Chelsea Skin & Laser **Patient Registration / Acknowledgement of Office Policies**

Last Name ______________________________ **First Name** ____________________ **Middle Initial** ______

Address ____________________________ **Apt** _____ **City** _______________ **State** _____ **Zip** _________

Sex ___ M ___ F ___ T **Date of Birth** _______________ **SS #** ________-______-________

Cell Phone __________________ Home ___________________ Work ___________________

Appointments are confirmed via text and email. **Email** ___________________________________

**** Respond "Yes" to TEXT reminders and click in email CONFIRM NOW. Call office directly to cancel or reschedule.****

Referring Physician ______________________ Referring Physician's Phone _________________________

Insurance Carrier ________________________ Member ID ______________________ Group # ______________

Does your insurance require a referral prior to treatment? ___ Yes ___ No ___ Not Applicable

- Notify Front Desk if you have **SECONDARY** Insurance coverage.
- If unable to verify participation in your plan prior to visit or a referral is not filed, we will happily see you as a self-pay patient.
- We are NOT in network for Affordable Healthcare Exchange Program affiliated plans, we will happily see you as a self-pay patient.

Please familiarize yourself with your insurance policy & our policy below. We do not have access to particulars of your insurance plan.

1. I understand my insurance company determines my co-pay, co-insurance, annual or out of network deductibles, covered services and financial responsibility. I understand I am responsible to pay any fees as determined by or left unpaid by my carrier including any ACA, Medicare, Medicaid or Medicaid sponsored plans. I am responsible for supplying accurate contact, credit card and current insurance information/card. If my participation cannot be verified prior to a visit, I may pay for services rendered in full and personally submit a claim to my carrier. Co-pays/Balances are collected prior to appointments.
2. **Attaining referrals is the responsibility of the patient**. If required by my plan, I understand it is my responsibility to obtain a referral from my Primary Care Provider and present it prior to my visit. Referrals must be provided **before** appointment or I may not be seen or I may pay for service rendered in full and submit claim to my carrier. If a claim is denied due to missing/invalid referral, I am responsible for a $50 claim denial administration fee and all applicable charges for services/treatments.
3. If my insurance requires I meet an **annual deductible** before my healthcare is covered, I understand that I am responsible in full for services rendered in meeting those deductible requirements.
4. **24 Hour Cancellation Policy**: In respect of our providers and patients on our waiting list, we require 24 hours prior notice to cancel/reschedule appointments. For accuracy and to protect your privacy, leaving a message, sending email or text will not be considered a cancellation. Speak directly to a receptionist. Cancel Monday appointments by noon the previous Friday. Without appropriate notice, a cancellation fee will billed automatically to your account ($50 for medical visits/$200 for cosmetic consults/treatments.) Late arrivals will be seen schedule permitting; may require rescheduling. $50 missed appointment fee may apply.
5. **New Medical Patients** without insurance; patients who choose to go **Out of Network**; or those having a 1st time **Cosmetic Consultation**, the office visit fee for an initial visit is $300. The cosmetic consultation fee covers your office visit and may be applied to the cost of the first cosmetic treatment if appropriate/chosen. Fee cannot be waived/refunded if no treatment is appropriate or chosen as cost covers consultation. Cancellation policy applies.
6. CS&L does not have a lab on premesis. All specimens are sent to an independent lab. Claims for specimens sent to a lab will be processed by that lab separately from the office visit at CS&L. Patient is responsible to the lab for fees as per their insurance plan.

A. Assignment and Release

I authorize Chelsea Skin & Laser to provide treatment to me/my child. I, the undersigned, have insurance coverage and assign all medical benefits to Chelsea Skin & Laser (Eidelman Dermatology, PLLC). I understand it is my insurance company who decides my financial responsibility and I am financially responsible for all charges, in full or in part, not paid by my insurance. I understand the practice is not in network for any plans associated with the ACA Healthcare Exchange Program, Medicaid or Medicaid sponsored programs. I am responsible for any fees submitted to Medicaid as primary, secondary or terciary as they will be processed as out of network. I am legally reponsible to pay my outstanding balances including: co-pays, deductibles, co-insurance, non-medical treatments, non-covered procedures, claims unpaid due to out-of-network status, lack of referral and/or No Show/Late Cancel fees as per office policy. I agree to pay all outstanding balances within 30 days of billing statements. Balances including those due to incorrect information supplied to office, invalid/denied card transactions will be considered in default and forwarded to a collection agency after 60 days of 1st billing statement without notice. A 25% service fee will be added to balances forwarded to collections. I authorize the Practice to release all information necessary to secure payment of benefits and to use the signature below on all my insurance submissions.

If uninsured, or a self-pay patient, or receiving treatment for a non-medically related visit, I agree to satisfy all charges on the day of my visit.

B. Required Credit Card Information. This required information is secured in our HIPPA compliant system. Once your insurance has paid their portion & notified us of your share, remaining balance will be charged to your card. No Show/Late Cancel fees will also be charged to this account.

This will not compromise your ability to dispute a charge or your insurance company's determination of payment.

I, the undersigned, authorize Chelsea Skin & Laser (Eidelman Dermatology, PLLC) to charge outstanding service balances/applicable fees to the account:

All Information is Required	Credit Card Number	Exp. Date	Billing Zip
❑ AMX ❑ MC ❑ Visa ❑ HSA			

C. HIPAA Privacy Practices Notification

I, the undersigned, have been issued the HIPAA Notice of Privacy Practices. I fully understand that the Practice is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose my health information for the purposes of treating me, obtaining payment for services rendered to me and conducting health care operations.

Signature *Required* **(1-5, ABC)** ________________________________ **Date** *Required* ______________

Print Form Sign/Date AREAS IN RED ARE REQUIRED

V 1-1-2017 a

Chelsea Skin & Laser
Medical History

Name ____ **Nickname** _______________________

Who referred you to Chelsea Skin & Laser? Friend ___ Dr. _______________________ Other ___

Pharmacy _____________________ **Address** ____________________ **Phone** ________________
or
❑ **Mail Order / Specialty Pharmacy** ____________________________ **Phone** ________________

Are you taking any medications, supplements or homeopathics? ___ Yes ___ No

If so, please list: ____

Are you allergic to any medications? ___ Yes ___ No

If so, please list: ____

What is your current occupation? ________________________________

Have you ever had or been treated for any of the following conditions:

___ Arthritis, Joint Problems, Bone Disease, Lupus, etc.
___ Blood Disorder
___ Cancer. If so, what type? ____________________
___ Diabetes
___ Eye Disease (Glaucoma, Cataracts, other)
___ Heart Disease (Rheumatic Fever, Pacemaker, other)
___ High Blood Pressure
___ HIV: Viral Load ________ CD4 ______
___ Kidney Disease
___ Liver or Gall Bladder Disease
___ Lung Disease (Tuberculosis, Pleurisy, other)
___ Neurological Disorder
___ Stomach / Intestinal Problems
___ Stroke

- **Is there a history of skin cancer in your family?** ___ Yes ___ No

  If so, what is the relationship? __________________________________

- **Have you previously had a skin problem?** ___ Yes ___ No

  If so, please describe: ____

- **Are you pregnant?** ___ Yes ___ No

  Taking Birth Control Medication? ___ Yes ___ No

Please inform the doctor if you become pregnant or are planning to become pregnant.

We offer a line of skin care products only available through a doctor's office.

Would you like us to introduce you to a skin care regimen? ___ Yes ___ No
If so, please mention to your practitioner.

Have you had Botox, Dysport, Fillers or Laser Treatments? ___ Yes ___ No

Are you interested any of the following products, treatments or procedures?

___ Acne Treatments
___ Botox / Dysport
___ Chemical Peels
___ Crow's Feet
___ Dark Circles
___ Dermal Fillers / Mini Facelift
___ Double Chin
___ Dry Skin
___ Facial Veins
___ Fine Lines
___ Forehead wrinkles
___ Improving skin tone / texture
___ Laser Hair Removal
___ Maintaining a more youthful appearance
___ Red or Blue Leg Veins
___ Skin Discolorations / Age Spots
___ Sunscreen Advice
___ Topical Wrinkle Treatment
___ Wrinkles around the eyes or mouth

Other ________________________