Patient Registration / Acknowledgement of Office Policies

Last Name ________________________________

First Name ________________________________

Address ______________________________ Apt ______

City ________________ State ______ Zip __________

Sex (circle) M F T Date of Birth __________________

SS # _________-_______-_________ Cell Phone ______________________

Appointments are confirmed via text

Email ____ (We require an email to give normal results rather than play phone tag. In addition, all promos for cosmetic procedures and skin cancer screening reminders are sent via email. We don't like to be bothered by too-frequent emails either, so we will not over-email!

Who referred you to the office? (circle) Friend Physician Other

Name of referrer:____

Insurance Carrier _____________________________

Member ID __________________________ Group # _________________

Please familiarize yourself with your insurance policy & our policy below. We do not have access to particulars of your insurance plan. If you are unable to verify participation in your plan prior to a visit or a referral is not filed, we will happily see you as a self-pay patient. We do not participate in Medicaid, Medicare, or Affordable Healthcare Exchange Plans.

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.)

5. Lateness policy: You will not be seen if you are 15 minutes or more late. You have missed your appointment. We do our best to run on time, and usually do. We do not overbook. If you are late, if affects all the patients who come after you, and it is not fair to those patients, nor to the physician and staff.

6. Please note a cosmetic consultation is NOT covered by insurance. The cosmetic consultation fee covers your office visit and may be applied to the cost of the first cosmetic treatment if performed within a 6-month window of the consultation. Fee cannot be waived/refunded if no treatment is performed within 6 months as cost covers consultation. Cancellation policy applies.

7. While we will draw your blood as a convenience to you, we do not have a lab on premises. 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. Patient is responsible to the lab for fees as per their insurance plan.

A. Assignment and Release

I authorize the office of Cybele Fishman, MD PLLC to provide treatment to me/my child. I, the undersigned, have insurance coverage and assign all medical benefits to Cybele Fishman MD 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, and I am responsible for the cost of the medical visit and any other procedures performed. . I am legally responsible 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. 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 Cybele Fishman, MD PLLC to charge outstanding service balances/applicable fees to the account:

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_______________

Pharmacy ______________________

Address _____________________

Phone _________________

Are you taking any medications, supplements? ___ Yes ___ No If so, please list:
____

Are you allergic to any medications? ___ Yes ___ No If so, please list:
____

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

___ Arthritis, Joint Problems, Bone Disease, Lupus, other autoimmune disease

___ Blood Disorder

___ Cancer. If so, what type? ______________________ ___

___ Diabetes

___ Thyroid problems

___ Heart Disease

___ High Blood Pressure

___ HIV

___ Lung disease, including tuberculosis

___ Kidney disease

___ Liver disease

___ Neurological Disorder

___ Stomach / Intestinal Problems

___ Psychiatric disorder

Is there a history of melanoma in your family? If so, what is the relationship?
____

Have you used tanning beds? ____Yes ____No

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.

What is your current occupation? ___________________________________

Do you smoke cigarettes?   ____Yes   ____No

On a scale of 1-5, with 5 being the highest, what is your stress level? ______

What do you do to deal with stress? ___________________________