



## 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 \_\_\_\_\_ 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 \_\_\_\_\_

### **Cancellation/No-Show Policy**

***Frederick Dermatology Associates requires a 24-hour notice when canceling a medical appointment. I understand that I will be charged \$40.00 if I fail to give such notice or if I am a no-show. A 72-hour cancellation notice is required for a cosmetic/surgical/aesthetician appointment. I understand that I will be charged \$100.00 if I fail to give such notice or if I am a no-show.***

# FREDERICK DERMATOLOGY ASSOCIATES, LLC

NAME: Last \_\_\_\_\_ First \_\_\_\_\_ MI \_\_\_\_\_

Preferred Name or Nickname: \_\_\_\_\_ Today's Date \_\_\_\_/\_\_\_\_/\_\_\_\_

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: \_\_\_\_\_

I certify that I have provided all active and accurate insurance information. I understand that I am responsible for balances if I failed to provide this information in its entirety. Initials: \_\_\_\_\_

GUARANTOR (Responsible Party)  Self  Other (complete the section below)

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

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### 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 canceling a medical appointment. I understand that I will be charged \$40.00 if I fail to give such notice or if I am a no-show. A 72-hour cancellation notice is required for a cosmetic/surgical/aesthetician appointment. I understand that I will be charged \$100.00 if I fail to give such notice or if I am a no-show.*

### 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: \_\_\_\_\_

Preferred Name: \_\_\_\_\_

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*

\_\_\_\_\_  
\_\_\_\_\_

Height: \_\_\_\_\_

Most recent sun exposure: \_\_\_\_\_

Weight: \_\_\_\_\_

Date of last menstrual cycle: \_\_\_\_\_

Are you experiencing any of the following symptoms?

- |                                 |   |  |
|---------------------------------|---|--|
| <input type="checkbox"/> Pain   | <input type="checkbox"/> Weight Loss      | <input type="checkbox"/> Hair Loss/Growth    |
| <input type="checkbox"/> Fever  | <input type="checkbox"/> Weight Gain      | <input type="checkbox"/> Itching             |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Swollen Lymph Nodes |

Have you taken Accutane in the past?  Y  N Dates: \_\_\_\_\_

## Past Medical History

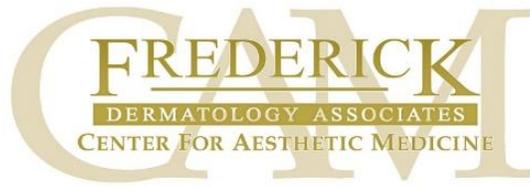
- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cold Sores       | <input type="checkbox"/> Keloid                       | <input type="checkbox"/> Eczema                         |
| <input type="checkbox"/> Diabetes Type I  | <input type="checkbox"/> Malignant Lymphoma           | <input type="checkbox"/> Asthma                         |
| <input type="checkbox"/> Diabetes Type II | <input type="checkbox"/> Malignant Melanoma           | <input type="checkbox"/> No Significant Medical History |
| <input type="checkbox"/> Heart Disease    | <input type="checkbox"/> Basal Cell Carcinoma         | <input type="checkbox"/> Pregnancy                      |
| <input type="checkbox"/> High Cholesterol | (Location) _____                                      | <input type="checkbox"/> Seasonal Allergies             |
| <input type="checkbox"/> Hypertension     | <input type="checkbox"/> Squamous Cell Carcinoma      |   |
| <input type="checkbox"/> Hyperthyroidism  | (Location) _____                                      |   |
| <input type="checkbox"/> Hypothyroidism   | <input type="checkbox"/> Non-Melanoma Skin Cancer     |   |
| <input type="checkbox"/> Joint Problems   | <input type="checkbox"/> Systemic Lupus Erythematosus |   |
|   | <input type="checkbox"/> Scleroderma                  |   |

## Family History

- |   |  |
|---|--|
| <input type="checkbox"/> Asthma _____               | <input type="checkbox"/> Skin Cancer _____             |
| <input type="checkbox"/> Lupus _____                | <input type="checkbox"/> Malignant Melanoma _____      |
| <input type="checkbox"/> Atopic Dermatitis _____    | <input type="checkbox"/> Squamous Cell Carcinoma _____ |
| <input type="checkbox"/> Psoriasis _____            | <input type="checkbox"/> No Significant Family History |
| <input type="checkbox"/> Basal Cell Carcinoma _____ |  |

## Social History

- |   |   |
|---|---|
| <input type="checkbox"/> History of Blistering Sunburns | <input type="checkbox"/> History of Tanning Salon Use       |
| <input type="checkbox"/> Non-Smoker                     | <input type="checkbox"/> History of Drug Use                |
| <input type="checkbox"/> No Alcohol Use                 | <input type="checkbox"/> Tobacco Use Pack(s) per day: _____ |
| <input type="checkbox"/> Alcohol Use Frequency: _____   |   |



**Are you interested in any of the following??**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Skin Tightening<br><input type="checkbox"/> Face/Neck<br><input type="checkbox"/> Body | <input type="checkbox"/> Fat Reduction<br><input type="checkbox"/> Specify body site:<br>_____ | <input type="checkbox"/> Rosacea<br><input type="checkbox"/> Chemical Peels |
| <input type="checkbox"/> Removing Facial Blood Vessels  | <input type="checkbox"/> Excessive Hair Growth   | <input type="checkbox"/> Skin Care Regimen                                  |
| <input type="checkbox"/> Mouth Lines  | <input type="checkbox"/> Lip Augmentation  | <input type="checkbox"/> Botox  |
| <input type="checkbox"/> Acne   | <input type="checkbox"/> Excessive Sweating  | <input type="checkbox"/> Skin Care Products                                 |
| <input type="checkbox"/> Lashes   | <input type="checkbox"/> Facial Redness  | <input type="checkbox"/> Dermal Filler                                      |
| <input type="checkbox"/> Lower Face Folds   | <input type="checkbox"/> Freckles / Brown Spots  | <input type="checkbox"/> Laser Treatments                                   |
| <input type="checkbox"/> Sun Damage   | <input type="checkbox"/> Frown Lines   | <input type="checkbox"/> Large Pores  |
| <input type="checkbox"/> Wrinkles   | <input type="checkbox"/> Scar Reduction  | <input type="checkbox"/> Other _____  |

**Have you had any cosmetic surgery or procedures in the past five years?  YES  NO**

**If so, please describe:**

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**Would you like to receive information about specials or our biannual open house event?  YES  NO**

**Please give us your email** \_\_\_\_\_

**Name** \_\_\_\_\_

**Signature** \_\_\_\_\_

