

patient information

DUNDEEDERMATOLOGY

New Patient Name Change Address Change Insurance Change

Name _____ Today's Date _____
last first M.I.

Mailing Address _____
street city state zip

Home Phone ____/____/____ Work Phone ____/____/____ Mobile ____/____/____

Date of Birth ____/____/____ Male Female E-Mail Address _____

Employment Status Full Time Part Time Not Employed Self-Employed Retired Student

Spouse's Name _____ Spouse Work Phone _____

Person to notify in case of emergency _____ Phone _____

Referred By _____ Primary Care Physician _____

How did you hear about our practice? friend/ relative insurance directory referral service yellow pages street sign

Parent **Spouse** **Responsible Party** (if not patient, describe relationship to patient _____)

Name _____ Date of Birth ____/____/____
last first M.I.

Address _____
street city state zip

Home Phone ____/____/____ Work Phone ____/____/____ Mobile ____/____/____

Insurance Carrier Information

Primary Insurance _____ Policy ID _____

Secondary Insurance _____ Policy ID _____

Please provide the receptionist with the following.

- This Completed Form
- Insurance Card
- Drivers License or Photo ID

Treatment Consent

I hereby authorize and consent to treatment at Dundee Dermatology (DD). This may include the administration of medication, diagnostic tests and procedures as deemed necessary by my physician, or his assistants or designees, for purposes of diagnosis or treatment.

Authorization & Assignment

I authorize Paul Getz MD SC, also known as Dundee Dermatology, to furnish information to my insurance carriers concerning my diagnosis and treatment. If I do not make payment in full for such services, I assign to Paul Getz MD SC all payments for services rendered to my dependents or me.

Medicare Claims

I authorize any holder of medical or other information about me to release to the Social Security Administration and Centers for Medicare and Medicaid or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Payment Guarantee

► **Patient Responsibility.** I understand that I am responsible for any amount not covered by insurance. I agree to provide payment within 30 days of notification by statement of this responsibility. Failure to do so will incur additional billing charges. This applies whether covered by an HMO, PPO, or a traditional group health plan.

If my account becomes delinquent, I understand that it is subject for placement with an outside collection agency. A collection fee, not to exceed 30% of the unpaid balance including, but not limited to collection agency fees, attorney's fees, filing fees, and court costs when necessary, will be added to the balance referred. If your account is placed with a collection agency, we will terminate the availability of our services to you and you will be dismissed from the practice.

► **Contracted Insurers.** If we participate (are contracted) with your insurance plan, we file claims as a courtesy to you. You will be responsible for:

- Co-payments
- Annual deductibles
- Coinsurances
- Non-covered services

► **Non-Covered Services.** Insurers routinely state, "**The determination of coverage is made at the time the claim is submitted.**" We often don't know if treatments will be covered until we receive the insurer's EOB (explanation of benefits). After the EOB for your submitted claim has been received at DD, you will be billed for any items not covered by your insurance plan. Services may be denied for coverage because the carrier considers the services: 1.) medically unnecessary 2.) pre-existing condition 3.) cosmetic

I feel that these services are necessary. In the event that Medicare or any insurance carrier should deny payment, I agree to be personally and fully responsible for payment.

► **Transfer of Credit Balance.** A credit balance resulting from payment to DD from insurance or other sources may be applied to any other accounts owed by the insured and/or family of the insured.

► **Pathology & Laboratory Charges.** Final laboratory charges cannot be anticipated at the time of service and are *not* within our control. Clinical laboratories will perform all needed tests to clarify or confirm a diagnosis. This can result in significant additional fees. You will be responsible for any amount not covered by insurance.

Fees

► **Co-Pay Rebilling Charge.** Our contract with your insurer requires us to collect any co-payments *in full* at the time of service. If for any reason the correct co-pay is not collected at the time of service, a \$10 service charge will apply for additional billing to collect the correct co-pay.

► **Insurance Rebilling Charge.** If your insurance claim requires a second submission because of incorrect insurance policy information, there will be an additional \$15 charge. This charge will be the patient's responsibility. If the correct insurance information is not obtained before your insurer's claim filing deadline, you will become responsible for the full cost of the visit.

► **Rebilling Charges.** After the first 30 days, any outstanding charges will be subjected to an additional \$5 charge each billing period for mailing and handling fees.

► **Returned Checks.** A \$25 processing fee will be charged for returned checks. Bad checks may also be forwarded to the Bad Check Restitution Program of the State's Attorney's Office. Per Illinois law, we may, via electronic funds transfer, debit your account for a returned check service fee of \$25.

► **Transfer of Records.** Under Illinois Statute there is a photocopy and handling charge for medical record transfers. The 2010 fees are \$24.44 *plus* \$0.94/page (pages 1-25), \$0.61/page (pages 25-50), and \$0.31/page (pages over 50).

► **Appointment Cancellation or 'No Show'.**

As a courtesy, our office has an automated appointment reminder system that calls 2 days before to verify your appointment. This provides adequate time to cancel or change your appointment if needed. 24 hour notice is required to avoid the \$25 late cancellation or no-show charge. This charge is not billable to any insurance carrier.

Medication Refills

Patients are given enough medication to sustain them until their next visit. A follow up visit is usually required for prescriptions written over 6 months ago. Depending on the medication, a one-time refill may be given. Under the Illinois Pharmacy Practice Act of 1987, it is illegal for a prescription to be refilled "in excess of one year from the date of original issuance."

No Insurance Card

If you present without your insurance card for your first visit, you will be charged our standard commercial fee. We are not able to provide an insurance discount or contracted fee without that card and supporting identification. No refunds or insurance discounts will be provided after the fact.

A copy of this authorization shall be valid as the original.

signature/ patient or legal representative

date