LUPO CENTER PATIENT INFORMATION FORM

DATE _____ CLAIM CENTER _____
ACCOUNT #_____

PATIENT INFORMATION

PATIENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ E-MAIL ADDRESS*_____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
SOCIAL SECURITY # _____ DRIVER'S LICENSE # _____
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART
REFERRED BY _____

SPOUSE/PARENT INFORMATION

SPOUSE/PARENT _____ SEX: M/F
MAILING ADDRESS _____ CITY _____
STATE _____ ZIP _____ SOCIAL SECURITY # _____
HOME # _____ WORK # _____ CELL # _____
DATE OF BIRTH _____ AGE _____ MARITAL STATUS: M/S/W/D
EMPLOYER _____ OCCUPATION _____ STUDENT: FULL/PART

RESPONSIBLE PARTY

_____ SELF _____ SPOUSE _____ PARENT _____ GUARDIAN _____ OTHER

INSURANCE INFORMATION

PRIMARY INSURANCE _____ PRIVATE _____ PPO

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP_____
CONTRACT#_____
GROUP #_____
INSURED'S NAME_____
INSURED'S EMPLOYER_____
INSURED'S SS #_____
INSURED'S D.O.B._____

SECONDARY INSURANCE _____ PRIVATE _____ PPO

INS. CO. _____
ADDRESS _____
CITY, STATE, ZIP_____
CONTRACT#_____
GROUP #_____
INSURED'S NAME_____
INSURED'S EMPLOYER_____
INSURED'S SS #_____
INSURED'S D.O.B._____

PRIMARY CARE PHYSICIAN (if applicable)

NAME _____ PHONE _____
FULL ADDRESS _____

IN CASE OF EMERGENCY CONTACT

NAME _____ RELATIONSHIP _____
ADDRESS _____ PHONE _____

**By providing your email address, you are giving us permission to send email correspondences to you pertaining to our office's news, updates, specials and events. If at any time you would like to unsubscribe from receiving future emails, we include unsubscribe instructions at the bottom of each email blast. We will never share your email address with others.*

LUPO CENTER AUTHORIZATION FORM

I. **GENERAL CONSENT TO TREATMENT**:
I AGREE AND CONSENT TO A PHYSICAL EXAMINATION BY THE LUPO CENTER FOR AESTHETIC AND GENERAL DERMATOLOGY, DR. MARY P. LUPO OR ANY OF HER ASSOCIATES. I UNDERSTAND THAT ADDITIONAL DIAGNOSTIC PROCEDURES AND TREATMENT MAY BE RECOMMENDED BY THE PHYSICIAN AND WILL BE DISCUSSED WITH ME BEFORE BEING DONE. I ACKNOWLEDGE THAT THERE ARE NO GUARANTEES, EXPRESSED OR IMPLIED, AS TO THE RESULTS OF ANY PROCEDURES OR MEDICAL TREATMENT.

II. **RELEASE OF INFORMATION**:
I AUTHORIZE PHYSICIANS PROVIDING SERVICES ON BEHALF OF THE PATIENT TO RELEASE ALL BILLING AND MEDICAL INFORMATION (INCLUDING INFORMATION CONCERNING SUBSTANCE ABUSE AND HIV STATUS, IF APPLICABLE) TO PHYSICIANS OR INSTITUTIONS PROVIDING FOLLOW-UP CARE, THE SOCIAL SECURITY ADMINISTRATION, MEDICARE, MEDICAID (OR THEIR VARIOUS INTERMEDIARIES), AND THE INSURANCE COMPANY, EMPLOYER, PERSON ACTING ON BEHALF OF A PREFERRED PROVIDER ARRANGEMENT OR THIRD PARTY NAMED ON THIS PATIENT INFORMATION FORM (OR ANY OF THEIR AGENTS OR REPRESENTATIVES), WHEN SUCH INFORMATION IS REQUESTED FOR PAYMENT, WORKERS' COMPENSATION, UTILIZATION REVIEW, OR COVERAGE DETERMINATION PURPOSES. I UNDERSTAND THAT THIS AUTHORIZATION WILL REMAIN IN EFFECT UNLESS REVOKED BY ME IN WRITING AND DELIVERED TO THIS PHYSICIAN'S OFFICE.

III. **ASSIGNMENT OF INSURANCE OR THIRD PARTY COVERAGE**:

A. I AUTHORIZE ANY THIRD PARTY PAYOR TO PAY DIRECTLY TO THE PHYSICIAN PROVIDING SERVICES TO THE PATIENT, ALL BENEFITS DUE PAYABLE AS A RESULT OF SERVICES RENDERED.

B. I AUTHORIZE ASSIGNMENT TO THE PHYSICIAN WHO HAS PROVIDED SERVICES TO THE PATIENT THE INSURED'S RIGHTS TO PENALTIES AND ATTORNEY'S FEES IN THE EVENT THAT THE INSURER FAILS TO TIMELY PAY SUCH BENEFITS IN ACCORDANCE WITH LOUISIANA LAW (LA. R.S. 22:657).

IV. **ACKNOWLEDGEMENT OF RESPONSIBILITY TO PAY FOR SERVICES**:
I ACKNOWLEDGE AND AGREE THAT, EXCEPT AS PROVIDED BY LAW, AND IN CONSIDERATION OF THE SERVICES PROVIDED, I WILL PAY ANY CHARGES WHICH, FOR ANY REASON, ARE NOT PAID BY ANY THIRD PARTY PAYOR UNLESS THERE IS A SPECIFIC WRITTEN AGREEMENT BETWEEN THE PHYSICIAN AND THE PATIENT OR BETWEEN THE PHYSICIAN AND THE PAYOR. I ACKNOWLEDGE THAT THIS FEE IS INCURRED ON OPEN ACCOUNT FOR PROFESSIONAL MEDICAL SERVICES, IN ACCORDANCE WITH R.S. 9:2781. I ACKNOWLEDGE THAT IF I FAIL TO PAY THE BALANCE DUE ON THIS OPEN ACCOUNT WITHIN THIRTY (30) DAYS AFTER WRITTEN DEMAND, AND IN THE EVENT JUDGMENT IS RENDERED AGAINST ME, IN ADDITIONAL TO THE PRINCIPAL BALANCE DUE, I SHALL BE LIABLE FOR REASONABLE ATTORNEY FEES, LEGAL INTEREST FROM DATE OF JUDICIAL DEMAND, UNTIL PAID, PLUS COSTS OF COURT.

V. **INSURANCE PATIENTS**:
I REQUEST THAT PAYMENT OF AUTHORIZED INSURANCE BENEFITS BE MADE EITHER TO ME OR ON MY BEHALF TO THE LUPO CENTER FOR AESTHETIC & GENERAL DERMATOLOGY FOR ANY SERVICES FURNISHED ME BY THE LUPO CENTER FOR AESTHETIC AND GENERAL DERMATOLOGY, DR. MARY P. LUPO OR ANY OF HER ASSOCIATES. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES.

VI. **I HAVE RECEIVED A PATIENT INFORMATION BROCHURE**.

_____ _____

DATE PATIENT OR GUARDIAN SIGNATURE

LUPO CENTER FINANCIAL AGREEMENT

We are committed to provide you the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance, and your understanding of our payment policy.

Payment for services is due at the time services are rendered. We accept cash, checks, Visa, MasterCard, Discover and American Express. The receipt that is given to you after your visit is designed to be used for insurance purposes. Our office staff will file insurance for plans we participate in. We ask you to provide us with a completed, signed claim form if your insurance company requests their own claim forms. We will need a copy of your insurance card so that we can submit a claim for your visit.

Returned checks and balances older than 30 days may be subject to additional collection fees. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. You must realize, however, that:

1. Your insurance is a contract between you, your employer and the insurance company. We follow the guidelines insurance plans we participate in. Payment from your Insurance Plan is expected 30 days after the claim is received by your plan.
2. Our fees are generally considered to fall within the acceptable range by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This applies only to companies who pay a percentage (such as 50%, or 80%) of "U.C.R", defined as usual, customary and reasonable fees for this region. Thus, our fees are considered usual, customary and reasonable by most companies. This statement does not apply to companies who reimburse on an arbitrary "schedule" of fees, which bears no relationship to the current standard, and cost of care in this area.
3. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
4. Some insurance plans have deductibles that must be met each year. These deductibles are the responsibility of the patient and will be collected at the time of the visit.
5. You are responsible for notifying this office of any change in insurance coverage.

We must emphasize that as health care providers, our relationship is with you, not your insurance company. While the filing of insurance claims is part of the contract this office has with certain insurance Plans and Medicare, all charges are your responsibility from the date the services are rendered. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

If you have any questions about the above information or any uncertainty regarding insurance coverage, PLEASE do not hesitate to ask us. We are here to help you.

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance on my account for any professional medical services rendered. I acknowledge that this fee is incurred on open account for professional medical services. In accordance with R.S. 9:2781, I acknowledge that if I fail to pay the balance due on this open account within thirty (30) days after written demand, and in the event judgment is rendered against me, in addition to the principal balance due, I shall be liable for reasonable attorney fees, legal interest from date of judicial demand, until paid, plus costs of court. I have read all the information on both forms and have completed the patient information sheet. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my health status or the information provided.

_____ _____

Signature Date

LUPO CENTER APPOINTMENT POLICY

In an effort to help keep appointments running smoothly and in a timely manner, the following policies have been implemented. Please completely read the policy before signing. If you have any questions, they may be directed to our business office staff.

- For first office visits, please arrive 30 minutes early. Patient Forms must be completed prior to seeing the doctor. These forms are also available on our website at www.drmarylupo.com under "Appointments" if you wish to complete prior to your office visit.

- If you are unable to make your appointment, please call at least 24 hours in advance to cancel the appointment. **Failure to do so will result in a $50.00 "No Show" fee for any type of medical visit and a $100.00 "No Show" fee for all cosmetic services.**

- Any time that you will be late for an appointment, please call to inform us. If you are running more than 30 minutes late, you may be asked to reschedule. We will always try to accommodate as we all run late sometimes.

Appointment times reflect the health issues provided to the receptionist at the time the appointment is scheduled (i.e., is the visit for acne, a mole check, a surgical procedure or a consultation regarding a specific skin and/or cosmetic concerns?). Lengthy delays result from patients asking for additional time to address issues other than those originally scheduled. Please be considerate of those waiting.

The Lupo Center is committed to timely appointments, so we appreciate your cooperation and understanding on these matters.

Patient's name: _____ Date: _____
(please print)

Signature of Patient or Legal Guardian: _____

LUPO CENTER NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

The Lupo Center for Aesthetic and General Dermatology is required by law to maintain the privacy of my health information and provide me with a notice of its legal duties and privacy practices with respect to my information. I may request the most current copy of this notice at any time and The Lupo Center reserves the right to revise this notice at any time.

By signing below, I acknowledge that a copy of the Notice of Privacy Practices was made available to me.

_____ _____

Print Name of Patient Date

_____

Signature of Patient or Legal Guardian

LUPO CENTER NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU, AS A PATIENT OF THIS PRACTICE, MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Lupo Center for Aesthetic and General Dermatology (hereafter referred to as The Lupo Center) is required by law to maintain the privacy of your health information and to provide you with notice of its legal duties and privacy practices with respect to your information. The terms of this notice apply to all records containing your health information that are created or retained by our practice. We reserve the right to revise or amend this notice. Any revision or amendment will apply to all your past records and records created or maintained in the future. You may request our most current copy of this notice at any time. If you have questions about any part of this notice or if you want more information about the privacy practices at The Lupo Center, please contact:

Compliance Officer
Lupo Center for Aesthetic and General Dermatology
145 Robert E. Lee Blvd., Ste. 302, New Orleans, LA 70124
(504) 288-2381

I. How The Lupo Center May Use or Disclose Your Protected Health Information

The Lupo Center collects information from you and creates records regarding the treatment and services we provide to you. This information is stored in a chart and on a computer. The medical record is the property of The Lupo Center, but the information in the medical record belongs to you. The Lupo Center protects the privacy of your health information. The law permits The Lupo Center to use or disclose your health information for the following purposes:

Treatment: We may use and disclose your health information to treat you. For example, we may disclose your health information to a laboratory if you require blood work, cultures or pathological services. We may use your health information to order a prescription for you at a pharmacy. Additionally, we may disclose your information to others who may assist in your care, such as your spouse, children or parents.

Payment: We may use and disclose your health information to bill and collect payment for services and items you may receive from us. For example, we may disclose treatment information to your insurance company to determine if your carrier will pay for services or medications. We may also use your health information to bill third parties responsible for costs or to bill you directly.

Health Care Operations: We may use and disclose your health information to operate our business. For example, we may use your health information to evaluate the quality of care you received from us. We may use your health information to conduct cost-management and business planning activities for our practice.

Release of Information to Family/Friends: We may disclose your health information to a friend or family member that is involved in your care or assists in taking care of you. For example, we may disclose your information to a home health aide who assists directly in your care. We may also disclose information to adults who accompany minors to a visit.

As Required By Law: We will use and disclose your health information as required by federal, state or local law.

Public Health: As required by law, we may disclose your health information to public health authorities for purposes such as:

- Preventing or controlling disease, injury or disability
- Reporting abuse, neglect or domestic violence
- Reporting problems with products and reactions to medications to the FDA or appropriate drug company representatives
- Notifying of a person regarding potential exposure to a communicable disease or the potential risk for spreading or contracting a disease or condition
- Reporting disease or infection exposure

Public Safety: We may disclose your health information to appropriate persons or organizations in order to reduce or prevent a serious threat to the health and safety of you, another person or the general public.

Health Oversight Activities: We may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings necessary for the government to monitor government programs and the overall health care system.

Judicial and Administrative Procedures: We may disclose your health information during the course of any administrative or judicial proceeding.

Law Enforcement: We may disclose your health information to a law enforcement official for purposes such as:

- Identifying or locating a suspect, material witness, fugitive or missing person
- Providing information about the victim of a crime in certain situations, if we are unable to obtain the victim's agreement
- Reporting criminal conduct at our office
- Compliance with a warrant, court order, summons, subpoena or similar legal process

Research or Publications: We may use or disclose your health information for the purposes of research being conducted with approval from an Institutional Review Board. We may also use or disclose your health information in articles written for publication in medical journals after obtaining your written consent.

II. Your Rights Regarding Your Health Information

You have the following rights regarding the health information we maintain about you:

Confidential Communications: You have the right to request that we communicate with you in a particular manner or at a certain location. For example, you may request that we contact you at home rather than at work. To request a specific type of communication, you must submit a written statement to our compliance officer detailing your specific request.

Requesting Restrictions: You have the right to request a restriction in our use or disclosure of your health information. *For example* – you may request that your health information be disclosed only to specific persons involved in your care or for the payment of your care. Your request may be denied. If we agree, your information may still be disclosed as required by law. To request a restriction, you must submit a written statement to our compliance officer detailing your specific request.

Inspection and Copies: You have the right to inspect and request copies of the health information we maintain about you. We may charge a fee for the costs of copying, mailing, labor or supplies associated with your request. Your request may be denied. If it is denied, you may request a review of our denial that will be conducted by another licensed health care professional chosen by us. You can make an oral request for copies to any staff member. To request an inspection, you must submit a written statement to our compliance officer.

Amendment: You may request that your health information be amended if you believe it is incorrect or incomplete. You may request an amendment for as long as the information is kept by our practice. To request an amendment, you must submit a written statement to our compliance officer detailing your specific request. You do not need to submit a request for changes in name, physical address, phone number or insurance coverage. Your request may be denied if you do not submit a written request or if, in our opinion, the information is accurate and complete.

Accounting of Disclosures: You have the right to an "accounting of disclosures" which is a list of non-routine disclosures of your health information by our practice for non-treatment or operations purposes. An accounting of disclosures does not include information shared between the doctor and nurse or other staff members or information used by our billing department to file a claim with your insurance company. To request an accounting of disclosures, you must submit a written statement to our compliance officer. The request must include a time period not longer than six (6) years from the date of disclosure.

Right to a Paper Copy of This Notice: You are entitled to a paper copy of our Notice of Privacy Practices. You may request a copy of our most recent notice from any staff member.

Right to File a Complaint: If you believe your privacy rights have been violated, you may file a complaint with our compliance officer or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, you must submit your complaint in writing to our compliance officer. You will not be penalized for filing a complaint.

Right to Provide Authorization for Other Uses: Our practice will obtain your written authorization to use or disclose your health information in a manner not identified in this notice or allowed by applicable law. Any authorizations you provide may be revoked at any time by submitting a written statement to our compliance officer.

Should you have further questions about the information contained in this notice or the policies and procedures of The Lupo Center, please contact our compliance officer using the information provided on the front of this document.