Frederick Dermatology Associates Financial Policy

Frederick Dermatology Associates uses a secure, web-based credit card payment solution. Your credit or debit card information is securely stored by a payment processor that meets Payment Card Industry Data Security Standards (PCI DSS) requirements. Please present a valid credit or debit card at check-in so that we may securely maintain your payment information on file.

Your insurance company will be billed for today's services 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. The card on file will not be used to collect payment for VA-authorized services or VA copayments, but will be utilized for the collection of late cancellation and no show fees.

Maintaining a credit or debit card on file does not affect your right to dispute a charge, question a payment, or contact your insurance company regarding its Explanation of Benefits (EOB). If you have any questions about our credit card policy or how charges are processed, please do not hesitate to ask. We are happy to assist you.

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

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?

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

Have you taken Accutane in the past? ❑**Y** ❑ **N** **Dates:** _____

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
- ❑ Basal Cell Carcinoma (Location) _____
- ❑ Squamous Cell Carcinoma (Location) _____
- ❑ Non-Melanoma Skin Cancer
- ❑ Systemic Lupus Erythematous
- ❑ Scleroderma
- ❑ Eczema
- ❑ Asthma
- ❑ No Significant Medical History
- ❑Pregnancy
- ❑Seasonal Allergies

Family History

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

Social History

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

FREDERICK
DERMATOLOGY ASSOCIATES
CENTER FOR AESTHETIC MEDICINE

Are you interested in any of the following??

❑Skin Tightening
- ❑ Face/Neck
- ❑ Body

❑Fat Reduction
- ❑Specify body site: _____

❑Rosacea

❑Chemical Peels

❑Removing Facial Blood Vessels

❑Excessive Hair Growth

❑Skin Care Regimen

❑Mouth Lines

❑Lip Augmentation

❑Botox

❑Acne

❑Excessive Sweating

❑Skin Care Products

❑Lashes

❑Facial Redness

❑Dermal Filler

❑Lower Face Folds

❑Freckles / Brown Spots

❑Laser Treatments

❑Sun Damage

❑Frown Lines

❑Large Pores

❑Wrinkles

❑Scar Reduction

❑Other_____

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

If so, please describe:

_____

_____

_____

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

Please give us your email _____

Name _____

Signature _____