Siperstein Dermatology Group

----------*Please print clearly and fill out all sections*----------

Patient Information:

Name: *(as it appears on your insurance policy)* _____

Cell Phone #: (☐ *preferred*) _____ Home Phone #: (☐ *preferred*) _____

Street Address: _____ Apt/Unit #_____ City: _____

State: _____ Zip Code: _____ Date of Birth: _____

Alternate Address: _____

Email: (☐ *preferred*) _____ Social Security #: _____

Marital Status: *(please circle)* ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Other _____

Birth Sex: *(please circle)* Male ☐ Female ☐ Race: _____ Ethnicity: _____

Emergency Contact: _____ Phone #: _____

Relation to pt: _____

Primary Care Physician: _____ Phone #: _____

Pharmacy Name: _____ Phone #: _____

Employer: _____ Work #: _____

Policy Holder Name: _____ DOB _____

How did you hear about our office? ☐ Family Member _____ ☐ Community Event _____

☐ Internet Search: _____ ☐ Insurance Company Listing ☐ Newspaper: _____

☐ Physician Referral: Dr. _____ ☐ Friend Referral: _____

☐ Print Advertisement _____ ☐ Magazine: _____ ☐ Other: _____

Please place a check next to the products/procedures you are interested in:

- ☐ **Complimentary Consultation** regarding skincare products and cosmetic treatments.
- ☐ **Aesthetic Services** (Customized Facials, Chemical Peels, Electrolysis, Laser Hair Reduction, Photofacials, Moxi non-ablative Laser for texture improvement, Hydratherapy Facials)
- ☐ **Fillers** (Restylane products, Juvederm products, or Sculptra)
- ☐ **Neuromodulators** (Botox, Dysport)
- ☐ **Laser treatments** (Brown or Red Spot Removal, Laser Resurfacing for Wrinkles & Scars)
- ☐ **Latisse** for longer lashes
- ☐ **Asclera** injections for leg vein reduction
- ☐ **Coolsculpting** for Fat Reduction
- ☐ **Radiofrequency Microneedling**
- ☐ **Dermagraphix Artificial Intelligence Mole Mapping**
- ☐ **Upneeq** (raises the upper eye lid)
- ☐ **BBL/Photofacial/IPL** (brown/red spot removal)

By signing below, I acknowledge that I will disclose all of my health information known to me at this time and that all of my other personal information is accurate.

Signature: _____ Date: _____

Siperstein Dermatology Group

HIPAA Patient Consent Form

Our Notice of Privacy Practices Act provides information about how we use and disclose your protected health information. The notice contains a patient rights section describing your rights under the law. You have the right to review our Notice before signing the consent. The terms of our notice may change. If we change our notice you may obtain a revised copy by contacting our office. You have the right to revoke this consent in writing signed by you. However such a revocation shall not affect any disclosure we have already made in reliance on your prior consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that their protected health information may be disclosed or used for treatment, payment, or health care operations. The practice has a Notice of Privacy Practices and the patient has the opportunity to review this notice. The practice reserves the right to change the Notice of Privacy practices. The patient has the right to restrict the use of their information but the practice does not have to agree to those restrictions. The patient may revoke this consent in writing at any time and all future disclosure will then cease. The practice may condition receipt of treatment upon execution of this consent.

Communication Authorization Exception

How would you like to be contacted by us?

PATIENT'S RIGHTS OF DISCLOSURES: In general, the HIPAA privacy rule gives individuals the right to request restriction on uses and disclosures of health information. The individual is also provided the right to request confidential communication of health information to be made by alternative means. Communication with the practice using email, fax, and cell phone are not guaranteed to be secure or confidential. If these methods are initiated below, I waive the practice's obligation to ensure confidentiality. I also understand that email and fax are not appropriate means of communication for emergencies.

I, _____, (patient's first and last name) wish to be contacted in the following manner:

(Please check box and initial ALL preferential methods of contact

- ▪__ Home Telephone ☐ Ok to leave detailed message ☐ Leave message with call back number only__ **INITIAL: _____**
- ▪__ Cell Phone__ ☐ Ok to leave detailed message ☐ Leave message with call back number only **INITIAL: _____**
- ▪__ Work Telephone ☐ Ok to leave detailed message ☐ Leave message with call back number only__ **INITIAL: _____**
- ▪__ Email Address: ☐ Ok to leave detailed message ☐ Leave message with call back number only__ **INITIAL: _____**

- ▪__ Mail to home address__ **INITIAL _____**
- ▪__ FAX Home # _____ **INITIAL _____** **Patient's Date of Birth: _____**
- ▪__ Work FAX # _____ **INITIAL _____**

I allow the release of my health information to the following people: (please print names clearly)

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

Patient Name or Guardian Name (please print) **Signature**

_____ _____

Relationship to Patient if Guardian **Date**

Office Use only: I attempted to obtain the patient's signature in acknowledgement on the Notice of Privacy Acknowledgement, but was unable to do so as documented. Date: _____ Initials: _____ Reason:_____

Siperstein Dermatology Group

Office Policies and Assignment of Benefits

YOU ARE RESPONSIBLE FOR YOUR INSURANCE POLICY

Due to the many changes in insurance policies, we cannot be responsible for interpreting each individual policy. **It is the responsibility of the patient to understand their individual coverage and its limitations, as well as the providers accepted by the plan.** We urge you to check with your insurance company regarding your benefits because failure to comply could result in you, the patient, being responsible for all costs incurred.

Insurance Policies are a contract between the patient and the carrier. It is the responsibility of the patient to know which providers are in their specific network.

Financial Responsibility: Patients are financially responsible for all charges, whether paid by their insurance for all services rendered on their behalf or dependent's behalf.

Payment: Any and all co-pays, co-insurance, deductibles and account balances are due at the time of service.

Balances: Balances outstanding for more than 90 days will be subject to collection fees (*at the patient's expense)* and may be referred to a collection agency.

Referral/Authorizations: If the patient's health insurance policy requires a referral/authorization, it is the patient's responsibility to obtain it prior to the scheduled appointment. Since most insurances will deny wellness visits for Dermatologists, we do not offer this service.

Return Policy: Any defective product or any product that has caused an allergic reaction which has been documented by a physician, may be returned within 30 days. Prescription strength products are non-returnable.

Appointment No Show / Cancellation Policy: We require a 24-48 hour cancellation notice. A $50 fee will be charged for all medical appointments and $100 for any surgical appointment that is cancelled without providing proper notice. Cosmetic appointments will require a deposit of $50-$200 depending on the type of the appointment, and this deposit amount will be charged as a fee if the appointment is cancelled with less than 24-48 hours' notice. These fees can be waived at the discretion of the billing office, one time only, if there is an emergency (hospitalization, accident, etc....).

Lab Fees: Please be advised that all specimens (biopsy, cultures, etc) will be sent to an independent Lab to be processed and you will receive a separate bill from that lab. _____

Returned Check Policy: A fee of $50 will be charged for each check that is returned (subject to change).I certify that all the insurance information that I have provided is current and correct. I authorize Siperstein Dermatology Group to administer medical care as deemed necessary. I authorize the release of any medical information requested by my insurance carrier in order to process insurance claims. I understand that I am personally responsible for all fees, including deductibles, co-pays and co-insurance incurred for services rendered to me or a dependent. I authorize payment of insurance benefits paid on my behalf, to be made directly to Siperstein Dermatology Group. I authorize Siperstein Dermatology to release medical information to a 3rd party or its agents.

I certify that I have read this form in its entirety and will abide by the above policies.

Print Patient Name:_____ DOB:_____Date: _____

Patient's Signature (*or Other Legally Authorized Person's)* _____