Dear New Patient:

Welcome to Alexandria Associates in Dermatology! Thank you for scheduling an appointment with us. We look forward to providing for your skin care needs.

The enclosed packet contains important information for your upcoming appointment as well as our new patient registration forms. To be prepared for your appointment, please review this information carefully and bring the requested information with you on the day of your appointment.

**It is very important to bring the following to your first visit:**

- Completed Patient Authorization & Consent for Treatment form
- Completed Financial Policy Agreement form
- Completed Credit Card on File Agreement form
- Insurance Card(s) and Insurance Referral, if applicable
- Picture Identification (such as a driver’s license)
- Any recent Laboratory (blood work) results related to your visit with us
- For patients enrolled in HMO plans, a referral may be required from your Primary Care Physician. Please check with your Insurance carrier to verify the requirements of your plan
- Co-payment, if applicable. Please note that payment is due at the time of service.

If you have been referred due to an abnormal laboratory or pathology result, it is imperative that we have a copy of these results so that we can complete your consultation without having to repeat testing.

**Providing the above information on the day of your appointment will allow us to serve you in the most prompt, accurate and efficient manner.**

Thank you for allowing us to participate in your medical care. We look forward to seeing you soon!

* Alexandria Associates in Dermatology complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.*
PATIENT AUTHORIZATION & CONSENT FOR TREATMENT

PLEASE PROVIDE THE REQUESTED INFORMATION BELOW IN ORDER TO MANAGE YOUR CARE, INSURANCE, CONSENTS, AND METHODS FOR CONTACT

PATIENT DEMOGRAPHICS:

NAME (FIRST, MIDDLE, LAST): ____________________________________________________________
DATE OF BIRTH (MONTH, DATE, YEAR): ___________________________________________________________________________
SOCIAL SECURITY NUMBER: ________________________________________________________________________________________
GENDER: ______________________ RACE: __________________ ETHNICITY: ___________________________________________
MARITAL STATUS: _________________________________________________________________________________________________
STREET ADDRESS: ____________________________________________________________________ UNIT/APARTMENT #: ____________
CITY: ________________________ STATE: ___________ ZIP: __________________
PHONE (H): ______________________ (C): ______________________ (W): ______________________
EMAIL ADDRESS: __________________________________________________________________________________________________

PREFERRED CONTACT METHOD (CHECK ONE): ❑ HOME ❑ CELL ❑ WORK ❑ TEXT ❑ EMAIL
❑ OK TO LEAVE A VOICEMAIL MESSAGE IF WE CANNOT REACH YOU? (IF YES, CHECK)
❑ OK TO PROVIDE APPOINTMENT REMINDERS? (IF YES, CHECK)

PRIMARY CARE PHYSICIAN (PCP) INFO:

PCP NAME: __________________________________________________________________ PCP PHONE#: ______________________
PCP ADDRESS: __________________________________________________________________

REFERRING PROVIDER INFO:

NAME: __________________________________________________________________ PCP PHONE #: ______________________
ADDRESS: __________________________________________________________________

INSURANCE INFO:

PRIMARY INSURANCE NAME: ___________________________________ MEMBER ID#: ______________________
POLICY HOLDER NAME: ___________________________________ DOB: ______________________
ADDRESS FOR THE PRIMARY INSURANCE (STREET, CITY, STATE):
______________________________________________________________________________________________

DO YOU HAVE ANOTHER HEALTH INSURANCE POLICY? (i.e. SECONDARY INSURANCE) ❑YES ❑NO
SECONDARY INSURANCE NAME: ___________________________________ MEMBER ID#: ______________________
POLICY HOLDER NAME: ___________________________________ DOB: ______________________
ADDRESS FOR THE SECONDARY INSURANCE (STREET, CITY, STATE):
______________________________________________________________________________________________

RESPONSIBLE PARTY INFO (WHO’S ULTIMELY RESPONSIBLE FOR YOUR BILL?):

❑ CHECK HERE IF SAME AS PATIENT INFO ABOVE
NAME: ___________________________________________________________ RELATIONSHIP: _________________________________
ADDRESS (STREET, CITY, STATE): ___________________________________________________________________________________
PHONE (H):_____________________________ (C):___________________________________ (W):________________________________
PREFERRED CONTACT METHOD (CHECK ONE): ❑ HOME ❑ CELL ❑ WORK ❑ TEXT ❑ EMAIL

EMERGENCY CONTACT INFO (WHO CAN WE CONTACT IN CASE OF AN EMERGENCY?):
NAME: ___________________________________________________________ RELATIONSHIP: _________________________________
ADDRESS (STREET, CITY, STATE ZIP): _______________________________________________________________________________
PHONE (H):_____________________________ (C):___________________________________ (W):________________________________

GENERAL CONSENT (THIS PROVIDES US WITH YOUR CONSENT TO RECEIVE CARE & TESTING):
___ (INITIAL HERE) General Consent: I consent to medical care at Alexandria Associates in Dermatology. This includes needed lab work and HIV testing. By law, I understand that if there is an at-risk exposure to my blood or body fluids, I may be tested for HIV, Hepatitis B or C virus. Those test results will be shared with the healthcare worker who was exposed. I am aware that healthcare is not an exact science. No guarantees have been made.
___ (INITIAL HERE) Consent for electronic prescription submission

BY SIGNING THIS FORM, I UNDERSTAND THAT I CONSENT AND AUTHORIZE USE AND DISCLOSURE OF MY PROTECTED HEALTH INFORMATION TO CARRY OUT THE FOLLOWING:

a) Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment; i.e. release of radiographs and or treatment plans to referring physicians)

b) Obtaining payment from third party payers (i.e. my insurance company)

c) The day-to-day healthcare operations of our practice.

WHO ARE YOU AUTHORIZING ACCESS OF INFORMATION TO & WHAT INFO MAY BE RELEASED?

May we discuss your medical condition with any member of your family or medical team? YES NO

If YES, please provide the name & contact information for the person(s) with whom we may discuss your care:

NAME:___________________________________________________________________________________________________________
RELATIONSHIP:___________________________________________________________________________________________________________
PHONE: _____________________________________ EMAIL ADDRESS:_____________________________________________________

WHAT INFORMATION MAY BE SHARED? (CHECK ALL THAT APPLY):
❑ FINANCIAL INFORMATION ❑ MEDICAL OFFICE VISIT NOTE
❑ LABS/PATHOLOGY RESULTS
❑ BREACH OF INFORMATION

SIGN BELOW TO ACKNOWLEDGE AGREEMENT WITH THE ABOVE GENERAL CONSENT & THAT YOU WERE PROVIDED A COPY OF THE NOTICE OF PRIVACY PRACTICES:

PATIENT/GUARANTOR SIGNATURE: ___________________________ DATE: __________
FINANCIAL POLICY AGREEMENT

Welcome to Alexandria Associates in Dermatology! We are pleased that you have chosen us as your provider for your dermatologic care. Our mission is to provide you with the highest level of professional medical care and patient satisfaction. To avoid any misunderstandings and to ensure timely payment for services, it is important that you understand your financial responsibilities with respect to your healthcare. We require that all patients sign our Patient Authorization and Consent for Treatment form, as well as this Financial Policy Agreement before receiving medical services. The Financial Policy Agreement form confirms that you understand that the services provided are necessary and appropriate, and advises you of your financial responsibility with respect to services received.

PATIENT RESPONSIBILITY (initial here: _____)

Patients or their legal representative are ultimately responsible for all charges for services provided. We expect your payment at the time of your visit for all charges owed for that visit, as well as any prior balance. Some insurance plans tell us exactly what you will owe at the time of your visit; in that case, we may request full payment for your share when you check in or out. Other insurance plans do not provide immediate information regarding your patient responsibility; in that case, you will be asked to save a credit card on file to settle your account when you check out.

If you save a credit card on file, we will charge your card for the balance due when your account reaches pre-collections status. If your card is declined, your account will be outsourced to a collections agency.

INSURANCE (initial here: _____)

We ask all patients to provide their insurance card and proof of identification (such as a photo ID or driver’s license) at every visit. If you do not provide current proof of insurance, you may be billed as an uninsured patient (i.e. self-pay). We accept assignment of benefits for many third-party carriers, so in most cases, we will submit charges for services rendered to your insurance carrier. You are expected to pay the entire amount determined by your insurance to be the patient’s responsibility. Our fees are for physician services and procedures only; you may receive additional bills from laboratory, radiology, or other diagnostic related providers.

You are responsible to:

- Know if a referral or authorization is necessary for office visits (if it is required and you do not have the appropriate referral or authorization, you may be billed as an uninsured patient)
- Check with your insurance plan to determine if prescribed testing (lab, radiology, etc.) is covered under your insurance policy. (If you choose to have non-covered testing, we will require full payment at the time of your visit)
- Check with your insurance plan to review the schedule of benefits and whether a co-payment or deductible applies.
- File any appeals with your insurance plan, if needed.
● Coordinate benefits if you have more than one insurance plan. You may be required to contact your insurance company to clarify which plan is primary or to correct any demographic or other issues.

● Arrive for appointments with all required documentation.

INSURANCE VERIFICATION (initial here: ____)

We will attempt to verify insurance eligibility (2) business days prior to your visit. If we are unable to confirm active insurance, we will contact you about your insurance eligibility. If you are unable to present an alternative form of active insurance coverage prior to the visit, you will be required to either pay at the time of your visit or reschedule your appointment. For same-day appointments, we will check eligibility when the appointment is made.

TYPES OF PAYMENT (initial here: ____)

1. Co-payments. Insurance carriers require that we collect your copayment at the time of your visit. If you are not prepared to make your copayment, you may reschedule your appointment.

2. Deductibles. Most insurance plans require a predetermined amount (the “deductible”) before insurance will cover certain charges. We will bill you for the balance due for the services provided that are not met by your deductible.

3. Co-insurance. Some insurance plans require that you pay a certain percentage (for example, 20%) of the allowable charge amount. We will ask that you pay your co-insurance at the time of your visit.

4. Uninsured patients / Self-pay. If you do not have insurance or if the services provided are not covered by your insurance, payment for all services is due at the time of your visit.

5. Out-of-network. We participate with most insurance plans. You can contact your insurance company to confirm if your provider is in network prior to making your appointment. If we do not participate with your insurance plan and you choose to be seen in our practice as “out-of-network”, you will be responsible for the payments your insurance does not cover.

6. Non-covered services / Cosmetic procedures (i.e. procedures that are not medically necessary) / Products: It is your responsibility to contact your insurance plan to determine whether a particular service is covered. If we provide you non-covered services, cosmetic services, or products, you are expected to pay for those in full at the time of your visit.

OUTSTANDING BALANCES (initial here: ____)

After your visit, we will send you a statement for any outstanding balances. All outstanding balances are due upon receipt. If you come for another visit and have an outstanding balance, we will request payment for both the new visit and your outstanding balance. Your outstanding balance can be paid conveniently by credit card through our website, by cash or check or credit card in our office.
We generally send statements once monthly, beginning when the balance becomes patient responsibility. If you have an outstanding balance for more than (90) days, you will be referred to an outside collection agency and charged a collection fee of 35% of the balance owed in addition to the balance owed. Also, if you have unpaid delinquent account, we may discharge you as a patient and you may not be allowed to schedule any additional services unless special arrangements have been made.

**LATE ARRIVALS, CANCELLATIONS, AND NO-SHOWS (initial here: ____)**

**Late arrivals.** If you arrive late for a scheduled appointment, you may be asked to reschedule your appointment or wait for an open appointment time on that day’s schedule.

**Cancellations.** If you are unable to keep a scheduled *medical* appointment, you must call at least one (1) business day in advance or we may consider you a “no-show”. If you are unable to keep a scheduled *cosmetic* appointment, you must call at least two (2) business day in advance or we may consider you a “no-show”.

**No shows.** If you miss your appointment, you will be charged a $50 fee for a missed medical appointment, a $100 fee for a missed cosmetic or surgical appointment. This fee will need to be paid prior to rescheduling. This fee cannot be applied to insurance. As permitted by state law, you may be discharged as a patient following three (3) no shows in one year period (365 days).

**CARD ON FILE PROCESS (initial here: ____)**

When you check into a hotel and rent a car, you are required to provide a credit card to cover the cost of any incidental charges and/or pay your bill. This process benefits both you and the hotel or rental company by making the check out process easier, faster, and more efficient.

We have implemented a similar process at our practice. You will be requested to provide a credit card when you check-in for your visit and we will scan the card into our system. The information will be held securely until your insurance has paid their share and notified us of any additional amount owed by you. At that time, we will notify you of the remaining balance owed by issuing you a statement. We will we will charge your card for the balance due when your account reaches pre-collections status. An account reaches pre-collections status when there is non-payment following issuance of the third (3rd) statement and before submitting your account to an outside collections agency. You may call our office if you have a question about your balance. We will send you a receipt for the charge.

The “card on file“ program simplifies our payment for you and eases the administrative burden on both you and the practice. Our billing team is available to answer any questions about the balance due. If you have any questions about the card on file payment method, please let us know.

**Patient/Guarantor signature:** ________________________ **Date:** ________
PATIENT CREDIT CARD ON FILE AGREEMENT

OVERVIEW & PURPOSE

We have implemented a policy which enables you to maintain your credit card information securely on file. In providing us with your credit card information, you are giving Alexandria Associates In Dermatology permission to automatically charge your credit card on file for your co-pay [or any other patient(s) you have listed on this form] at the time of service. By signing this, you authorize this agreement will remain in effect until the expiration of the credit card account and that you may revoke this form at any time by submitting a written request.

Co-pays: Co-pays are due at the time of the office visit.

Outstanding Balance: If your insurance provider has paid their portion of your bill [or any other patient(s) you have listed on this form] and there is an outstanding balance owed, Alexandria Associates In Dermatology will notify you via mailed patient statement. If by the final billing notice, we do not receive a response from you or your payment in full, at that time, any balance owed will be charged to your credit card. A copy of the charge will be sent by email or mailed to you. This in no way compromises your ability to dispute a charge or question your insurance company’s determination of payment.

Multiple Users: This card will only be authorized for the use of the credit card holder, his/her minor(s), or any person(s) listed below.

I, the undersigned, am an authorized user of the credit card swiped today. I hereby authorize Alexandria Associates In Dermatology to charge my credit card for balances due for items and services provided by Alexandria Associates In Dermatology. I agree to pay all amounts charged pursuant to this authorization in accordance with the issuing bank cardholder agreement.

CHECK CARD TYPE: ☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER

Patient Signature: _________________________________________________________________________
Credit Card Holder’s Name: _________________________________________________________________________
Last 4 digits of Credit Card: _____________________________ Expiration Date: _______________________

IF YOU WISH TO LEAVE THIS CREDIT CARD ON FILE FOR OTHER PATIENT(S), PLEASE PRINT NAME(S) BELOW:

Patient Full Name (Please print): _________________________________________________________________________