WELCOME TO FREDERICK DERMATOLOGY ASSOCIATES

Thank you for choosing Frederick Dermatology Associates and entrusting your dermatology care to us. We are a full-service dermatology practice with the goal to provide the best dermatological care possible in an atmosphere that takes customer service seriously. We are honored to have you as our patient and will strive to combine the expertise of a university dermatology division with a warm and friendly environment. In our practice we take care of a variety of skin conditions, ranging from acne, moles, and warts, to psoriasis and skin cancer. In addition, we possess expertise in surgical and cosmetic dermatology. If you haven't visited our website, please visit us at www.frederickdermatology.com.

We want your experience at our office to be smooth from the day you make your appointment. In order to make your initial visit pleasant and effortless, please help us by filling out the patient information form that we have included. Additionally, after your appointment, please feel free to provide your feedback through an anonymous survey at www.drscore.com. This way we can listen to your constructive comments and make any necessary changes to achieve the highest level of satisfaction.

Our commitment to our patients is to provide shorter wait times for appointments and excellent customer service. We participate with most insurance plans. If you ***do not*** carry insurance, you will be responsible for the cost of the appointment at time of service. (An average medical appointment ranges from $110-$160 for a new patient and $72-$100 for established patients). Surgical and other procedures may increase the charge for the visit. Payment at the time of the visit may be paid by check, cash, or major credit cards. You may also use a flexible spending account or health savings account to pay for your visit**.**

Payment for all cosmetic procedures is NON-REFUNDABLE,

but TRANSFERABLE to other cosmetic services.

Again, we are privileged to take care of all your skin care needs. We look forward to seeing you at your appointment. If you have any questions or concerns about our practice, please do not hesitate to contact us.

Kevin Hogan, M.D.

Kathleen Moe, M.D.

& Staff of Frederick Dermatology Associates

45 Thomas Johnson Drive, Suite 209&210 Frederick, MD 21702 - 301.662.6755

FREDERICK DERMATOLOGY ASSOCIATES

FINANCIAL POLICY

Frederick Dermatology uses a secure web-based credit card payment solution. Your credit card information is stored in a compliant site which meets the Payment Card Industry Data Security Standards (PCI/DSS). Please present a valid credit or debit card.

Your insurance company will be billed charges for today and any future appointments. By signing this form, you agree that any remaining allowed amount (i.e. coinsurance/deductible) that is due as the **patient's responsibility will be charged automatically** to your credit card on file. A receipt will be emailed to you immediately when a transaction is processed. This method of payment eliminates paper statements being generated and mailed to you, a cost savings, and to provide you an easier and more efficient way to resolve the balance on your account.

This in no way will compromise your ability to dispute a charge/payment or question your insurance company's explanation of benefits. If you have any questions, please do not hesitate to ask.

Cosmetic procedures are not reimbursed by health insurance plans and full payment is expected at the time of the procedure.

I authorize Frederick Dermatology Associates, LLC to charge my credit card the outstanding balance on my account. Please indicate which card: Credit Card (preferably)_____ Debit Card_____

Please circle: Visa MasterCard American Express Discover

Last 4 digits on card _____ Expiration Date: _____/_____/_____

Patient's Name_____ D.O.B_____

Name on card (please print) _____

City and Zip of Card Holder _____

Email Address _____

Signature _____Date_____

<u>Cancellation Policy</u>

Frederick Dermatology Associates requires a 24 hour notice when cancelling a <u>medical</u> appointment. I understand that I will be liable for a charge of $40.00 if I fail to give such notice. A 72 hour cancellation notice is required for a <u>cosmetic/surgical/aesthetician</u> appointment or a $100.00 fee.

Frederick Dermatology Associates

Frequently Asked Questions Regarding the Financial Policy

Do I have to leave my credit card information to be a patient at this practice?
Yes. This is our policy. You have the option to seek dermatologic care elsewhere if you do not want to accept our policy. We appreciate that you have a choice and respect your decision if you decide to go elsewhere.

How much and when will money be taken from my account?
The insurance companies on average take approximately 2 weeks to process submitted claims. Whatever the allowed amount is, your copay, coinsurance, and deductible are taken into consideration. It simply depends on your individual policy what you may owe. Once the insurance explanation of benefits is received and posted to your account, any patient financial responsibility will be processed at the time.

Which secure software system are you using and how does it work?
The software system is PayTrace a Nationwide Payment Solution System. This system is compliant with the Payment Card Industry Data Security Standards (PCI DSS). No data is stored on our local computers or servers. All customer payment account numbers are encrypted as soon as they enter the PayTrace system. And, the data is stored in geographically remote and fully redundant high security data centers.

What are the benefits?
It saves you time and eliminates the need to write checks, buy stamps or worry about delays in the mail. Plus, if you have a rewards program linked to your card, you can earn rewards for bills you already pay.

What if there is a payment discrepancy or I have other payment questions?
Please contact our billing specialist directly to settle payment discrepancies or for other payment questions.

Will I still receive a paper bill by mail?
No. We want to eliminate printing and mailing statements.

FREDERICK DERMATOLOGY ASSOCIATES, LLC

❑New Patient ❑Name Change ❑Address Change ❑New Ins.

Today's Date _____/_____/_____

NAME: Last_____ First_____ MI_____

Preferred name or nickname:_____

Date of Birth: _____/_____/_____ ❑Male ❑ Female

Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed ❑Separated ❑Partnered

Address: _____

City_____ State_____ Zip_____

Home # (_____) _____ Work # (_____) _____ Cell # (_____) _____

E-Mail _____

Preference of communication: ❑Home ❑Work ❑Cell

How did you hear about us? _____

Your Primary Care Doctor: _____

PRIMARY INSURANCE

Insurance Company_____ Employer_____

Policy Holder Name: _____ID# _____ DOB: _____/_____/____

Relationship to patient: _____

SECONDARY INSURANCE

Insurance Company_____

Policy Holder Name: _____ID#_____ DOB: _____/_____/_____

Relationship to patient: _____

GUARANTOR (Person responsible for bill) ❑Self or

Name_____ Relationship_____

DOB_____ SS#_____

Address: _____City_____

State_____ Zip_____ Contact # (_____) _____

EMERGENCY CONTACT INFORMATION

In case of Emergency, who should be notified? _____
Phone: (_____) _____ Relationship_____

Do you give our office permission to discuss your medical information with family members?

❑YES ❑NO If yes, please provide their name and phone number below.

Name: _____ Phone (_____) _____

Name: _____ Phone (_____) _____

May we leave personal medical on your voice mail? ❑YES ❑NO

Notice of Privacy Practices/HIPAA

A notice of Privacy Practice is attached at the end of this document. My signature below indicates that I have received and/or reviewed a copy of the offices Notices of Uses and Disclosure of Protected Medical Information (Notice of Privacy Practices).

Patient or Responsible Party Signature_____ Date_____

Financial Policy

Frederick Dermatology Associates, LLC participates with Medicare, Blue Cross Blue Shield PPO, POS & FEP, Cigna, NCPPO & PHCS, United Healthcare, Aetna and Tricare. If your insurance plan requires a referral it is **your responsibility** to obtain the referral and present it at the time of service. I agree to pay FDA for all services deemed not covered by my insurance. I also understand it is my responsibility to verify any "Out-of Network" coverage for insurances that FDA does not participate with. For those insurances that FDA participates with, I agree to pay balances that my insurance indicates are my responsibility. **For those insurances that FDA does NOT participate with, I understand that I am responsible for the balance at the time of service.** I understand that Frederick Dermatology Associates, LLC is not responsible for securing my reimbursement from my insurance company. **Payment for cosmetic procedures is non-refundable, but transferable to other cosmetic services.**

Cancellation Policy

Frederick Dermatology Associates requires a 24 hour notice when cancelling a medical appointment. I understand that I will be liable for a charge of $40.00 if I fail to give such notice. A 72 hour cancellation notice is required for a cosmetic/surgical/aesthetician appointment or a $100.00 fee.

Return Check Policy

Frederick Dermatology Associates, LLC charges $40.00 for all returned checks.

I have read and understand the previous statements.

Signature_____Date_____

MEDICAL HISTORY FORM

Patient Name: _____ DOB: _____

Why are we seeing you today? _____

What is name and location of you preferred pharmacy?_____

Please list any allergies and the type of reaction you have:

_____

Medications You Are Currently Taking: *Including Over-The Counter, Vitamins, Herbal & Topical Medications*

_____ _____ _____

_____ _____ _____

Are you experiencing any of the following symptoms?

- ❑ Fever
- ❑ Chills
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Heat Intolerance
- ❑ Hair Loss/Growth
- ❑ Itching
- ❑ Swollen Lymph Nodes

What is your height: _____

Weight: _____

Most recent sun exposure: _____

Date of last menstrual cycle: _____

Have you taken Accutane before? ❑Y ❑ N Dates: _____

Family History Relationship

- ❑ Asthma _____
- ❑ Lupus _____
- ❑ Atopic Dermatitis _____
- ❑ Psoriasis _____
- ❑ Basal Cell Carcinoma _____
- ❑ Skin Cancer _____
- ❑ Malignant Melanoma _____
- ❑ Squamous Cell Carcinoma _____
- ❑ **No Significant Family History**

Past Medical History

- ❑ Cold Sores
- ❑ Diabetes Type I
- ❑ Diabetes Type II
- ❑ Heart Disease
- ❑ High Cholesterol
- ❑ Hypertension
- ❑ Hyperthyroidism
- ❑ Hypothyroidism
- ❑ Joint Problems
- ❑ Keloid
- ❑ Malignant Lymphoma
- ❑ Malignant Melanoma
- ❑ Pregnancy
- ❑ Basal Cell Carcinoma (Location) _____
- ❑ Squamous Cell Carcinoma (Location) _____
- ❑ Non-Melanoma Skin Cancer
- ❑ Systemic Lupus Erythematous
- ❑ Scleroderma
- ❑ Eczema
- ❑ Asthma
- ❑ **No Significant Past Medical History**
- ❑ **Other**

_____

Social History

- ❑ History of Blistering Sunburns
- ❑ Non-Smoker
- ❑ No Alcohol Use
- ❑ Alcohol Use Frequency: _____
- ❑ History of Tanning Salon Use
- ❑ Tobacco Use Pack(s) per day: _____