Welcome to Upstate Dermatology, PC.

The staff at Upstate Dermatology, PC is committed to providing you with quality dermatological care. Enclosed are several patient documents, that provide a clear understanding of our Patient policies at Upstate Dermatology, PC.

New Patients:

Prior to your upcoming new patient visit, take a few minutes to complete the required new patient health documents and bring them with you to the office. Important note: to expedite the new patient registration process, please arrive at least 20 minutes prior to your scheduled appointment time. Plan to arrive on time for your appointment, as late arrivals will be given the next appointment time available either on the same day or a future date.

- *New Patient documents: Patient demographics; Medical History; General and Financial Consent; Current Medications listing; HIPAA authorization.* Be sure to bring your Insurance card(s) and photo ID. Additional documents may apply.
- *Minor Consent Form* (if you are a minor, your guardian will need to review and sign the enclosed document(s)). For the initial appointment, a minor must be accompanied by a parent or legal guardian.
- *Medicare Authorization Form / Assignment of Benefits/E-prescribing Consent*
- *Referral:* if your health plan requires a referral from your PCP, please confirm that your valid referral has been received by our office prior to your appointment or bring the referral with you. Patients who have not obtained a valid referral, will be asked to sign a waiver to pay for their visit, or reschedule their appointment, until the referral is obtained.

Health Insurance: Copayments, Deductible Plans, Prior Authorizations:

If you are a member of a health insurance plan with which we participate, all co-pays and co-insurance payments as required by your insurance plan, are due at the time of service. Note: these payments are not billable.

- *Deductible Plan subscribers: a deposit will be required for the following visit types: New Patient* visit: $150.00; Existing Patient: $125.00; Biopsy appointment: $150.00 and MOHs Surgery: $500.00

Insurance Verification:

All patient insurance relationships will be verified prior to the scheduled visit, to determine if in an insurance policy is active or inactive. If a policy is inactive, it is the responsibility of the patient to pay for all services performed at the time of the visit. ***Upstate Dermatology, PC*** participates with several insurance companies, please contact our office to verify if your insurance plan is a participant.

Missed Appointments:

For no show appointments and cancellations less than 24 hours of scheduled appointment time, a $50.00 fee will be billed.

Additional information is available online at: www.upstatederm.com

Upstate Dermatology, PC

Patient Responsibilities:

We encourage patients to become knowledgeable about their insurance plan, its benefits (covered services and non-covered services) and the application of your plan as it relates to medical treatment you seek from Upstate Dermatology, PC. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. If your insurance company has not paid your account, the balance will be billed to you.

At the time of your visit, you will be required to furnish valid (current) proof of your insurance coverage and photo id.

Self-Pay Accounts:

If you do not have health insurance, you will be considered a Self-Pay Patient. All self-pay accounts are required to pay in full at the time services are rendered. Note: these services are not billable.

Cosmetic Procedure:

Insurance providers consider these types of procedures medically unnecessary, or elective procedures. Fees related to a cosmetic procedure are discussed with patients prior to the service(s) being performed. Payment is the responsibility of the patient, and due in full prior to the services rendered.

Payment Options:

Upstate Dermatology, PC accepts the following payment options: FSA, HSA,Check, Cash, VISA, MasterCard, Discover and Care Credit (to apply for a Care Credit charge card, go online to: www.carecredit.com). Patients will be assessed and billed a $30.00 surcharge for any returned check from the bank.

Billing Information:

Billing Office: 1-844-887-7090, extension: 16

Billing statements will be mailed to the address of record and to the responsible party listed on the patient account. Billing statements are issued monthly. Payments are due within 30 days of the date of the statement. If your account is inactive for 2 billing cycles, you will become eligible for submission to collections. Patients will be responsible for all fees and charges associated with the collection process. If a patient is due a refund, Upstate Dermatology, PC will issue a refund. Upstate Dermatology, PC, at its sole discretion, shall have the option of terminating its professional relationship with a patient, as a result of their collection status.

There are 4 office locations to serve your medical and surgical skin care needs:

Schenectady location: 518-374-7222; 461 Clinton Street Extension, Schenectady
Chatham location: 518-392-6742; 113 Hudson Avenue, Chatham
Clifton Park location: 518-631-2933; 1770 Route 9 North, Clifton Park
East Greenbush / Schodack location: 518-479-4156; 1547 Columbia Turnpike, Castleton

I certify that I have read the financial and no show policy of Upstate Dermatology, PC and agree to abide by the policy.

Patient (or Representative) Signature: _____ Date: _____

Practice Employee Signature: _____ Date: _____

Upstate Dermatology, PC

Authorization to Release PMI

Authorization of benefits and information release (For Patients with Private Insurance):

I authorize my insurance company to pay benefits on my behalf directly to Upstate Dermatology and acknowledge that I am financially responsible for any unpaid balance. I understand I am responsible for the payment of any medical services performed for myself or my dependent if my insurance is in a retroactive period, a grace period (The Patient Protection and Affordable Care Act requires insurance plans to provide a three-month grace period before terminating coverage for individuals enrolled in a plan through the Individual Health Insurance Marketplace), or is inactive at the time of service.

Medicare Authorization (Only for Patients with Medicare):

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignments of benefits apply.

MEDIGAP Authorization (Only for Patients with Medicare Supplemental Policies):

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to my MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

E-prescribing (RxNT) Consent:
New York State has passed legislation that requires all prescriptions to be transmitted in electronic format no later than March 27, 2016. I understand that Upstate Dermatology will transmit my prescriptions electronically, to the pharmacy that I designate as my primary pharmacy provider through RxNT.

Please sign for permission to treat and agreement to the authorizations above:

Patient (or Representative) Signature: _____ Date: _____

Upstate Dermatology, PC

Patient Demographics and Privacy Notice

Name:	**Cell Phone):**
Address:	**Home Phone:**
City/State/Zip:	**Social Security:**
E-Mail:	**Date of Birth (DOB):**
Language:	**Sex:**
Marital Status:	
Emergency Contact:	**Phone:**
Primary Care Physician:	**Office Phone:**
Insurance:	**Policy Number:**
Primary Insured (Name & DOB):	**Group Number:**
Co-pay:	**Effective Date:**
Responsible Party:	**Phone (Primary):**
Address:	**Phone (Secondary):**
City/State/Zip:	**Date of Birth (DOB):**

I authorized the individual(s) listed below to obtain medical information on me:

Name:	**DOB:**	**Relationship:**
Name:	**DOB:**	**Relationship:**
Name:	**DOB:**	**Relationship:**
Name:	**DOB:**	**Relationship:**

I acknowledge that I was provided with the Notice of Privacy Practices of Upstate Dermatology, PC.

Any questions regarding Upstate Dermatology's privacy notice can be directed to the privacy official, Brian Brill.

Patient (or Representative) Signature: _____ Date: _____

Practice Employee Signature: _____ Date: _____

Upstate Dermatology, PC

Credit Card on File Policy

As you know if you have ever checked into a hotel or rented a car, you are asked for a credit card, which is swiped and later used to pay your bill. We have implemented a similar policy. You will be asked for a credit card number at the time you check-in and the information will be held encrypted. We do not store your sensitive credit card information in your medical record. We store it on a secure gateway that allows your credit card information to be kept confidential.

You will receive a letter in the mail from your insurance carrier that explains how much of your office services they pay and how much you pay, called an Explanation of Benefits (EOB). Your EOB arrives 10-20 days after your appointment has been billed. You will receive a bill from us regarding your financial responsibility as stated on your EOB. We ask you to pay your balance within 60 days; otherwise we will automatically charge your credit card on file for the amount due.

As always, our office is pleased to work with your health benefit plan to coordinate your benefits, and minimize your financial and administrative burden, allowing us to focus on more important issues, like your care. You can feel secure sharing this information with us – it is our policy to treat your financial information with the same respect and privacy guidelines as your medical records.

This in no way will compromise your ability to dispute a charge or question your insurance company's payment determination. Co-pays remain due at the time of the visit. If you have a question for us, you may call our office.

Additionally, in the event you are delinquent in timely paying an overdue balance, we reserve the right to charge that amount on your credit card as well. We also request that you provide us with updated credit card information anytime that is warranted (card expires, etc...).

If you have any questions about this payment method, do not hesitate to ask.

I authorize Upstate Dermatology to charge the portion of my bill that is my financial responsibility (determined by my EOB statement from my insurance company) to the following credit or debit card:

☐ Visa ☐ Mastercard ☐ Discover ☐ American Express

Credit Card Number: _____

Expiration Date: _____/_____ Security Code: _____ Email Address: _____

I authorize and request Upstate Dermatology to charge my credit / debit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibility.

This authorization relates to all payments not covered by my insurance company for services provided to me by Upstate Dermatology.

This authorization will remain in effect until I (we) cancel this authorization. To cancel, I (we) must give a 60 day notification to Upstate Dermatology in writing and the account must be in good standing.

Patient Name: _____

Patient (or Representative) Signature: _____ Date: _____

Practice Employee Signature: _____ Date: _____

Patient Medical History

Date: _____

Patient: _____ Date of Birth: _____

Past Medical History (Please circle all that apply):

Anxiety / Depression	Diabetes	Kidney Disease
Arthritis	GERD	**Pacemaker**
Asthma	Hepatitis	Seizures
Atrial Fibrillation	High Blood Pressure	Stroke
Cancer - Type: _____	High Cholesterol	Thyroid Disease
COPD	HIV Disease	Transplantation - Type: _____
Coronary Artery Disease	**Joint Replacement - Type:** _____	**Valve Replacement - Type:**_____
Other: _____		NONE

Past Surgical History (Please list the procedure, body location, and approximate date):

_____

_____

Skin Disease History (Please circle all that apply):

Acne	Flaking / Itching Scalp	Precancerous Moles
Basal Cell Carcinoma (BCC)	Hay Fever / Allergies	Psoriasis
Dry Skin / Eczema	Melanoma	Squamous Cell Carcinoma (SCC)
Other: _____		NONE

Do you have a family history of Melanoma?	☐ No	☐ Yes - Who? _____
Do you have a family history of SCC or BCC?	☐ No	☐ Yes - Who? _____
Do you have a family history of skin disease?	☐ No	☐ Yes - Disease: _____
Have you ever tanned in a tanning salon?	☐ No	☐ Yes - Frequency: _____
Have you ever worked as a life guard?	☐ No	☐ Yes - Duration: _____
Have you ever had a sun burn?	☐ No	☐ Yes - Severity: _____
Do you wear Sunscreen?	☐ No	☐ Yes - SPF: _____

Occupation: _____

Tobacco Usage (please circle all that apply):

Never Smoked

Former Smoker

Current Smoker

Chewing Tobacco / Cigar / Pipe / Other

Alcohol Usage (please circle all that apply):

Never

Less than 1 drink per day

1-2 drinks per day

3 or more drinks per day

MD/PA/NP: _____

Patient Medications List

Date: ______________________

Patient: ____ Date of Birth: ________________

Allergen	Reaction

This list ***must*** include all known prescriptions, over the counters, herbals, and vitamins / minerals / dietary supplements.

This list ***must*** also contain the medication name, dosage, frequency and route of administration.

Medication	Dosage	Frequency	Route of Administration
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________
			☐ Oral ☐ Topical ☐ Other: ____________

Pharmacy: ____ Phone: ___________________________

Address: ____ City/State: ________________________

For office use only: This list has been verified and updated with the patient. (Date and Signature of Medical Staff):

________________ ________________ ________________ ________________ ________________

________________ ________________ ________________ ________________ ________________

________________ ________________ ________________ ________________ ________________

MD/PA/NP: ________________________