Chelsea Skin & Laser **Patient Registration / Policies / Permission to Treat**

Last Name _____ **First Name** _____ **Middle Initial** _____

Address _____ **Apt** _____ **City** _____ **State** _____ **Zip** _____

Gender ___M ___F ___T ___O **Date of Birth** _____ **SS #** _____-_____-_____

Appointments are confirmed by text and email. Reply YES to texts or click in email CONFIRM NOW.
Call office to cancel or reschedule.

Cell _____ **Email** _____

Home _____ Work _____

Insurance Carrier _____ Member ID _____

Does your insurance require a referral from your Primary Care Physician? _____Yes _____No

If YES: Referring Physician _____ Referring Physician's Phone _____

- Notify Front Desk if you have **SECONDARY** Insurance coverage.
- If unable to verify your plan as active/in network prior to visit or a referral is not filed, we will happily see you as a self-pay patient.

Familiarize yourself with your insurance policy & our policies below. We have limited access to particulars of your plan.

- We are NOT in network with Affordable Care Act Exchange Program affiliated plans, we will happily see you as a self-pay patient.

1. I understand my insurance company determines co-pay, co-insurance, out of network benefits, deductibles, covered services, financial responsibility. I understand I am responsible to pay any fees as determined by or unpaid by my carrier including 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 I will obtain a referral from my Primary Care Provider. Referrals must be provided **before** my 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/Late 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 24 hours notice, a cancellation fee will beP billed automatically to your account ($50 for medical visits/$200 for cosmetic consults/treatments.) Late arrivals will be seen schedule permitting; may require rescheduling. Missed appointment fee may apply.
5. **New Medical Patients without insurance**; patients who choose to go **Out of Network**; or those having a **Cosmetic Consultation**, the office visit fee for an initial visit is $300. The cosmetic consultation fee covers your office visit. A portion might be applied to the cost of the first cosmetic treatment if appropriate/chosen. Fee cannot be waived/refunded if no treatment is appropriate/chosen as cost covers consultation. Cancellation policy applies.
6. **All specimens are sent to an independent lab**. CS&L does not have a lab on premesis. Claims for specimens sent to a lab will be processed by the lab separately from the office visit at CS&L. Patient is responsible to the lab for fees as per their insurance plan.

A. Permission to Treat, 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 my insurance company decides my financial responsibility. 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 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 my 1st billing statement. 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. The agency will add a 25% service fee to balances forwarded to them. 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, 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 is secured in our HIPPA compliant system. Once insurance has paid their portion, any remaining balance you owe will be charged to your card/HSA account. 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 to charge outstanding service balances/applicable fees to the account:

All Information is Required	Health Savings Account or 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* _____ **Date** *Required* _____

AREAS IN RED ARE REQUIRED

Chelsea Skin & Laser
Medical History

Name _____ **Preferred Name** _____

How did you hear of Chelsea Skin & Laser? ❑ Friend Dr. _____ ❑ Other

Pharmacy _____ **Address** _____ **Phone** _____

or

Mail Order / SPECIALTY PHARMACY Name_____ **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 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 any skin problems?** ❑ 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.

Ask your provider if you'd like us to introduce you to a skin care regimen.
We offer a line of skin care products only available through a doctor's office.

We offer many customizable treatments and are happy to discuss them with you.

- Acne Treatments
- Botox / Dysport / Jeuveau
- 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 / Facials
- Red or Blue Leg Veins
- Skin Discolorations / Age Spots
- Sunscreen Advice
- Topical Wrinkle Treatment
- Uneven skin tone
- Wrinkles around the eyes or mouth
