive credit card information in our office. The required information is secured in our PCI compliant system. (PCI or Payment Card Industry compliance, refers to the technical and operational standards that businesses must follow to ensure that credit card data provided by cardholders is protected).

We access your information only on this secure site to process a payment. No one in our office has access to/ can see your credit card information.

What if I need to dispute my bill?

We will always work with you to determine if there has been a mistake, and will refund you if we have made a billing error. We will only charge the amount that we are instructed to by your insurance carrier, in the EOB letter they sent to us.

What if I don't want to leave a credit card on file?

You can leave a deposit of $200 for a regular office visit, $250 for an excision, or $600 for a Mohs procedure for any unpaid charges or pay your estimated bill in full and we will refund the insurance portion to you after they pay.