DERMATOLOGY CENTER OF WASHINGTON TOWNSHIP, PC

100 Kings Way East, Suite A-3 • Washington Pavilions • Sewell, NJ 08080 • Phone (856) 589-3331 • Fax (856) 589-3416

Account #: _____ Date: _____

PATIENT INFORMATION

(Please circle) Mr. Mrs. Ms. Miss Dr. Rev. Fr. Sr.

Name: _____
(First) (M.I.) (Last)

Street: _____

Zip: _____City: _____ State: _____

Primary Phone: (_____) _____Secondary Phone: (_____) _____

Email Address: _____ Birth Sex: _____ Male _____ Female

Age: _____ Date of Birth: _____/_____/_____ Race: _____

Ethnicity (check one): □ Hispanic/Latino □ Not Hispanic/Latino □ Decline to Answer

Marital Status: _____ Employed_____ Retired_____ F/T Student_____ P/T Student____ None_____

Employer: _____ Occupation: _____

Responsible Party: (if patient is minor) Name: _____Relationship:_____

Emergency Contact: _____**Phone#:**(_____)_____Relation:_____

PHYSICIAN, LAB & PHARMACY INFORMATION

Physician Requesting Consult: _____ Phone: (_____) _____

City: _____State:_____ Fax: (_____) _____

Primary Care Physician (PCP): (if different) _____Phone: (_____)_____

City: _____State:_____ Fax: (_____) _____

Lab used for blood work: Quest_____ Labcorp_____ Other_____

Pharmacy Name: _____Location/Address: _____

City: _____Phone: ( )

INSURANCE INFORMATION- INSURANCE CARD(S) MUST BE PRESENTED AT EVERY VISIT

PLEASE NOTE: PLEASE BE AWARE THAT IT IS YOUR RESPONSIBILITY TO HAVE A VALID REFERRAL FOR EACH VISIT.

Primary Insurance Name: _____ Id#:_____

Group#: _____ Insured Name: (if other than self) _____

Insured's Date of Birth: _____/_____/_____Insured's SS#: _____ _____ _____Ph:(_____)_____

Insured's Address (if other than self): _____Zip:_____

City: _____State:_____ Employer: _____

Relationship of patient to insured: Self_____Spouse_____Son_____Daughter_____Stepchild_____Other_____

Secondary Insurance Name: _____Id#:_____

Group#: _____ Insured Name: (if other than self) _____

Insured's Date of Birth: ____/____/_____ Insured's SS#: _____ _____ _____Ph:(_____)_____

Insured's Address (if other than self): _____Zip:_____

City: _____State:_____ Employer: _____

Relationship of patient to insured: Self_____Spouse_____Son_____Daughter_____Stepchild_____Other_____

Office use only

DATE	INITIALS	YEARLY DEDUCTIBLE	REMAINING	COPAY	CO-INS	REFERRALS

DERMATOLOGY CENTER OF WASHINGTON TOWNSHIP, PC

Jonathan Winter MD ▪ Elana Segal MD ▪ Joshua Freedman MD ▪ Gregory Persichetti DO ▪ Amy Morris PA-C ▪ ▪ Marissa Ionno PA-C

FOR ALL PATIENTS

AGREEMENTS & AUTHORIZATIONS

Since the signing of the patient protection and affordable care act (PPACA), commonly referred to as "Obama Care", health care reform, or the Affordable Care Act (ACA), there have been many changes to health care, health care plans, and health care premiums, (as I'm sure you are aware). Changes to health care benefits and coverage can occur at **ANY** time. Therefore, it has become **MANDATORY** and **NECESSARY** to copy **ALL INSURANCE CARDS EACH AND EVERY VISIT.** We are sorry for any inconvenience this may cause.

All Patients:

I request that payment of authorized Medicare and/or insurer benefits be made to me or on my behalf to The Dermatology Center of Washington Township, PC for services furnished to me by said provider. I authorize The Dermatology Center of Washington Township, PC to release to my insurance company any medical information needed to determine the benefits or benefits payable to related services. I understand that if, under my insurance guidelines, a necessary service is determined to be non-covered, and I will personally be responsible for payment. I understand I am financially responsible for any amount denied or partially paid by the Third Party Insurance Carrier. I authorize release of medical information for treatment, payment and healthcare operations. **I understand that I am financially responsible for ANY charges that are not covered by my insurance company.**

Patient Signature: Date:

I understand that insurance co-pays, deductibles, and co-insurances may be collected at time of service.

I understand that office procedures may be applied to my deductible (if applicable), and are due at time of service. Procedures include treatment of skin lesions (including warts, molluscum, moles, precancers, skin cancers) by ANY method (including freezing, biopsy and in-office application of medication). I will be charged the same "allowable" fee that my insurance plan is charged.

I understand that if my insurance plan requires that I obtain a referral from my primary physician, I am responsible to make sure that I have a **VALID** referral for **EACH** and **EVERY** visit, or I will be responsible for **payment in full** for services rendered.

MEDICAL RECORDS RELEASE:

I authorize you to release to my insurance company, referring, primary or consulting physicians and pharmacies any information concerning health care, advice, treatment or medication/supplies provided or prescribed to me. This authorization may also include any pictures taken in the office and included in my medical record. This information can be sent by mail, fax or secure internet or given over the phone. Refer to HIPAA Privacy Notice.

HIPAA POLICY: (HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT of 1996) (Updated 2013)

I have been given the opportunity to read and receive a copy of the Dermatology Center of Washington Township, PC's **Notice of Privacy Practices.** The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information. I understand that the Dermatology Center has reserved the right to change their privacy practices that are described in the Notice and that a copy of any Revised Notice will be made available to me.

I acknowledge that I have read the Agreement & Authorization form and agree to its contents.

Patient or Responsible Party **Signature:** **Date:**