

PATIENT INFORMATION

CHelsea DERMATOLOGY

NAME _____
LAST FIRST MIDDLE

HOME ADDRESS _____ APT # _____
_____ DOB _____

HOME #: () _____ CELL/WORK () _____

HEIGHT _____ WEIGHT _____ SEX: MALE FEMALE

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED DOMESTIC PARTNERSHIP

SSN - - - - - EMAIL ADDRESS: _____

REFERRED BY: _____
NAME ADDRESS

OCCUPATION: _____ WORK #: () _____

EMPLOYER NAME AND ADDRESS: _____

MEDICAL INSURANCE COVERAGE

PRIMARY CARRIER: _____ ID#: _____

SECONDARY COVERAGE: _____ ID#: _____

EMERGENCY CONTACT

CONTACT: _____ RELATIONSHIP: _____

HOME #: () _____ WORK #: () _____

ACKNOWLEDGEMENT OFFICE POLICIES

- I understand and have received the financial policy for Chelsea Dermatology. I understand that I am financially responsible for all services rendered to me including balances not covered or fully covered by insurance.
- I have received and read the privacy policies of Chelsea Dermatology. I authorize the release of any medical or any other information needed to process my medical claims. I also authorize Chelsea Dermatology to accept assignment from my insurance company. I also have received a copy of the "Notice of Privacy Practices" from the office.
- I understand that Chelsea Dermatology has a 48 hour cancellation/rescheduling policy. If I cancel or reschedule past this point. I agree to the fees outlines in the policy that I have received including but not limited to a \$50 fee.
- Confirmation of appointments will be made 2-5 business days before my appointment. I understand that I can opt out of this notification. If I chose to opt out, I will be considered confirmed at the time I schedule an appointment and subject to the cancellation/no-show policy that I have been provided. My option for appointment confirmation is selected below:
 - _____ I would like to receive a confirmation email at the address listed above.
 - _____ I would like to receive a confirmation call at the number listed above.
 - _____ I would not like to be contacted.
- I also acknowledge the receipt of the other policies for Chelsea Dermatology in regards to the following, in/out of network insurance participation, Medicare/Medicaid and their affiliates, payment for cosmetic services, non-participation with FSA's or cards attached to such accounts, deductibles, referrals, and supply proper identification.

SIGNATURE: _____ DATE: _____

Initial Visit Questionnaire

To help give you the best possible care, please complete all questions. If you are unaware of an answer, leave it blank, (circle "Yes" or "No" Where indicated)

Have you ever had or been treated for any of the following?

- | | | |
|---|-----|----|
| 1. Duodenal or Peptic Ulcer..... | YES | NO |
| 2. Other intestinal disease of Colitis..... | YES | NO |
| 3. Liver Disease or Gall Bladder Disease..... | YES | NO |
| 4. Lung Disease (Tuberculosis, Pleurisy, Other)..... | YES | NO |
| 5. Heart Disease (Rheumatic Fever, Pacemaker, Other)..... | YES | NO |
| 6. High Blood Pressure..... | YES | NO |
| 7. Stroke..... | YES | NO |
| 8. Kidney Disease..... | YES | NO |
| 9. Urinary or Bladder Problem or Infection..... | YES | NO |
| 10. Venereal Disease (if yes, Specify)..... | YES | NO |
| 11. Blood Disorder or Lymph Gland Disorder..... | YES | NO |
| 12. Eye Disease (Glaucoma, Cataract, Other)..... | YES | NO |
| 13. Arthritis, joint problem or Bone Disease..... | YES | NO |
| 14. Thrombophlebitis..... | YES | NO |
| 15. Cancer..... | YES | NO |
| 16. Frequent Infection..... | YES | NO |
| 17. Neurological Infections..... | YES | NO |
| 18. Emotional or Psychiatric Problem..... | YES | NO |
| 19. HIV..... | YES | NO |
- Have you Had:
- | | | |
|---|-----|----|
| 1. Asthma..... | YES | NO |
| 2. Hay Fever..... | YES | NO |
| 3. Eczema..... | YES | NO |
| 4. Hives..... | YES | NO |
| 5. Diabetes..... | YES | NO |
| 6. Psoriasis..... | YES | NO |
| 7. Skin Cancer..... | YES | NO |
| 8. Glaucoma..... | YES | NO |
| 9. Other Skin Conditions (specify)..... | YES | NO |
| 10. Allergies (Drugs, food, skin)..... | YES | NO |

Has any member of your immediate family (Blood relative, please specify who) Had:

- | | | |
|-------------------------------|-----|----|
| 1. Asthma..... | YES | NO |
| 2. Hay Fever..... | YES | NO |
| 3. Eczema..... | YES | NO |
| 4. Hives..... | YES | NO |
| 5. Diabetes..... | YES | NO |
| 6. Psoriasis..... | YES | NO |
| 7. Skin Cancer..... | YES | NO |
| 8. Glaucoma..... | YES | NO |
| 9. Other Skin Conditions..... | YES | NO |

Have you ever had:

- | | | |
|---|-----|----|
| 1. Excessive bleeding when cut..... | YES | NO |
| 2. Difficulty with the healing of wounds..... | YES | NO |
| 3. Overgrown scars or keloids..... | YES | NO |
| 4. Allergy to local anesthetics..... | YES | NO |

Have you previously had a skin problem or been under the care of a dermatologist? If yes, describe:

Are you concerned about:

- | | | |
|------------------------------------|-----|----|
| 1. Hair loss..... | YES | NO |
| 2. Spider veins..... | YES | NO |
| 3. Sun Damaged Skin..... | YES | NO |
| 4. Skin line or scar revision..... | YES | NO |

Have you ever been given x-ray or Grenz treatments to your Skin? No Yes, (specify when) _____

Do you take any medications, drugs or over the counter preparations or remedies? No Yes, (specify) _____

List prior hospitalizations & surgeries (please give approximate dates)

Have you had vaginal yeast infections?.....YES NO

Are you pregnant?.....YES NO

Are you currently planning a pregnancy?..... YES NO

Please inform the doctor at any time if you do plan to become pregnant during your treatment period.

NOTE: The dermatological examination which you are about to receive is not a complete physical examination. It's suggested that you have a complete physical examination by your family physician or internist.

Date _____ Signature _____

Acknowledgment of Financial Responsibility:

Dear Patient,

We at Chelsea Dermatology value you as a patient, and appreciate that you have entrusted us with your health care needs.

As you know, there are charges for each of the medical care services that we will provide to you. The co-payments, deductibles and co-insurance amounts that we are obligated to collect from you are determined by the type and extent of health benefit coverage that your health benefit plan provides. Our office will be pleased to work with your health benefit plan in verifying your eligibility and benefits and requirements for prior authorizations or referrals, but *please be aware that your health plan does not guarantee the accuracy of its confirmation of coverage or benefits.* Since you are ultimately responsible for payment of the medical services provided to you, it is our policy to obtain your credit card number and authorization to process a charge to your credit card for payment should your health plan not honor the claim we submit for the services we provided to you.

Your health benefits, including your responsibility for co-payments, deductibles, and co-insurance is a decision made by your employer, not this office or your health plan.

In providing credit card information and signing below, you authorize payment to Chelsea Dermatology by credit card for services provided by Chelsea Dermatology in the absence of coverage by your health benefit plan (including, but not limited to, co-payments, co-insurance, deductibles, and/or uncovered services).

THIS AUTHORIZATION IS VALID FOR 1 YEAR FROM THE DATE SIGNED BELOW

Patient's Name: _____ Date: _____

Name on Credit Card: _____

Credit Card Type: _____

Card Number: _____ Expiration Date: _____

Billing Zip Code For Credit Card: _____

Signature of Patient:

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

NOTICE TO PATIENT:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this Notice. You may refuse to sign this acknowledgement if you wish.

I, _____ acknowledge that I have been informed of the
(please print name)

Privacy Practices of Chelsea Dermatology as they apply to my Protected Health Information.

Patient Signature

Date

From time to time this office may wish to contact you by telephone, mail, or e-mail to advise you of new treatments, new products, health care advances as well as changes to our practice. None of these communications will contain your personal health information. We assure you that under no circumstances will your e-mail address be shared, sold, or given to any third party.

_____ Yes, you may contact me.

_____ No, I do not wish to be contacted.

e-mail address: _____

Patient Signature

Date

Name _____

Date _____

COSMETIC SERVICES QUESTIONNAIRE

Do you suffer from any of the following?

Please check all that apply:

- | | | | |
|-----------------------|-------|----------------------|-------|
| Fine Lines | _____ | Sun Spots | _____ |
| Deep Wrinkles | _____ | Dark Patches | _____ |
| Excess hair | _____ | Red Blotches/Rosacea | _____ |
| Ingrown hairs | _____ | Acne Scars | _____ |
| Broken capillaries | _____ | Excessive Oiliness | _____ |
| Exposed Blood Vessels | _____ | Excessive Dryness | _____ |

Which of the following procedures would you like to know more about?

Please check all that apply:

- | | | |
|------------------------|---|-------|
| Botox | to improve the appearance of fine lines | _____ |
| Collagen/ Sculptra | to smooth out wrinkles and scars | _____ |
| Restylane/Juvederm | to smooth out wrinkles and scars | _____ |
| Laser Hair Reduction | to reduce unwanted hair growth long term | _____ |
| Acne Scar Rejuvenation | to diminish the appearance of depressed acne scars | _____ |
| Vein Treatments | to reduce the appearance of varicose and spider veins | _____ |
| Liposculpture | to redefine your body contour | _____ |
| Chemical Peels | to reduce the appearance of fine lines, dark spots; control acne. | _____ |
| Micro-dermabrasion | to erase fine lines, age spots, dark patches. To give skin smoother texture | _____ |

Tell us what most concerns you most regarding the appearance of your skin.

Do you wish to be contacted by email ____, mail ____, or phone ____ to learn more about these treatments? Your email address: _____

Signature: _____ Date: _____

Chelsea Dermatology Auto-Ship Program

June 2, 2008

It is our goal to ensure that proper skincare is maintained throughout your lifetime. Here at Chelsea Dermatology we offer a full line of skin care products to meet anyone's needs. We truly believe in the products we provide and are glad that you have chosen to trust the most visible part of you (your skin) to us.

With that in mind, we want to make sure that you never run out of the products that you use the most. Clients now have the option to enroll in our auto-ship program. Every sixty (60) days, the products that you have selected will be automatically shipped to your address on file. Most of the products sold here are packaged to last 60 days or longer depending on usage.

Participation in this program is strictly optional; however participants will receive a 25% discount on all products ordered. You have the option to speed up or slow down your shipments at any time based on your usage and you may cancel enrollment in the program by simply sending notification by email to confirmations@chelseaderm.com. Please allow one week for the cancellation to take effect. If you are scheduled to have a shipment during that week, please make sure to call the office to cancel the shipment.¹

____ Yes! I would like to participate in the program.

____ No. I would NOT like to enroll at this time.

Please list the products that you would like to have automatically shipped:

Payment information²:

Card Type: Visa / MasterCard / AMEX / Discover

Card Number: _____ Exp: _____

Name of Cardholder: _____

Billing Address: _____

Signature: _____

1. If your shipment has already been shipped you will still be responsible for payment. Return and exchange policies still apply in this program.
2. You authorize Chelsea Dermatology to automatically process payment for your products. Payment will be processed without notice. If payment can not be authorized shipments will be stopped until a valid form of payment is given. Credit card information is stored on our secure server and monitored 24 hours per day for security purposes

VIRGIL A. HATCHER, M.D., P.C. /CHELSEA DERMATOLOGY

OFFICE POLICIES:

-IN NETWORK: Please note that Dr. Hatcher is **in-network** with the following plans: **United Healthcare, Aetna, HIP, Cigna, Great West**, Please note that *in-network* means that you will be responsible for any co-payment and we will submit the claim to your insurance carrier. It is your responsibility to make sure your coverage is active, your deductible has been met, and to know if you need a referral.

-OUT OF NETWORK: Please note that Dr. Hatcher is **out-of-network** with the following plans: **Empire Blue Cross/ Blue Shield, Horizon, Oxford, Empire Government Plan (even if claim can be processed through Multiplan), 1199, GHI, Magnacare, Health Net, Medicare, PHCS, Multiplan, BeechStreet**. Please note that *out-of-network* means that you will be responsible for the full cost of the visit at the time of the visit. You may be eligible for reimbursement through these carriers if you have out-of-network benefits. Chelsea Dermatology does not guarantee reimbursement through out-of-network carriers. You should verify with your insurance carrier whether or not you have out-of-network benefits and whether or not you have an out-of-network deductible*. (*Out-of-network deductible is usually separate from in-network deductible.)

- Medicare/ Medicaid: **DR. HATCHER DOES NOT ACCEPT MEDICARE or MEDICAID!** Many Medicare and Medicaid plans now fall under the umbrella of plans we participate with such as HIP Medicaid or HIP Family Health Plus. However, we do not accept any forms of Medicare or Medicaid. It is your responsibility to know whether or not your plan is a Medicare or Medicaid plan.

-Cosmetic Services: Chelsea Dermatology offers a vast array of cosmetic services such as Laser Hair Removal, Medical Spa treatments like microdermabrasions, chemical peels and deep pore cleansings, Laser Scar Rejuvenation, Laser Blood Vessel Treatment, Filler Injections (Restylane, Juvederm, Sculptra), Botox Cosmetic, Liposuction, and Sclerotherapy (Spider Vein Treatment). These services will not be covered by your insurance carrier. Flexible Spending Accounts and/or Care Credit (low interest finance plan) can be very helpful.

-Flexible Spending Accounts (FSA's) also known as Health Reimbursement Accounts: Many employers are offering FSA's through your insurance carrier. Money is deposited into an FSA, usually directly from your paycheck, and subtracted from your taxable income. You can then use the money in the account for healthcare needs such as deductibles, co-payments, prescriptions and in some cases cosmetic services. Speak with your employer and/or insurance carrier for more information. **** PLEASE NOTE THAT WE DO NOT SWIPE CREDIT CARDS ATTACHED TO FSA'S OR HSA'S EVEN IF THEY ARE VISA/MASTERCARD/AMEX... WE WILL PROVIDE YOU WITH A RECEIPT WHICH YOU CAN SUBMIT TO THE FSA OR HSA TO BE REIMBURSED.****

-Deductibles: With most insurance carriers, deductibles are reset at the beginning of each calendar year. What this means is that your insurance carrier will not pay any claims until you meet this deductible. In other words, you will be sent the bill until your deductible is met. Please be mindful of this as you will be charged at the time of service if your deductible has not been met. Chelsea Dermatology *will not be responsible* for checking to see whether or not you have met your deductible, so make sure you stay on top of this to avoid unexpected charges.

-Referrals: If your insurance carrier is **HIP** or **Aetna** you may need a **referral**. To see whether or not you need a referral, please look at your insurance card. The information is usually located on the back of the card. If it says, "*All covered non-emergency services must be provided for by referral from your PCP,*" then you will be required to get a referral from your PCP (Primary Doctor). If you are not sure if you need a referral, you should call the insurance carrier to verify. If proper referral is not obtained, or if referral is expired by the time of service, HIP or Aetna may deny the claim and transfer the responsibility for the charges to the patient. Again, please be mindful of this to avoid unexpected charges. If you do not have a valid referral at least 48 hours before your appointment is scheduled then your appointment may be cancelled. While we will be helpful in aiding you to obtain a referral or warning you about an expiring referral, Chelsea Dermatology ultimately *will not be responsible* for obtaining your referral, or making sure it is not expired.

-Identification: All patients will be required to give their social security numbers and provide us with a photo ID. NO EXCEPTIONS. If you refuse to give these forms of identification you will not be seen.

By signing below I acknowledge that I have read and that I understand the above statements: