FERRARA DERMATOLOGY CLINIC, P.C.

20045 Mack Ave, Grosse Pointe Woods, MI 48236 Phone: 313-884-5100

CONFIDENTIAL PATIENT INFORMATION

☐ Mr. ☐ Mrs. ☐ Ms. ☐ Dr. ☐ Male ☐ Female

Last Name First Name Middle Initial

Address Apt #

City State Zip Code

Primary Phone # ☐ Cell ☐ Home

Secondary Phone # ☐ Cell ☐ Home

Date of Birth Age

Patient Social Security Number

E-Mail Address

Student: ☐ Full Time ☐ Part Time

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Patient Employer/ School

Patient Work Phone

Spouse's Name/ Parent's Name (If Minor)

Who Referred You to Our Office?

Who is your Primary Care Physician?

In Case Of Emergency Contact:

Contact Name

Relationship

Phone Number

May we release medical information to a family member? ☐ Yes ☐ No

Name / Relationship:

CONFIDENTIAL INSURANCE INFORMATION

(Please present cards for scanning)

Primary Insurance

Subscriber Name Date of Birth

Contract # Group #

Address of Subscriber if Different from Patient's

City State Zip Code

Secondary Insurance

Subscriber Name Date of Birth

Contract # Group #

Address of Subscriber if Different from Patient's

City State Zip Code

Do we have your permission to leave a message on your voice mail? ☐ Yes ☐ No

Do we have your permission to call your place of employment? ☐ Yes ☐ No

As a service to our patients, we provide courtesy appointment reminder calls/e-mails and possibly other important messages that may be e-mailed or placed using a prerecorded message. By providing your cell phone number and e-mail you are consenting to receiving such messages.

Ferrara Dermatology Clinic, P.C. accepts most major insurance plans. All insurance cards presented are verified for eligibility at the time of your visit. HMO patients must present with proper written authorization from their Primary Care Physicians before treatment can be administered. "I authorize my insurance benefits be paid directly to Ferrara Dermatology Clinic, P.C. for services rendered." Your signature below also authorize the clinic to release any such medical information necessary to process your insurance claims.

Patient or Authorized Signature Date

FINANCIAL & OFFICE POLICY

Thank You for choosing Ferrara Dermatology Clinic for your dermatology care. It is important that our patients understand office policies regarding credit, debt, and collections. The goal is to provide and maintain a good provider-patient relationship and keep policy as transparent as possible. Please read each section carefully and sign at the bottom.

CREDIT CARD ON FILE PROGRAM

We offer a credit card program to help manage your health care costs. With the credit card on file program, we can securely save your credit or debit card that can be used to pay your bill. This eliminates the hassle of mailing in a payment.

Appointments:

- We value the time we set aside to see and treat you. If you are not able to keep an appointment, we would appreciate no less than 24-hour notice.
- If you are late for your appointment (>15 minutes), we will do our best to accommodate you. However, it may be necessary to reschedule your appointment.
- All children under the age of 18 must be accompanied by an adult unless we have a current minor consent to treat on file. An authorization for treatment must be on file for all minors with an adult that is not a guardian and all children 16 and older unaccompanied.
- If a surgical appointment is not cancelled within 24 hours, the patient will be required to put a credit card on file to reschedule and if it happens again a fee of $75 will be charged to the card.
- If a patient no shows for an appointment they must put a credit card on file to reschedule and if they no show a second time a fee of $50 will be charged to the card.

Insurance Plans:

- It is your responsibility to keep us updated with the correct insurance information. Upon arrival we ask that you come prepared to present your current and active card.
- If the insurance card/plan you present is incorrect or invalid, you will be responsible for furnishing us with the correct information. If correct information is not provided you will be responsible for the payment.
- 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.

Referrals:

- You are responsible for making sure the referral is at our office on the day of your appointment. Ordinarily we will give you a courtesy call 2 days prior to the appointment to try to notify you if the referral is not available.
- If you do not have your referral at the time of your visit you will have to reschedule your appointment, or you can opt to pay cash for the visit.

Financial Responsibility:

- We do not get involved with domestic disputes or custody issues. Our policy is to obtain payment at the time of service from the parent/guardian bringing the child to the office.
- If you are a self-pay patient, you will be given a good faith estimate within 3 days of scheduling your appointment sent to you through your patient portal.
- 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.
- If a balance incurs $300 or greater after insurance payment and are unable to pay the balance in full you will be required to set up a payment plan and keep a credit card on file.
- 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.
- 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.
- Returned checks will incur a $40.00 service charge.
- Patient balances are billed monthly, and we ask that you pay your statement in a timely manner.
- If previous arrangements are not made any account balances over 90 days will be referred to a collection agency. We will send you 2 statements and a phone call on the third statement. If no response the account will go to collections.
- After going to collections 2 times the patient will be required to keep a credit card on file to make an appointment and all balances will be paid with the credit card on file.
- If you furnish a credit card that has insufficient funds or is expired, you will then be required to pay an amount specified by the biller upfront prior to your visit.

Medical Records:

- Medical Records may be obtained for free through your patient portal.
- Printed copies of medical records provided to a patient/outside medical facility will be charged a fee of $10. The fee must be paid up front before the medical records are furnished.

"I authorize my insurance benefits be paid directly to Ferrara Dermatology Clinic, P.C. for services rendered." Your signature below also authorizes the clinic to release any such medical information necessary to process your insurance claims.

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

_____ _____

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

FERRARA DERMATOLOGY CLINIC
SKIN & LASER CENTER

Michigan Surprise Medical Billing Disclosure Form

Your health benefit plan may or may not provide coverage for all the health care services you are scheduled to receive or the providers providing those services. You may be responsible for the costs of the services that are not covered by your health benefit plan.

The nonparticipating provider must provide a good faith estimate of the cost of the health care services to be provided. A good-faith estimate does not take into account unforeseen circumstances, which may affect the cost of the health care services provided.

You also have the right to request that the health care services be performed by a provider that participates with your health benefit plan and may contact your carrier to arrange for those services to be provided at a lower cost and to receive information on in-network providers who can perform the healthcare services that you need.

I have received, read, and understand the disclosure.

_____ _____

(Patient or patient's representative's signature) (Date)

_____

(Print patient's name)

Medicare Secondary Payer Questionnaire

1) Do you have coverage through a large group health plan (20 plus employees) through your current or former employer, or the current or former employer of a spouse or family member? If so, how many employees work for the employer providing coverage? _____

YES NO

☐ ☐

2) Are you receiving workers' compensation (WC) benefits or have a claim pending?

YES NO

☐ ☐

3) Is this condition a result of an accident? If so, are you filing a claim with a no-fault or liability carrier? _____

YES NO

☐ ☐

4) Do you have Veteran Affairs (VA) benefits?

YES NO

☐ ☐

5) Do you have black lung benefits?

YES NO

☐ ☐

6) Do you have end stage renal disease benefits?

YES NO

☐ ☐

If answers to all the above questions are no, then Medicare is Primary

NAME: _____ DATE OF BIRTH: _____

History and Intake Form

Past Medical History: (please circle all that apply)

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

Past Surgical History: (please circle all that apply)

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

Skin Disease History: (please circle all that apply)

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

[ ] changing mole

[ ] problems with bleeding

[ ] belly pain

[ ] night sweats

[ ] fever or chills

[ ] bloody urine

[ ] chest pain

[ ] cough

[ ] wheezing

[ ] problems with healing

[ ] problems with scarring (hypertrophic or keloid)

[ ] rash

[ ] neck stiffness

[ ] sore throat

[ ] hay fever

[ ] joint aches

[ ] muscle weakness

[ ] seizures

[ ] poor immune system

[ ] depression

[ ] anxiety

[ ] bloody stool

[ ] shortness of breath

[ ] thyroid problems

[ ] unintentional weight loss

[ ] headaches

[ ] blurry vision

Check any item that applies to you:

[ ] Pacemaker

[ ] Defibrillator

[ ] Artificial heart valve

[ ] Rapid heartbeat with epinephrine

[ ] Yeast infections with antibiotics

[ ] Allergy to adhesives

[ ] Artificial Joints within past two years

[ ] Premedication prior to procedures

[ ] Blood thinners

[ ] Allergy to topical antibiotic ointments

[ ] Allergy to lidocaine/Novocain

[ ] Pregnancy or planning pregnancy