

FERRARA DERMATOLOGY CLINIC

Financial Policy

Ferrara Dermatology Clinic, P.C. believes that part of good healthcare practice is to establish and communicate our financial policy. We are dedicated to providing the best care for you.

1. **PAYMENT** is expected at the time of your visit. We will accept cash, check, or credit card. Payment will include any unmet deductible, co-insurance, copayment, or non-covered charges from your insurance company. If you do not carry insurance, or if your coverage is currently under a pre-existing clause, payment in full is expected at the time of your visit unless other financial arrangements have been made.
2. **INSURANCE** as a courtesy we will verify your benefits with your insurance company. A quote of benefits is not a guarantee of payment. Your insurance claim will be processed according to your plan. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full. If your insurance does not pay the practice within a reasonable amount of time you will be billed. If we later receive payment from your insurer, we will refund you any overpayment. If our doctors are not listed in your plan's network, you may be responsible for partial or full payment.

Not all insurance plans cover all services. In the event your insurance plan determines a service to be "not covered" you will be responsible for the complete charge. Payment is due upon the receipt of a statement from our office. If a service is to be performed that we know is not covered by your insurance plan, we will have you sign a non-covered services form and payment arrangements can be made.

We highly recommend you also contact your insurance carrier and check into your coverage for dermatology. If you have more than one insurance please do not assume that all services will be paid for.

3. **COSMETIC PROCEDURES** are services not covered by insurance as they are considered not medically necessary, therefore electing to have treatment will incur an out of pocket expense due at the time of service unless other financial arrangements have been made.
4. **LATE CHARGES** of \$5.00 will be charged for each time balances are unpaid at the time of service unless other financial arrangements have been made.
5. **RETURNED CHECKS** will incur a \$30.00 service charge.
6. **ACCOUNTING PRINCIPALS** payments and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding date of service.
7. **MEDICAL RECORDS FEES** are a charge of \$5.00 and is due before the records will be processed. You can avoid this fee by accessing your patient portal and printing them yourself if the records are recent.

Your signature below acknowledges your part in understanding the policies of Ferrara Dermatology Clinic P.C.

Patient/Guardian Signature

Date

Medicare Patients Only

YES **NO**

- | | | |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Have you recently joined a Medicare HMO? If Yes Please identify: _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you or your spouse work in a company, which has more than 20 employees and have coverage through the insurance at this job? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you covered by any group plan that makes Medicare Secondary? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is this illness due to an auto accident or work injury? |
| <input type="checkbox"/> | <input type="checkbox"/> | Are you receiving Medicaid coverage? |

This office is required to keep your signature on file authorizing us to file claims to Medicare and to release information to that payer if they require it for the proper consideration of a claim.

I authorize Ferrara Dermatology Clinic, P.C. to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to myself, or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Patient Signature

Date

FERRARA DERMATOLOGY CLINIC SKIN AND LASER CENTER OF GROSSE POINTE

Patient Consent For Use and Disclosure of Protected Health Information

I consent that, **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** may use and disclose protected health information (PHI) from the past, present or future about me to carry out treatment, payment, and healthcare operations (TPO). Please refer to **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC's** Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Ferrara Dermatology Clinic's** Privacy Officer at 20045 Mack Avenue Grosse Pointe Woods, MI 48236

I consent that, **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** may call my home or other designated location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

I consent that, **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked personal and confidential.

I consent that, **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that, **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** restrict how it uses or discloses my PHI to carry out TPO. However the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, **Ferrara Dermatology Clinic, P.C. & Skin and Laser Center PLLC** may decline to provide treatment to me.

Signature of Patient or Legal Guardian

DATE

Patient's Name

Print Name of Patient or Legal Guardian

NAME: _____

DATE OF BIRTH: _____

History and Intake Form

Past Medical History: (please circle all that apply)

Anxiety	Hypertension (High Blood Pressure even if taking Medication)
Arthritis	HIV/AIDS
Artificial joints	Hypercholesterolemia (High Cholesterol)
Asthma	Hyperthyroidism (Over Active Thyroid)
Atrial fibrillation	Hypothyroidism (Under Active Thyroid)
BPH (Benign Prostatic Hyperplasia)	Leukemia
Bone Marrow Transplantation	Lung Cancer
Breast Cancer	Lymphoma
Colon Cancer	Pacemaker
COPD (Emphysema)	Prostate Cancer
Coronary Artery Disease	Radiation Treatments
Depression	Seizures
Diabetes	Stroke
End Stage Renal Disease	Valve Replacement
GERD (Acid reflux)	None
Hearing Loss	
Hepatitis	
Other _____	

Past Surgical History: (please circle all that apply)

Appendix Removed	Kidney Removed (Right, Left)
Bladder Removed	Kidney Stone Removal
Mastectomy (Right, Left, Bilateral)	Kidney Transplant
Lumpectomy (Right, Left, Bilateral)	Ovaries Removed: Endometriosis
Breast Biopsy (Right, Left, Bilateral)	Ovaries Removed: Cyst
Breast Reduction	Ovaries Removed: Ovarian Cancer
Breast Implants	Pacemaker
Coronary Artery Bypass	Prostate Biopsy
Defibrillator	Skin Biopsy
Gallbladder Removed	Basal Cell Cancer Surgery
Heart Transplant	Squamous Cell Carcinoma Surgery
Heart Valve Replacement	Melanoma Surgery
Joint Replacement, Knee (Right, Left, Bilateral)	Spleen Removed
Joint Replacement, Hip (Right, Left, Bilateral)	Hysterectomy: Fibroids
Joint Replacement within last 2 years	Hysterectomy: Uterine Cancer
Other _____	None

Skin Disease History: (please circle all that apply)

Acne	Flaking or Itchy Scalp
Actinic Keratosis	Hay Fever/Allergies
Asthma	Melanoma
Basal Cell Skin Cancer	Poison Ivy
Blistering Sunburns	Precancerous Moles
Dry Skin	Psoriasis
Eczema	Squamous Cell Skin Cancer
Other _____	

Do you wear Sunscreen? Yes No
If yes, what SPF? _____

Do you tan in a tanning salon? Yes No

Do you have a family history of Melanoma? Yes No
If yes, which relative(s)? _____
Any other family history: _____

Medications: (Please enter all current medications including name, strength, and how often taken) _____

Allergies: (Please enter all allergies) _____

Immunizations:

Have you ever had a pneumonia shot? Yes No
If yes when? _____
Have you had a Flu shot this year? Yes No

Social History: (Please circle one)

Cigarette Smoking:

Never smoked
Quit: former smoker
Smokes less than daily
Smokes daily

Alcohol Use:

YES
NO

Language:

English
Spanish
Other: _____

Race:

White
Black/African American
Asian
American Indian or Native Alaskan
Native Hawaiian/Pacific Islander

Ethnicity:

Hispanic/Latino
Non-Hispanic/Latino

Prescription coverage: _____yes _____no

Pharmacy: Name: _____
Street: _____ Zip code: _____

Height: _____ **Weight:** _____

How often do you exercise?

Once a day
A few times a week
A few times a month
Never

What is your caffeine use?

Once a day
A few times a week
A few times a month
Never

Occupation and Workplace _____

Please make a check mark next to any condition that applies to you today:

- | | | |
|---|--|--|
| <input type="checkbox"/> changing mole | <input type="checkbox"/> problems with healing | <input type="checkbox"/> poor immune system |
| <input type="checkbox"/> problems with bleeding | <input type="checkbox"/> problems with scarring (hypertrophic or keloid) | <input type="checkbox"/> depression |
| <input type="checkbox"/> belly pain | <input type="checkbox"/> rash | <input type="checkbox"/> anxiety |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> neck stiffness | <input type="checkbox"/> bloody stool |
| <input type="checkbox"/> fever or chills | <input type="checkbox"/> sore throat | <input type="checkbox"/> shortness of breath |
| <input type="checkbox"/> bloody urine | <input type="checkbox"/> hay fever | <input type="checkbox"/> thyroid problems |
| <input type="checkbox"/> chest pain | <input type="checkbox"/> joint aches | <input type="checkbox"/> unintentional weight loss |
| <input type="checkbox"/> cough | <input type="checkbox"/> muscle weakness | <input type="checkbox"/> headaches |
| <input type="checkbox"/> wheezing | <input type="checkbox"/> seizures | <input type="checkbox"/> blurry vision |

Check any item that applies to you:

- | | |
|--|--|
| <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Artificial Joints within past two years |
| <input type="checkbox"/> Defibrillator | <input type="checkbox"/> Premedication prior to procedures |
| <input type="checkbox"/> Artificial heart valve | <input type="checkbox"/> Blood thinners |
| <input type="checkbox"/> Rapid heartbeat with epinephrine | <input type="checkbox"/> Allergy to topical antibiotic ointments |
| <input type="checkbox"/> Yeast infections with antibiotics | <input type="checkbox"/> Allergy to lidocaine/Novocain |
| <input type="checkbox"/> Allergy to adhesives | <input type="checkbox"/> Pregnancy or planning pregnancy |