DuBois Dermatology & Cosmetics New Patient Paperwork

105 Beaver Drive, Suite 200
DuBois, PA 15801
Phone: 814-371-(SKIN) 7546
Fax: 814-371-1906
Dr. Lisa Pfingstler
Catherine Holsopple, PA-C
Alisha Torretti, PA-C
Amber Hryn, PA-C

Patient Name: _____

Appointment Date/Time: _____

You will be seeing: _____

Please bring the following to your appointment:

- Photo ID
- Insurance Card(s) – if you do not have insurance or if we do not participate with your insurance, please refer to our Financial Policy on page 3 and 4.
- Prescription Card(s)
- Form of Payment – All copayments will be collected at Check-In. We also collect on Deductibles and Co-insurance. (We accept cash, check, Visa, Master Card, and/or Discover) Please refer to our Financial Policy on page 3 and 4 for more information regarding payment.
- List of all current Medications & Allergies
- Completed Registrations Forms

No Show Policy

In an effort to improve access to a dermatologist, a No Show Policy has been implemented. Patients who wish to cancel their appointment are required to notify the office at least 24 hours BEFORE their scheduled appointment time. Patients who do not show up for their appointment or do not provide notification to cancel at least 24 hours before the appointment time will be charged a $50.00 NO-SHOW fee for medical appointments. This fee is NOT covered by insurance and must be paid in full by the patient prior to his or her next appointment. Thank you for your understanding and cooperation as we strive to best serve the needs of all patients in our community. This policy voids any no-show policy that was in place prior to this notice.

Please arrive 10 minutes prior to your appointment time.

Please call the office if you have any questions regarding your appointment.

Thank you for choosing DuBois Dermatology & Cosmetics as your health care provider.

We look forward to seeing you at your appointment.

DuBois Dermatology & Cosmetics Registration

105 Beaver Drive, Suite 200, DuBois, PA 15801
814-371-(SKIN) 7546
Dr. Lisa Pfingstler

Patient Information

Last Name	First Name	Middle Initial	Preferred Name:

Circle One: Male Female	Marital Status	Maiden Name	Home Telephone #

Email Address:	Mobile Telephone #	Date of Birth

Address	City	State	Zip Code

Preferred Language:	Race (Please Circle One): Caucasian(white) Latino American Indian Asian African American Pacific Islander Other: _____
Social Security Number:	

Occupation:	Employer:	Please Circle: Full Time OR Part Time ☐ Student ☐ Retired ☐ Unemployed

Primary Care Physician:	Drug Allergies:
Referred By:	
How long have you been at your current address?	

What state were you born in?	Check box if born outside of U.S. ☐

Patient General Consent

Consent for Treatment: I, the undersigned, consent to the care and treatment by the attending physicians, his/her associates or assistants of DuBois Dermatology & Cosmetics, L.L.C.

Notice of Privacy Practices Receipt: I have received the Notice of Privacy Practices provided by DuBois Dermatology & Cosmetics, L.L.C.

In accordance with Pennsylvania State Law, any person under the age of 18 must have a legal parent or guardian sign for consent, unless the patient is married, graduated from high school, or has been pregnant.

Patient **OR** Guardian Signature: _____ Date: _____

May we give lab results/medication information on your answering machine?
(Please Circle)

YES OR NO

Insurance Information

Please complete this outlined section with the information of the PRIMARY Policy Holder. (Please give your insurance card(s) to the receptionist upon arrival)

Name of Policy Holder:	Policy Holder DOB: Policy Holder SSN:	Please list the name of your insurance:
Relationship to patient:	Address of Policy Holder:	
Policy Holder Primary Telephone#	Policy Holder Employer:	Please check this box if you have a secondary insurance: ☐

Patient Permission to Contact Information

Any physician, staff, employee, or representative of DuBois Dermatology & Cosmetics has my permission to discuss my account and medical conditions which may include symptoms, treatments, diagnosis, test results, medications, or any other type of protected health information with the following persons in order to facilitate and coordinate my care, treatment, and payment **(If patient is a minor, please list parent/guardian information. If patient is in assisted living, please list POA and nurse/care facilitator information. Any listed names are the only people that we will contact as per HIPPA):**

NAME	RELATIONSHIP	PHONE NUMBER(S)
NAME	RELATIONSHIP	PHONE NUMBER(S)
NAME	RELATIONSHIP	PHONE NUMBER(S)

I understand that authorizing the release of my information to the above individual(s) is voluntary and does not affect my access to treatment. I can refuse to sign this form. I can revoke it by writing to DuBois Dermatology & Cosmetics or completing a new form at any time. This authorization will remain in effect until I change or revoke it. I understand that if information is shared with the above individual(s) it may be subject to re-disclosure by the individual(s).

Patient **OR** Guardian Signature: _____ Date: _____

DuBois Dermatology & Cosmetics Financial Policy

Thank you for choosing DuBois Dermatology & Cosmetics as your health care provider. We are committed to providing you with quality and affordable health care. This financial policy was developed to assist with questions you may have with regards to financial and insurance issues. We believe that stating our expectations with regards to financial issues helps us concentrate of our mission of providing excellent patient care.

1. **Insurance:** We participate with most insurance plans. If you are not insured by a plan that we are contracted with OR you are insured but do not have a copy of a current card, payment is due in full at the time of service. We will bill your insurance company once we receive a copy of your current card but payment will be your responsibility at the time of service. We will reimburse any money owed when we receive a response from your insurance company.
2. **Co-payments:** All copays, deductibles, and coinsurances must be paid at the time of service.
3. **Deductibles:** Insurance companies are issuing policies with very high deductibles, therefore, for all insurance companies that provide us with a "patient financial responsibility estimator" we will collect patient deductibles on the day of service. We have formulated a fee amount for all procedures that is as close as possible to the allowable amount set by your insurance company. Any overpaid or underpaid fees will either be credited or billed accordingly.
   If you are not prepared to pay for procedures performed today, please inform the doctor PRIOR to the procedure being performed.
   PATIENT INITIALS STATE THAT THE DEDUCTIBLE POLICY OUTLINED ABOVE IS UNDERSTOOD: _____
4. **Methods of payment:** We accept payment by cash, check, Visa, Master Card, and Discover.
5. **Non-covered and Out of Network Services**: Medical services that are considered by your insurance company to be non-covered, out of network, or not medically necessary will be the financial responsibility of the patient.
6. **No Insurance:** If you do not have group or individual medical insurance, payment for professional services and procedures is expected on the day of service. Please note, we do offer discounted fees for patients without health insurance.
7. **Payment Plan:** Please let us know if there are financial hardship issues. We may be able to assist by setting up a payment plan based on your financial information.
8. **Statements:** All patient accounts that become delinquent after 90 days will receive a pre-collection letter giving ten days to pay the balance in full. If we do not receive payment, the account will be turned over to collections. Guarantor will be responsible for all costs and fees of collections, not to exceed 33 1/3% of the debt.
9. **Late Arrivals/No Shows:** A patient who arrives more than 15 minutes late from their scheduled time will be worked into the schedule based on other appointments. If more than 30 minutes late, the appointment may be rescheduled. A patient who fails to present themselves for three scheduled appointments may be dismissed from the practice.

ASSIGNMENT FOR THE GUARANTEE OF ACCOUNT

I, the undersigned, understand that all medical and surgical charges incurred are the responsibility of the patient and/or guarantor and payable by the same regardless of what the insurance pays. I hereby authorize and direct my insurance carrier(s) to pay directly to DuBois Dermatology & Cosmetics, LLC any benefits due under my insurance plan. I agree to pay the balance of expenses not paid under this plan, including deductibles, copays, and co-insurance.

I have read and understand this financial policy and agree to abide by it.

Signature of patient or responsible party **Date**

Printed name of patient or responsible party **Date**

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS.

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND ABOUT HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW CAREFULLY.

The policy of DuBois Dermatology & Cosmetics is to protect the confidentiality, integrity, and security of the protected health and personal information of our patients and to prevent unauthorized access to, or the use or disclosure of such information. We are required by law to maintain the privacy of your health information and provide you with this notice of our duties and obligations. This policy applies to patients who are current or former patients of DuBois Dermatology & Cosmetics.

Individually identifiable health and personal information are any information obtained by DuBois Dermatology & Cosmetics in connection with providing healthcare treatment, obtaining payment, and related healthcare operations. This related to the past, present, and future information that DuBois Dermatology & Cosmetics receives from you as our patient.

DuBois Dermatology & Cosmetics collects personal information in order to learn about your medical history, medical conditions, render treatment, and collect payment for our services. We gather this information from your patient forms, health questionnaires, and other forms you will be asked to complete from time-to-time. In addition, we will assemble information based on our discussions and conversations with you, your personal representative, and your family members. Your healthcare plan or insurance carrier may provide information to our office.

We will use this information to provide caring and quality medical care to you. Examples include diagnosis, treatment, and communications such as follow up and appointment reminders as well as treatment alternatives and other health related benefits that may be of interest to you or your particular medical condition. As part of our standard treatment and health care operations, we may share information with a facility such as a hospital, laboratory, diagnostic service, or healthcare provider to efficiently coordinate your treatment plan. We will obtain your authorization before using you information for marketing purposes. For contracted insurers, your information will be used for claims management and to obtain payment from your insurance carrier. We will exchange paper and electronic data with your insurance carrier for activities such as eligibility, benefit and coverage determinations, precertification, utilization review, and related activities. For worker's compensation, information about a work related condition can be exchanged with the employer.

Your information is maintained in our office in our computer system. DuBois Dermatology & Cosmetics limits the access to your protected health information to those employees and business associates who need to know that information. With some limitations, you have the right to inspect, amend, copy, and receive accounting of disclosures of your medical and billing records.

We do not disclose personal information to third parties unless one of the following exceptions applies.

- We receive explicit authorization from you to release individually identifiable information. This authorization must be in writing and give exact details regarding to whom the disclosure applies, the nature of the data to be released, the applicable dates, and signed by the patient or guardian. You may revoke this authorization by providing a written statement to DuBois Dermatology & Cosmetics Privacy/Security Officer.
- Federal, state, or other applicable law requires us to share protected information or records. Your information may be disclosed to a health agency for purpose such as licensure, certification, audits, investigations, and inspections. As required for law enforcement purposes or in response to a valid subpoena or court order, your information may be disclosed. Other disclosures could be required by law for military duty, national security activities, or for coroners/funeral director to carry out their duties.

We are obligated to abide by the terms of this notice. We will contact you for permission to use and disclose your information for reasons not described in this Notice of Privacy Practices. We will notify you in the event you are effected by any unsecure breach of information. We reserve the right to change the terms of this Notice of Privacy Practices and to make new notice provisions effective for all health information that we maintain.

With some exceptions, you have right to inspect, review, or obtain a copy of your health information. The request must be in writing and there may be reasonable charge to provide information. You also have the rights to request your records be amended, to request special accommodations and restrictions of your health information, including to your health plan, and to receive and accounting to the disclosures of your information. You have the right to request to receive communications of your information in a special manner or location. Dubois Dermatology & Cosmetics is not obligated to agree to a requested restriction. We must receive a written request from you to administer these rights. Please speak to the receptionist for further information or to begin the process to exercise any of these rights.

If you have a complaint about the management of your health information or believe your privacy rights have been violated, please contact our Privacy/Security Officer Lori Skraba at 814-371-7546. You have the right to file a complaint with the Office for Civil Rights and there will be no retaliation for filing a complaint.

Other optional uses of PHI:

- Your medical information may be reviewed by our medical staff for possible inclusion and referral in research studies. You WILL be contacted prior to the use of your information in a research study.
- We may contact you for fundraising opportunities and you have the opportunity to opt-out of such communications.
- In order to coordinate your care or service for your account, DuBois Dermatology & Cosmetics and our agents may contact you by telephone at any telephone number you provide, including wireless telephone numbers, which could result in charges. DuBois Dermatology & Cosmetics may also contact you by sending text messages or emails, using any email address you provide. Methods of contacting may include prerecorded or artificial voice messages and or use of automatic dialing devices, as applicable