HAMPTON DERMATOLOGY, PC

325 Meeting House Lane Southampton, NY 11968 (631)283-3131

PATIENT INFORMATION

Patient's Name _____ Date of Birth _____

Sex _____

Social Security No. _____ Marital Status _____

BILLING ADDRESS:

Street/ PO Box _____ Email Address _____

City _____ State _____ Zip Code _____

Home phone (if applicable) _____

Cell phone _____

Emergency Contact Name and phone: _____

INSURANCE INFORMATION: Please Present ALL insurance cards at the front desk at the time of your visit.

Primary Insurance _____ **Secondary Insurance** _____

POLICY HOLDER / RESPONSIBLE PARTY INFORMATION:

*** Policy Holder / Parent** _____ Address (if different) _____

*** Date of Birth** _____ _____

PRIMARY PHYSICIAN: Please Note: If your insurance company requires a referral for specialists. A referral must be filled out by your Primary Doctor.

Name: _____ Phone _____

Address _____

MY PHARMACY: _____ Phone _____

Hampton Dermatology, PC does not participate with all insurance plans. If Hampton Dermatology, PC does not accept my insurance or I have no insurance coverage, I understand that I am expected to pay in full on the day that professional services are rendered, unless other arrangements have been made in advance. If Hampton Dermatology, PC does accept my insurance, I understand that I am responsible for any amount not covered by my insurance, including deductibles and co-payments.

I hereby authorize treatment of my/my dependent's medical condition by Hampton Dermatology, PC.

I hereby authorize Hampton Dermatology, PC to furnish information to my insurance plan(s) concerning my illness and treatment, and assign to the physician all payments for medical services rendered to myself and my dependants. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original.

Signature _____ Date _____

TURN PAGE OVER

PATIENT MEDICAL HISTORY

Have you ever been treated for any of the following? (Please circle)

Heart disease or pacemaker	yes	no
Prosthetic Heart Valve	yes	no
Stents or Bypass	yes	no
Joint replacement	yes	no
High blood pressure	yes	no
Hepatitis B/C	yes	no
Emotional / Physical Problems	yes	no
Venereal Disease	yes	no

Have you or anyone in your family had any of the following: (please circle and list family member if other than yourself)

Asthma	yes	no	_____
Hay Fever	yes	no	_____
Hives	yes	no	_____
Eczema	yes	no	_____
Diabetes	yes	no	_____
Psoriasis	yes	no	_____
Skin Cancer	yes	no	_____
Melanoma	yes	no	_____
Autoimmune Disease	yes	no	_____

In the last 6 months have you had an accident or operation? _____

I use sunscreen:	always	sometimes	never
I smoke:	always	sometimes	never
I drink alcohol:	always	sometimes	never

OPTIONAL:

We also offer the following services, please check off anything you may be interested in and we will be happy to schedule a consultation for you:

___ Acne scarring
___ Fine lines
___ Skin tightening
___ Sun damage
___ Brown spots
___ Hair removal
___ Redness and Rosacea
___ General anti-aging
___ Spider veins on legs
___ Botox/Filler
___ Micro-needling
___ AviClear (laser for acne)

WOMEN:

Are you pregnant or planning a pregnancy? Yes No
Do you take birth control pills? Yes No

HIPPA:

In order to ensure your privacy Hampton Dermatology, PC will only discuss your medical records with you, unless written consent is granted to do otherwise.
If you wish to permit other person (s) (I.e. husband, wife, parent, doctor, etc) to discuss your medical condition with us or to have access to your medical records, those person (s) must be listed below.

NOTE: This consent will remain in effect until changed in writing by the patient or guardian.

1. _____
2. _____
3. _____

MEDICATIONS:	DOSE/ HOW OFTEN:

ALLERGIES:	ALLERGIC REACTION:

To the best of my knowledge, the medical information provided is correct.

Signature _____

Date: _____

PATIENT BILLING & FINANCIAL INFORMATION

Health Insurance Policies (full or partial coverage)

We offer the following information to help you understand our financial policies and encourage you to ask us any questions relating to the services you may receive. Any members of our billing department will be glad to discuss payment arrangements with you or your responsible party.

Hampton Dermatology, PC participates with many insurance companies, including HMO, PPO, POS, and several local plans. It is your responsibility to make sure that we are participating with your health plan or that you have out-of network benefits. If we do not participate in your plan, payment in full is expected at each visit. We make every effort to verify your insurance coverage prior to your appointment, in order to notify you of your financial responsibility at the time of your appointment. In the event that your coverage cannot be verified prior to your appointment you will be responsible to pay for any services administered at the time you are seen.

Hampton Dermatology, PC will file your insurance claim for you. Therefore, at the time you check in, you will be asked to present your health insurance card so we may retain a copy for our records. If your policy requires, it will be your responsibility to make sure a referral from your primary care physician is obtained prior to your appointment. If you do not have a referral you may reschedule your appointment or contact your doctor from our office. However, you will not be seen until your referral has been received in our office.

If your insurance company declines to cover the services provided or pays less than the actual cost, you will be responsible for any remaining balance that your coverage deems your responsibility. All co-payments and deductibles are due at the time services are rendered. A $25 surcharge will be added to your account if your co-payment is not paid at the time of your appointment. If you pay by check and your bank returns your check you will be charged a $25 fee and/or a $35 fee for any payments written on a closed account.

Summary: You may be responsible for a bill if:

- You have a deductible that has not been met at the time services are rendered. Please keep in mind that some insurance plans have a separate surgical and/or pathology deductible which is not included in your annual medical deductible.
- The service is not a covered service under your plan
- Your insurance company deems the services to be not medically necessary
- Your plan requires you to pay a co-insurance on any services rendered

By signing this document you acknowledge that you have read the above information regarding our billing policies.

_____ _____

Patient Signature Date

HAMPTON DERMATOLOGY, PC

325 Meeting House Lane **Southampton, NY 11968**

PAYMENT METHOD FOR DEDUCTIBLES AND CO-INSURANCE

To Our Patients:

**** Co-payments are always due at time of visit. ****

Kindly provide your credit/debit card information below. Your card will be held securely according to privacy laws and only used should there be an outstanding and undisputed balance. After your insurance company has paid its share, we will notify you if additional monies are due. Upon their clearance, you will receive a copy for your records.

*****PLEASE FILL IN CREDIT/DEBIT CARD INFO**
****OR****
CHECK LINE BELOW***

_____ I do not wish to provide a credit/debit card number. I will pay towards or satisfy my deductible or co-insurance at the time of my visit. I understand co-payments are always due on the date of service. I agree to pay all fees should I not possess insurance or if my insurance is inactive for any reason at the time of my visit.

Please sign below

I authorize Hampton Dermatology, PC to charge outstanding balances on my account to the following credit/debit card:

Visa Master Card Discover Amex

Account Number_____ Expiration Date _____

Name on Card _____Security Code _____
Please Print

Patient's Name _____
Please Print

Signature _____ Date_____

Q & A about credit card on file

Why did Hampton Dermatology PC implement a credit card on file policy?

The current healthcare market has resulted in insurance plans increasingly transferring costs to you, the patient. In addition, many insurance plans require deductibles, co-insurance, and copays in amounts that are unknown to you or us at the time of your visit. To manage payments easier for both our patients and our staff, we will now ask you for a credit card at check-in. Once your insurance processes the claim, you will receive a statement and can elect to pay using the card on file or by an alternative method.

I always pay my bills on time. So why do I have to do this?

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. However, the few patients that we have to bill multiple times or even send to a collection agency cost us a lot of time and expense. Reducing unnecessary costs is essential for us to continue to accept insurance and Medicare.

What types of payments will be processed using my credit card on file?

Cards on file will be used for: copays, deductibles, co-insurance and outstanding balances. If you need help satisfying your financial responsibility, please reach out to our billing department to work out a payment plan.

What if I don't have a credit card?

It is our policy that payment is due at the time of service. You may also keep you HSA or FSA credit cards on file. If you don't have either of these types of cards, then you may use a debit card.

How can I be assured that my credit card information will remain safe?

We are under strict rules and guidelines of Payment Card Industry Compliance, and HIPAA Compliance to protect patient privacy and credit card information is considered protected health information.

What if I need to dispute my bill?

We will always work with you to understand if there has been a mistake. We will only charge the amount that we are instructed to by your insurance plan in the EOB they send to us. We routinely review the accuracy of claims processed by insurance and will contact you if WE find a problem. But, if you find a problem, call us, and we'll investigate it. If we owe you money, we will refund it to the card on file or by check.

What if I receive a Laboratory bill?

If you should undergo a biopsy in our office, your insurance carrier will be billed separately by the Lab. You will receive a separate bill form the Lab for any uncovered charges. Such as, copays, deductibles and co-insurance.

TURN OVER FOR CREDIT CARD INFORMATION

HAMPTON DERMATOLOGY PC

Procedure Consent

Many patients that are treated at Hampton Dermatology PC undergo some type of procedure. This form establishes your consent for Dr. Steven Fishman and Associates to perform procedures as part of your therapy. In some instances, photos may be taken.

The risks of undergoing procedures may include but are not limited to scars, pigmentary changes/blemish, infection, bleeding and numbness. Less likely risks include permanent nerve damage and deformity. Often the risks noted may be remedied by secondary procedures. Sometimes multiple procedures are required to treat a dermatologic problem. The benefits of undergoing procedures include diagnosing and potentially curing a skin problem.

I understand that dermatologic procedures may be performed on me at Hampton Dermatology and that I will have the opportunity to discuss this with Dr. Steven Fishman and/or Associates.

I am aware that today my evaluation and management may be provided by ancillary staff such as a Physician Assistant. I am also aware that I may request evaluation and management by the Physician either today or an appointment can be made with the Physician in the near future for me.

I recognize that the practice of medicine is not an exact science and acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I understand that my appointment today was made with:

_____ Steven Fishman MD _____ Irene Vergilis-Kalner MD _____ Jeanine Gurdon PA

_____ Christina N DeMartino PA-C _____ Loree Ann Stanton RN

Patient/Guardian: _____

Date: _____