A&G Dermatology Financial Policy and Office Information

Welcome and thank you for using A&G Dermatology for your dermatologic care. We are committed to providing you with the highest quality medical care possible in a cost-effective manner.

Appointments:

- Please arrive for your appointment 15 minutes early so our front desk has ample time to verify your information.
- If you are more than 15 minutes late for your appointment, you will be marked a "no show" and our office has the right to reschedule
- Please inform the receptionist of any demographic changes, including phone number, address, and insurance information. Failure to notify us immediately of any changes may result in you being responsible for any services not covered by your insurance carrier.

Office Fees (Copays, Cancelled Appointments,etc.):

- All copays are due at the time of service
- There will be a $35 fee for any returned checks to our office
- All balances are due prior to any further service provided by our office

Insurance:

- Your insurance coverage and benefits are a contract between you and your insurance company, and therefore all disputes must be handled with them.
- Please remember that insurance is a method of reimbursing the patient for fees paid to the doctor's office and is not a substitute for payment.
- We are contracted with multiple insurers to accept assignments of benefits
- If we are not contracted with your insurance company, you will be billed as a self-pay patient.
- We are required to file with your primary insurance carrier only. As a courtesy, we will file a claim with your secondary insurance.
- For Medicare patients, your insurance requires that we provide you with written notification whenever it is likely that you will be responsible for a bill.
- Insurance refunds are issued to the appropriate party. Patient refunds will not be processed until all active or past due charges are paid in full.

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Payments and Late Fees

- Payment in full is due at the time services are rendered
- The provider serves the right to add a $10 late fee on any account that has unpaid balance.
- Any outstanding balance after 60 days of the date of service may be referred to an outside collection agency.
- Our office will be happy to work with you with any balance due. Please contact our billing department to work out a payment plan with our practice.
- You may also pay by credit card over the phone: (773)237-7546

Lab Charges:

- Any services provided by a lab are a contract with them. Any dispute with them should be handled directly with the lab, it is not the responsibility of our practice.

Minor Patients (under 18 years of age):

- The parent(s) or guardian(s) accompanying a minor are responsible for providing current insurance information for the minor as well as copays.
- Parents or guardians must have an Authorization for Medical Treatment form signed in order for minor patients to be seen without a parent or guardian
- In compliance with HIPPA regulations, we are unable to discuss any details of services rendered or to produce an itemized bill for any parties that are not the patient or parent/guardian unless otherwise documented.
- Both parents/legal guardians are responsible for payment of services rendered to a minor patient. A copy of this financial policy and all statements can be provided to each parent/guardian if living in separate residences, upon written request.

HIPPA and Medical Records:

- We fully comply with the federal standards regarding privacy and security of your personal health information.
- Your medical records will be held in the strictest confidence. If you request a copy of your records to be sent to another health care provider or to yourself, a written authorization will be required, and a processing fee and additional costs may apply. Only the records requested will be forwarded.

Cosmetic/Elective Procedures

- By definition, these procedures are not covered by insurance companies and this office does not submit claims on their behalf. Payment in full is required on the day of the scheduled procedure.

Signature:____

Date:______________________

Name:______________________________________

ALERTS: Important info to know about you - please circle any that apply.

- defibrillator / pacemaker
- artificial joint placed in the last 2 years
- Artificial heart valve
- Abnormal scarring or healing
- Organ transplant recipient
- Immunosuppressed
- Pregnant or currently planning
- Antibiotic prophylaxis
- History of passing out
- Allergy to adhesive
- Breast feeding
- On blood thinners
- Allergy to Lidocaine
- HIV/AIDS
- Hepatitis
- MRSA

Racial / ethnic group: (Circle)

- White
- African American or Black
- Asian
- Hispanic or Latino
- Other:____________________

Skin Health HISTORY:
circle any that apply

- Melanoma
- Basal or Squamous skin cancer
- Acne
- AK (pre-cancers)
- blistering sunburns
- eczema
- Pre-cancerous moles
- Use a tanning booth/bed? (Now or in the past)

ALLERGIES: (circle)

- **NKDA:** "I have no known medication allergies"

OR: ***"I am allergic to:*** (reaction: i.e. rash, swelling...etc.)

1. ____________________ (____________________)
2. ____________________ (____________________)
3. ____________________ (____________________)
4. **MORE?:** **please provide staff with a written list**

FAMILY HISTORY OF MELANOMA? (Circle)

- **YES** **Who?**____________________
- **NO**
- **Unknown**

DO YOU SMOKE? (Circle one)

- **Yes, daily**
- **Yes, but not daily**
- **No, I quit**
- **No, never**

MEDICATIONS: Please list **(Names Only)** of medications including prescription, supplements and over the counter.
Do not provide dosages.

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

More? Please provide staff with a written list.

Preferred method of contact: (circle and insert number)

- **Cell Phone:** ____________________
- **Home Phone:** ____________________

Occupation and Hobbies:

Occupation:____________________

Hobbies: ____________________

Assignment and Release: Though we certainly will assist you in obtaining payment for medical services from your insurance carrier, the ultimate responsibility for payment of any bills incurred at our office lies with the patient. **I authorize my insurance benefits to be paid directly to the doctor. I understand that I am financially responsible for any balance due. I authorize the doctor or insurance company to release my information required to process my claim.**

This office complies with federal HIPPA regulations.

Signature:______________________________ **Date:**______/______/______

A&G Dermatology: Medical Information

Patient Name:________________________________ ***First Visit?:*** Yes / No

Primary Care Physician:_________________________ ***Referring Physician:***______________

Preferred Pharmacy: [name,street,city]

___

Reason For Today's Visit?: _______________________________ ***Today's Date:***_____________

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PLEASE CIRCLE ALL THAT APPLY IN EACH COLUMN

Past Medical History:	*Past Surgery:*	**Review Of Systems:** Are You Currently Experiencing Any Of The Following Health Concerns?
PCOD (cystic ovary)	No Surgery In Past	Changed: Skin Lesion / Mole
Hepatitis (HBV / HCV)	Mastectomy (Reason:___________)	Rash
Heart Attack	Colon (Reason:_______________)	Fever
High Cholesterol	Kidney Removal	Chills
Anxiety Disorder/Depression	Joint Replacement (____________)	Headaches
Arthritis	Transplant (Organ:____________)	Unintentional Weight Loss
Asthma	Heart: Valve	Chest Pain
Bone Marrow Transplant	Heart: Stent	Muscle Weakness
Thyroid Disease (High/Low)	Mole Removal	Abdominal Pain/Nausea/Vomiting
Cancer: ______________	**Skin Cancer: Basal Cell**	Blurry Vision
Lupus	**Skin Cancer: Squamous Cell**	Cough
Seizures	**Melanoma**	Shortness of Breath
Diabetes (Insulin??)	***Other:***______________________	Joint Aches
Kidney Disease	__________________________	
Gastric Reflux (GERD)	__________________________	
Hearing Loss		
HIV/AIDS		
High Blood Pressure		

A&G Patient Information

Patient Name:____ **SS#**__________________ **DOB:**____/____/________

Gender :(Please Circle One) Male Female Non-Binary Prefer To Self Describe ______________________________

Marital Status: Single Married Partnered Divorced/Separated Widowed

Address:______________________________ **City:**______________ **State:**________________ **Zip Code** __________

Phone Numbers: (Please circle if we may leave a message)

Home: (_____)____________________ **May we leave a message at home?** Yes No

Cell: (_____)____________________ **May we leave a message on your cell?** Yes No

Work: (_____)______________________ **May we leave a message at work?** Yes No

Please Indicate Your Preferred Contact Number: Home Cell Work

- **May we leave a message with anyone else in your household?** Yes No
- **Please list who we may leave a message with (name & relationship)** ________________________________
- **Please indicate if you prefer us to contact someone else on your behalf for test results and other office matters:**
  (List contact's name & relationship to patient) ____

Insurance: Please provide us with a copy of your insurance card(s)

- **Primary Insurance Carrier:**________________________________ **Phone Number:**______________________

ID Number:____________________________________ **Group Number:**____________________________

Name of policy holder:_________________________________ **Gender:** F M **DOB:**_________________

Policy Holders Address:___________________________________ **Phone Number:** (____)________________

Employers Insurance Plan? Yes No **Relationship of patient to policy holder:** Self Husband Wife Child Other

- **Secondary Insurance Carrier:**_______________________________ **Phone Number:**____________________

ID Number:____________________________________ **Group Number:**____________________________

Name of policy holder:_________________________________ **Gender:** F M **DOB:**_________________

Policy Holders Address:___________________________________ **Phone Number:** (____)________________

Employers Insurance Plan? Yes No **Relationship of patient to policy holder:** Self Husband Wife Child Other