Upstate
DERMATOLOGY
MEDICAL & SURGICAL SKIN CARE

Welcome to Upstate Dermatology!

The medical team at Upstate Dermatology, PC is committed to providing you with quality dermatological care. Please note that all Upstate Dermatology staff are fully vaccinated against COVID. Feel safe knowing that anyone you see working at Upstate Dermatology, in all office locations are vaccinated.

Enclosed are several patient documents that provide a clear understanding of our Patient policies.

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 and HIPAA authorization. Be sure to bring your insurance card(s) and photo ID. Note: these 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 / Prior Authorizations: if your health plan requires a Referral or Prior Authorization, please confirm with our office that your valid Referral or Prior Authorization has been received prior to your appointment. Patients who have not obtained a valid Referral or Prior Authorization, will be asked to sign a patient waiver and pay for services rendered, or reschedule their appointment, until the appropriate documentation is received.*

Upstate Dermatology, PC / General Consent and Financial Policy

❖

Medical Claim Submission: Upstate Dermatology, PC will submit your claim(s) to your Insurance provider. Should your insurance company need additional information, it is the Patient's responsibility to comply with their request(s). Note: your insurance benefit is a contract between you and your insurance company; Upstate Dermatology, PC is not a party to that contract.

Prior Authorizations and Referrals: Insurance plans may require patients to obtain a prior authorization and/or referral. These documents are required to be received by Upstate Dermatology, PC prior to being seen as a Patient. If either required document is not received prior to your appointment, it will be necessary to either sign a patient waiver or reschedule your appointment.

Covered Medical Procedure: This is a medical procedure that is the financial responsibility of the insurance company. It is the patient's responsibility to know which medical procedure(s) their insurance plan covers (please contact your insurance company prior to scheduling a procedure). Upon request, Upstate Dermatology will provide patients with the CPT code (a set of numbers assigned to identify each medical procedure) and ICD-9 code (a set of numbers assigned to identify a medical diagnosis).

Non-Covered Medical Procedure: This is a medical procedure that is not covered by specific medical insurance plans and therefore not reimbursable. We strongly encourage patients to contact their insurance company prior to receiving services, in order to become familiar with the financial responsibility associated with having the services performed. Payment is the patient's responsibility and is due at time the services are rendered.

Copayments: If you are a member of a health insurance plan that we participate with, all co-payments and co-insurance payments (as required by your insurance plan) for office visits and lab services are due at time of service. *Note: Office visits and lab services are separate services.*

Deductible Deposit Payment: Patients with deductible insurance plans, are required to pay a deposit at the time of service, (unless your insurance deductible has been met and verified); Deductible Payment amounts include: Existing Patients: $150.00; New Patients: $175.00; Biopsy: $300; and Surgical/MOHs surgery: $1,200.00.

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 and scheduled. Payment is the responsibility of the patient and due prior to the time services are rendered.

Missed Appointments / No Show Policy: We understand that situations occur that cause cancellations. If you are unable to keep your scheduled appointment, please notify us 24 hours in advance to avoid a $50.00 no-show fee.

Insurance Verification:

All patient insurance relationships will be verified prior to the scheduled appointment, to determine if 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 participation with your insurance plan.

Patient Initials / Date: _____

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 on your account, the balance will be billed to you.

At the time of your visit, a valid photo i.d. & current proof of your insurance coverage is required.

Self-Pay Accounts:

If you currently are not enrolled in a health plan, your insurance status will be considered, Self-Pay. All self-pay accounts are required to pay in full at the time services are rendered. *Note: these services are not billable to insurance.*

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).

Note: Patients will be billed a $30.00 surcharge for any returned check from the bank.

Billing Information*: please call the telephone number on your statement.*

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.

Patient refunds are issued to patients, at the conclusion of the insurance reconciliation process.

Upstate Dermatology, PC, at its sole discretion, shall have the option of terminating its professional relationship with a patient, as a result of their payment status. Note: Should an account become a bad debt, collection administration fees up to 35% will be billed to each outstanding account.

I fully understand that at the time of my visit, if my insurance plan is not active or is an insurance plan that our office does not participate with, I am 100% responsible for payment at time the services are rendered.

I certify I have read the General Consent / Financial Policy of Upstate Dermatology, PC and agree to abide by the policies.

Patient or Representative Signature: _____ Date:_____

Upstate Dermatology, PC / Employee Signature: _____ Date:_____

Upstate Dermatology, PC

Schodack | Chatham | Schenectady | CliftonPark | Cobleskill

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 termination coverage for individuals enrolled in a plan through the Individual Health Insurance Markplace), or inactive at the time of services.

Medicare Authorization (Only for Patient 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 authorization above:

Patient (or Representative) Signature: _____ Date: _____

Upstate Dermatology, PC

Schodack Chatham Schenectady CliftonPark Cobleskill

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

Schodack Chatham Schenectady CliftonPark Cobleskill

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 service 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: _____

Upstate Dermatology, PC

Schodack Chatham Schenectady CliftonPark Cobleskill

Patient Medical History

Date: _____

Patient: _____ Date of Birth: _____

Past Medical History (Please check all that apply):

- ☐ Anxiety/Depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Cancer – Type:_____
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Diabetes
- ☐ GERD
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ HIV Disease
- ☐ Joint Replacement – Type _____
- ☐ Kidney Disease
- ☐ Pacemaker
- ☐ Seizures
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Transplantation – Type _____
- ☐ Valve Replacement – Type ____

Skin Disease History (Please check all that apply):

- ☐ Acne
- ☐ Basal Cell Carcinoma (BCC)
- ☐ Dry Skin/ Eczema
- ☐ Flaking/Itching Scalp
- ☐ Hay Fever / Allergies
- ☐ Melanoma
- ☐ Precancerous Moles
- ☐ Psoriasis
- ☐ Squamous Cell Carcinoma (SCC)

☐ Other _____

_____

☐ None

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

_____

_____

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 _____

Does Your Occupation Keep You: ☐ Indoors ☐ Outdoors ☐ Both

Tobacco Usage (Please check all that apply):

- ☐ Never Smoke
- ☐ Former Smoker
- ☐ Current Smoker
- ☐ Chewing Tobacco/ Cigar / Pipe/ Other

Alcohol Usage (Please check all that apply)

- ☐ Never
- ☐ Less than 1drink per day
- ☐ 1-2 drinks per day
- ☐ 3 or more drinks per day

MD/PA/NP _____

Upstate Dermatology, PC

Schodack Chatham Schenectady CliftonPark Cobleskill

Patient Medications List

Date: _____ Height: _____ Weight: _____

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

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).

Dates of Service						
						MD/PA/NP _____