image Dermatology P.C **Date: _____/_____/_____**

PATIENT INFORMATION:

Driver License Number: (REQUIRED)_____

Name: Last _____ **First** _____ **Middle**_____

Address_____ **City, State,** _____

Zip_____ **Sex**: ☐ Male ☐ Female

Phone: Home____(____) - ____ - ____ **Work**(____) - ____ - ____ **Ext**____

Cell Phone____(____) - ____ - ____ **Email**_____

Social Security# (REQUIRED):____ - ____ - ____ **Birthdate:** ____/____/____

Occupation _____ **Employer**_____

Referred by _____**Martial Status**: ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Your Physician: **Phone #** (____) - ____ - ____

Your Pharmacy: _____ **Phone #**(____) - ____ - ____

PRIMARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: _____ **ID#** _____**Group** _____

Policy Holder's Name:_____ **Birth date of Subscriber:**____/____/____

Claim Mailing Address _____**Relation to patient**: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

SECONDARY INSURANCE: (COPY OF INSURANCE CARD REQUIRED)

Insurance Company: _____ **ID#** _____**Group** _____

Policy Holder's Name:_____ **Birth date of Subscriber:**____/____/____

Claim Mailing Address _____ **Relation to patient**: ☐ SELF ☐ SPOUSE ☐ DEPENDENT

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian:

I certify that the information that I have provided is correct. I hereby assign to image Dermatology, PC, any insurance or third party payments for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Signature: _____ Date: ____/____/____

Person Responsible for Payment:

First Name: _____Initial:_____ Last Name:_____

Address:_____ Apt:_____ City:_____

State:_____ Zip: _____Home Phone: (____)_____ -_____ Cell Phone: (____) -_____-___

Relationship to patient: _____Date of Birth:_____ /____ /_____ SS#:_____-_____-____

I authorize the release my records to any referring physician or appropriate insurance company and medical information acquired in the course of my examination or treatment. If this account is referred to a collection agency for nonpayment, there will be an additional 30% fee added to the outstanding balance. I agree to pay a $50.00 cancellation fee if I cancel or do not show up for my appointment with less than 48 hours notice.

Signature of Patient or Responsible Party:_____

CREDIT CARD AUTHORIZATION
THIS FORM IS MANDATORY

image Dermatology® P.C.
51 Park Street
Montclair, New Jersey 07042

To our patients,

As you know, if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card to pay your bill. This is an advantage for everyone because it makes checkout easier and faster, and more efficient.

We have implemented a similar policy. You will be asked for your credit card information. Once the claim is process through your insurance. If any balances are due for example copay difference, co-insurance, deductibles. You will receive one statement. If no payments or correspondence from you, then we will charge your credit card on file. A copy of the charge will be mailed to your address. 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.).

Handling small balances in this manner is advantageous for both patients and our practice.

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 the office or our billers at 877-479-2622.

Same Day/Cancellations of appointments/no-show

When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 48 hours in advance to cancel your appointment. If for any reason, you need to cancel an appointment, please notify our office as a soon as possible. On any no-show occurrence, except emergencies and snow there will be a $50 charge to your account.

I accept and agree that Image Dermatology P.C. can charge outstanding balances on my account to the credit card below. I acknowledge that I have had an opportunity to ask questions about this process.

☐ ☐ ☐ ☐

Circle Credit Card Type: Amex Mastercard Visa Discover

Other HAS/ Flex Spending: _____

Credit Card#_____ **Exp. Date**:_____/__ /

Security code_____

NOTE: AMEX IS A 4 DIGIT CODE ON THE FRONT OF THE CARD.

Name on card :_____

Signature of cardholder:_____

Date: _____/_____/_____

If the above information of the card holder is different from the patient please include billing address.

Revised: 8/2017

image Dermatology PC
51 Park Street
Montclair, NJ 07042

PATIENT PAYMENT OBLIGATIONS
&
FINANCIAL POLICY

WELCOME TO IMAGE DERMATOLOGY® P.C.

All patients must complete our patient information sheet before having their procedure.

iMAGE DERMATOLOGY REQUIRES THAT PAYMENT IS DUE AT THE TIME OF SERVICE:
WE DO NOT BILL FOR SERVICES. We accept all major credit cards (and debit cards), checks and cash. We use electronic telecheck for the processing of checks, and it accesses funds in your account while you are checking out after receiving treatment, so sufficient funds must be available immediately in your account. Therefore, if you plan to pay by check, the funds must be in the account and checks cannot be post-dated. Also, if you have starter checks, telecheck cannot process those, so you must pay by another method.

REGARDING MANAGED CARE INSURANCE WE PARTICIPATE WITH;
You are responsible to supply our staff with your ID cards. We will automatically file the claim for you, however, you are responsible for any deductible or co-pay due at the time of service as described in your insurance handbook. If any of the procedures performed here are not covered item under your plan, you will be financially responsible for payment in full.

REGARDING NON-PARTICIPATING INSURANCE:
It is your responsibility to understand which insurance plans image Dermatology participates with. The bill is your responsibility and is due at the time of service. Your insurance policy is a contract between you and your insurance company. Our office is not a part of that contract. We are happy to give you a copy of your bill so you can file directly with your insurance company, however the ultimate responsibility for payment remains yours.

REGARDING MEDICARE AND SUPPLEMENTARY INSURANCE:
We will automatically file your claim directly with Medicare and any other supplementary insurance if applicable. However, you remain responsible for your yearly deductible as well as any remaining co-payment.

REGARDING LABORATORIES:
It is your responsibility to understand which laboratory your insurance company affiliates with. Our center will not be held liable for any services rendered to you by a non-participating laboratory.

PAYMENTS:
We accept cash, check, money order, Visa American Express, and Master Card and Discover. There is a $50.00 fee for any returned check. **WE DO NOT BILL.**

Thank you for understanding our Financial Policy.
Please feel free to let our billing office know if you have any questions or concerns
(877) 479-2622.

I have read the above Financial Policy, I agree and understand its term.

Signature of Patient or Responsible Party:_____ Date: ____/____/____

image Dermatology P.C.®

Patient Name: _____

Date of Birth: / /

Co-payments and Deductibles: Payment is required for all services at the time they are rendered. All applicable co-payments and deductibles will be collected at the time of service. I understand that in the event that my services are not covered under my insurance, I accept full financial responsibility of those non-covered services. An administrative billing fee of $10 will be applied if co-payments are not paid at the time of service. In the event that your account must be turned over for collections, interest and/or a collection fee at the provider's current rate may be charged on all balances owing that are past due and you hereby authorize the release of necessary information for us to initiate collections proceedings. I further acknowledge that I am responsible for the coinsurance and/or deductible under my health plan's agreement and should image Dermatology P.C. be required to send me to a collection agency, I shall be responsible for the greater of a 30% collection agency fee or the actual collection cost. Your signature below signifies understanding of this policy. I hereby guarantee payment in full to image Dermatology P.C. for all charges for services rendered and/or charges exceeding third-party payments (except when prohibited by law or under contract). I also authorize image Dermatology P.C. to release to government agencies, insurance carriers and others (including independent utilization review organizations), who may be financially liable for the services, all information necessary to pre-authorize services, determine medical necessity and/or the extent or amount of liability and to challenge denials of medical necessity. I hereby assign all amounts payable for services rendered to image dermatology P.C. I understand that this constitutes a waiver of confidentiality and that this authorization is revocable except to the extent that action has been taken in reliance thereon and will otherwise remain in force indefinitely in order to effectuate the purposes for which it is given. I understand that image Dermatology routinely collects credit card information so that any insurance balance can be paid for immediately.

Referrals: If a referral is required by my health insurance plan, I understand that it is my responsibility to obtain the referral from my primary care provider and assure that it is available at the time of my visit. I further understand that it is my responsibility to keep track of the number of visits I have used, the expiration date, and obtain a new referral as needed. I understand that should I fail to have a valid referral at the time of my visit, image Dermatology P.C. will reschedule my appointment. If we accept your insurance, and a referral is required, the referral must be presented prior to your being seen as a patient. If you elect to be seen without having the required referral, then you are required to pay for the treatment in full at the end of the treatment visit. It is also important to note that health insurance does not pay for any cosmetic procedures.

Insurance Cards: All patients new and returning are required to present their insurance card(s) at every visit. I understand by signing below that I am responsible for notifying the office of any changes to my insurance or contact information.

Patient or Legal Guardian's Signature: _____ Date: ____/____/____

Cancellation Policy: Should you be unable to keep your appointment, please contact our office to cancel your appointment. Failure to contact our office within 48 hours of the appointment will result in a $50.00 no-show fee. This fee is not reimbursable by your insurance company.

Patient or Legal Guardian's Signature: _____ Date: ____/____/____

HIPAA Policy: All patients are protected under the Federal **H**ealth **I**nsurance **P**ortability and **A**ccountability **A**ct. This federal law prohibits any staff member of image Dermatology P.C. from discussing appointments, medications, test results, and/or treatment plans with anyone other than the patient, except as provided above. Often, this causes difficulty for some patients who would like family members or caretakers to obtain information on their behalf. If you would like to permit someone to discuss your medical condition, obtain results or make appointments for you, please list their name(s) below. Only individual names listed below will be provided with information. Should you wish to update the names provided, please ask the patient service representative at the front desk for a new HIPAA form.

Name of Individual:	**Relationship to Patient:**
_____	_____
_____	_____

Acknowledgement: I acknowledge that a copy of image Dermatology P.C.'s Notice of Privacy Practices related to the Health Insurance Portability and Accountability Act of 1996 is available for review upon request. I may ask a front desk representative for a copy if I wish to review it in detail.

Must be signed by patient 18 years of age or older. Patients under 18, must be signed by a parent or legal guardian:
I certify that the information that I have provided is correct. I hereby assign to image Dermatology PC, any insurance or third party payments for health care services provided to me. I also understand that I am responsible for any co-insurance and/or deductibles at the time of service, as well as ensuring that I have a valid prior authorization and/or referral from my primary care physician.

Patient or Legal Guardian's Signature: _____ Date: ____/____/____

IMAGE DERMATOLOGY, P.C. ®

Patient Name **Date :** ____/____/____

What are your primary cosmetic goals/concerns today?

Are you planning to attend a special event (wedding, reunion, other) ? ☐ Yes ☐ No

If so, when ?

Other than the services we have already provided for you, what additional services would you like to learn about?

Please check all that apply

☐ Skin care advice	☐ BOTOX® Cosmetic	☐ Scars (Acne or Surgical)
☐ Skin care products	☐ Latisse	☐ Sagging skin
☐ Tired looking skin	☐ Juvederm /Restylane /Fillers	☐ Blue/ Red/ Spider leg veins
☐ Uneven skin tone	☐ Facial fine lines/wrinkles	☐ Neck wrinkles
☐ Skin discoloration	☐ Thin lips	☐ Collagen therapy
☐ Blotchy skin	☐ Frown lines between brows	☐ Excessive sweating
☐ Rough skin texture	☐ Lines around nose & mouth	☐ Laser Treatments
☐ Facial redness	☐ Dark circles/ puffiness in eyes	☐ Ear lobe repair
☐ Brown spots or freckles	☐ Facial veins/Facial redness	☐ Scar and Keloid Removal
☐ Age spots	☐ Drooping brow	☐ Unwanted Hair Removal
☐ Red spots	☐ Intracel microneeding for acne scars, stretchmarks an large pores	☐ Longer, thicker, darker lashes,
☐ Chemical peels	☐ Fraxel Laser Resurfacing for acne scars, brown spots, photo-damage, and stretchmarks	☐ Acne and Dark Spots
☐ Double Chin (Submental Fullness)		☐ Mole Removal
☐ Weak Chin		☐ Under Eye Hollows
☐ Loss of jaw definition		
☐ Kybella		

☐ Approval to contact you.	*Best phone number to reach you:* #: (____) - ____ - ____
☐ Approval to send you information on products and services (including special offers)	*Email address:* ____

☐ *I'm not interested in any additional services provided at this time*

↓ For Staff Use Only ↓

Physician / provider : Dr. Downie	**Leah**	**Megan**
Follow-up	*Date*	*Completed by (name)*
☐ Initial Inquiry/Information Given		
☐ Contact in future – give date		
☐ Products		
☐ Free consultation		

Revised: 6/17

image Dermatology P.C.®

Patient Name: _____

Birthday: ____/____/____

Occupation: _____

Referring Physician: _____

Primary Care Physician: _____

Pharmacy Name: _____

Town Located: _____

Name: of current MEDICATIONS:	What are you taking this for?
_____	_____
_____	_____
_____	_____
_____	_____

Medication Allergies:

Have you ever had a bad reaction to dental anesthesia? If yes what reaction?

☐ Yes ☐ No _____

SEX: ☐ **Male** ☐ **Female** **Age:** ____ **HT:** _____ **WT:** _____ **Marital Status** ☐ Single ☐ Married ☐ Widow ☐ Divorced ☐ Separated

Have you had any of the following conditions in the past?

Skin cancer	☐	Hepatitis/Liver disease	☐
Melanoma	☐	Lupus	☐
Atypical moles (dysplastic nevus)	☐	Herpes simplex	☐
Basal cell carcinoma	☐	Bleeding disorders	☐
Squamous cell carcinoma	☐	Crohn's/Colitis disease	☐
Actinic keratoses	☐	Heart valve replacement	☐
T-cell lymphoma	☐	Pacemaker	☐
Other cancer	☐	Hip replacement	☐
Diabetes	☐	Cataracts	☐
Sarcoid	☐	Glaucoma	☐
Heart disease	☐	Kidney/Renal disease	☐
Stroke/TIA	☐	GYN problems	☐
Seizures/Epilepsy	☐	HIV	☐
Thyroid disease	☐	AIDS	☐
Scar/Keloid	☐	Other/specify:	☐
Hypertension	☐		

Do you have any of the following?

Itchiness	☐	Nose bleeds	☐
Dry skin	☐	Swelling in hands/feet	☐
Oily skin	☐	Wheezing	☐
Irritated lesions	☐	Abdominal pain	☐
Changing lesions	☐	Joint pain	☐
Fever	☐	Headache	☐
Fatigue	☐	Depression	☐
Excessive sweat	☐	Recent weight gain	☐
Dry eyes	☐	Recent weight loss	☐
Itchy eyes	☐	Swollen glands	☐

Please identify any of the following that a family member may have had:

Skin cancer	☐	Lupus	☐
Melanoma	☐	Other cancer	☐
Atypical moles	☐	Diabetes	☐
Acne	☐	Sarcoid	☐
Eczema	☐	HIV	☐
Psoriasis	☐	AIDS	☐

Do you spend long hours in the sun?	☐		
Have you ever had a blisteringsunburn?	☐		
Do you smoke?	☐	Packs per day:____	**Females:** Pregnant or nursing: ☐ Yes ☐ No
Do you drink alcohol?	☐	Drinks per day: ___	Trying to get pregnant: ☐ Yes ☐ No
Do you use illegal drugs?	☐	Which drugs: _____	

Patient _____Medical Assistant _____M.D. _____