

University Dermatology Associates, PLLC  
1120 19<sup>th</sup> Street, NW Suite #250  
Washington, DC 20036-3605  
Tel: (202) 955-6995

## Welcome to Our Practice

Thank you for selecting us for your skin care needs. We hope you will find our office convenient and the staff courteous. Hours of operation are 8:30 am – 4:30 pm, Monday through Friday. We are closed on nationally-recognized holidays.

**Financial Policy:** Payment in full is required at the time services are rendered, unless you are currently enrolled and eligible under one of the insurance plans that list us as in network providers. Please check with your insurance company to verify this information as it varies by carrier and policy. Please understand health plans have different copays, deductibles, and rules regarding allowed visits for certain covered services, which may or may not be defined by your individual policy and/or employer group. If our office participates with your health plan, we will honor their fee schedule and discounts, and you will be responsible for your co-payments and/or deductible (both may apply). If our office does not participate with your health plan, payment in full is due at the time you exit our office for all services rendered. A claim form will be mailed to your home address within 10 business days of your visit. This claim form can be submitted to your health plan for consideration. We do not honor non-participating plan discounts. We accept the following methods of payment: cash, check, money order, debit card, MasterCard, or VISA. There will be a \$40.00 processing fee for all returned checks. Please refer to Financial Policies form for further details.

**Patient Statements:** When a claim is submitted to one of the above insurance plans on your behalf, we notify them of any payment made by you on the day of your visit. Once they consider your claim, and if you still owe a balance after their decision, a statement will be sent to you. Your account balance must be paid in full within 30 days. Our billing company will send three statements and one delinquency notice. If you do not make payment arrangements or ask for an extension your account will be turned over to a third party collection agency. If this happens you will be charged an additional 30% collection fee. This is the amount the collection agency charges us.

**Referral Forms for HMO Plans:** If your insurance plan requires a written referral for your visit, you must bring it with you at the time of your appointment. We do not accept faxed referrals from other medical offices, nor do we make contact with other physicians to have referrals sent on your behalf. It is the responsibility of the patient to be prepared for their visit at the time they are seen. If you do not have a referral at your appointment time, you may reschedule your appointment, or sign a waiver of benefits for that visit and make payment in full that day. By doing so, you may not submit charges to your insurance carrier, either. We request that you follow your health plan rules so you can receive the most optimal benefit your health plan provides. Waiving benefits may affect consideration of future services.

**Medical Records:** We will forward a copy of your medical records to you or another designated recipient upon receipt of a request signed by you. We charge a fee to cover the copying, mailing, and administrative costs. Copies of records sent to other healthcare providers are provided without a charge. Please ask our staff, or visit our website ([www.advancedskinhealth.com](http://www.advancedskinhealth.com)) Original slides and photographs will be provided at no cost, regardless of the recipient, once a signed request is received. *It is our policy to provide only copies of records created by University Dermatology Associates, PLLC.*

**Missed Appointments:** As a courtesy to our patients, the office staff confirms appointments 24-48 hours in advance. If you are unable to keep your appointment, a 24 hour notice is required. If you provide us with less than a 24 hour notice, or you do not appear for your appointment, a 'missed appointment' fee will be charged to your account in the amount of \$50.00. Cosmetic appointments and surgeries will be charged a 'missed appointment' fee of \$100.00. There is a \$250 "missed appointment" fee for Mohs surgery and a 72 hour notice. This amount must be paid prior to any future visits with our office.

**Notification of Lab/Pathology Results/Other Clinical Information:** Occasionally, it may be necessary to contact you to provide you with biopsy results, lab results, or other clinical information regarding your care, via telephone, voicemail/answering machine message, or e-mail. By providing this information below, you consent to receive information in this manner. Further, if the doctor deems an additional consultation, or a biopsy, is necessary and in your best interests, there may be an additional fee for which you will be responsible.

I understand the above administrative and financial rules of University Dermatology Associates, PLLC.

Patient's Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

Print Your Name: \_\_\_\_\_

Intake Initials: \_\_\_\_\_

Rev 12/10/09

**UNIVERSITY DERMATOLOGY ASSOCIATES, PLLC  
PATIENT REGISTRATION FORM**

PATIENT NAME: \_\_\_\_\_  
First Middle Last

HOME ADDRESS: \_\_\_\_\_  
City State Zip

HOME TELEPHONE: (    ) \_\_\_\_\_ WORK TELEPHONE: (    ) \_\_\_\_\_

SEX: Male Female DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_/\_\_\_/\_\_\_

REFERRING PHYSICIAN: \_\_\_\_\_ MARITAL STATUS: S M W D STUDENT: PT FT

E-MAIL ADDRESS: \_\_\_\_\_

EMPLOYER NAME: \_\_\_\_\_ OCCUPATION: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

SPOUSE / PARENT NAME: \_\_\_\_\_

SPOUSE / PARENT EMPLOYER: \_\_\_\_\_

SPOUSE / PARENT DATE OF BIRTH: \_\_\_/\_\_\_/\_\_\_ SOCIAL SECURITY NUMBER: \_\_\_/\_\_\_/\_\_\_

EMERGENCY CONTACT: \_\_\_\_\_ TELEPHONE #: (    ) \_\_\_\_\_

PRIMARY INSURANCE: SECONDARY INSURANCE:  
Insurance Name: \_\_\_\_\_ Insurance Name: \_\_\_\_\_

ID # \_\_\_\_\_ ID # \_\_\_\_\_

Group # \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber: \_\_\_\_\_ Subscriber: \_\_\_\_\_

Subscriber Date of Birth: \_\_\_\_\_ Subscriber Date of Birth: \_\_\_\_\_

**PATIENT PAYMENT AUTHORIZATION**

I hereby authorize my insurance company to send all payments for medical services rendered to me (or my dependents) directly to UNIVERSITY DERMATOLOGY ASSOCIATES, PLLC. With my signature, I confirm the above demographic and insurance information is true and correct, and for any future services this authorization applies to. If the information is found to be inaccurate, I agree to be personally responsible for payment in full for services provided. I further authorize the release of any information (including medical information) to my insurance company in order to determine the insurance benefits for which I may be entitled to. ***I confirm I have received a copy of University Dermatology Associates, PLLC 'Welcome to Our Practice' Letter.***

Patient / Representative's initials: \_\_\_\_\_ Intake Initials: \_\_\_\_\_

I acknowledge it is the policy of this office that payment is required at the time of service. An insurance claim submission on my behalf is a courtesy extended to me, or the party I represent, unless mandated by the health plan in which this practice participates. I understand I am financially responsible for all services not covered by my health plan. Should my insurance plan not forward notice of payment and/or a benefits statement within 60 days from the date of service, I will be responsible for payment in full. I also understand that should I be covered by a health plan UNIVERSITY DERMATOLOGY ASSOCIATES, PLLC is participating with at the time services are provided, I shall only be responsible for those services authorized and approved by my plan.

**LABORATORY / BIOPSY SERVICES:** We provide the professional services portion for these procedures. If a specimen is sent to an outside source to confirm a diagnosis, you will be billed separately by the laboratory that provides the service.

A COPY OF THIS AUTHORIZATION MAY BE CONSIDERED AS AN ORIGINAL FOR INSURANCE PURPOSES.

\_\_\_\_\_  
**Patient or Representative's Signature** \_\_\_\_\_  
**Date**

# Missed Appointments and Late Cancellations

Our office policy is to schedule patients in advance for their return visits. When you check out today, if a follow-up appointment is necessary, the date and time will be written on your receipt and an appointment card will be provided for you.

48 hours prior to your next scheduled appointment, a courtesy reminder call will be placed to a telephone number selected by you as a point of contact. This time frame allows you to contact us to cancel or reschedule your appointment.

Please note that our office charges \$50.00 for missed appointments (\$100 cosmetic and \$250 Moh's) and late cancellations. For cancellations and reschedules, you must provide a 24 hour notice, or the fee is applied. If you arrive late for your appointment, and are asked to reschedule, you will also be charged a missed appointment fee. This fee must be paid prior to your next service.

Our office cannot be held accountable for telephone number changes, unless they are provided in writing, more than 48 hours prior to your scheduled appointment time. It is your responsibility to monitor your appointment date and arrive on time.

My contact telephone number is: ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

This number is my:      HOME      CELL      WORK      telephone number.

I have read and understand the above office policy.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Intake Personnel: \_\_\_\_\_

# **NOTICE OF PRIVACY PRACTICES**

## **Acknowledgement Form**

- I HAVE RECEIVED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR UNIVERSITY DERMATOLOGY ASSOCIATES, PLLC.**
  
- I HAVE BEEN OFFERED A COPY OF THE NOTICE OF PRIVACY PRACTICES FOR UNIVERSITY DERMATOLOGY ASSOCIATES, PLLC, BUT DO NOT WANT A COPY.**

\_\_\_\_\_  
**Patient or Representative's Signature**

\_\_\_\_\_  
**Today's Date**

**University Dermatology Associates  
PATIENT MEDICAL HISTORY FORM**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Occupation: \_\_\_\_\_ Male Female

What is the reason for your visit today? \_\_\_\_\_

When did you notice it? \_\_\_\_\_ Is it now:  Better  Worse  No change

Drug Allergies (please check and list type of reaction):

- |   |   |
|---|---|
| <input type="checkbox"/> Anesthetics _____  | <input type="checkbox"/> Aspirin _____      |
| <input type="checkbox"/> Codeine _____      | <input type="checkbox"/> Erythromycin _____ |
| <input type="checkbox"/> Penicillin _____   | <input type="checkbox"/> Sulfa _____        |
| <input type="checkbox"/> Tetracycline _____ | <input type="checkbox"/> Other Drugs _____  |

Non-Drug Allergies (Include Reaction) \_\_\_\_\_

Current Medications:

	Name	Strength	Dose	Used since when?
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____
5.	_____	_____	_____	_____
6.	_____	_____	_____	_____
7.	_____	_____	_____	_____
8.	_____	_____	_____	_____

Do you require Pre-Medication prior to surgery of any type?  NO  YES (Describe) \_\_\_\_\_

**MEDICAL HISTORY:** (Please be sure to check all that apply - past or present)

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Acne                      | <input type="checkbox"/> Diabetes                    | <input type="checkbox"/> HIV disease           | <input type="checkbox"/> Rheumatic fever          |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Eczema                      | <input type="checkbox"/> Hives                 | <input type="checkbox"/> Scarring / keloids       |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Epilepsy                    | <input type="checkbox"/> Infections, chronic   | <input type="checkbox"/> Skin cancer              |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fainting spells             | <input type="checkbox"/> Kidney disease        | <input type="checkbox"/> STD / venereal disease   |
| <input type="checkbox"/> Bleeding, excessive       | <input type="checkbox"/> Glaucoma                    | <input type="checkbox"/> Liver disease         | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Blood clots               | <input type="checkbox"/> Hair loss                   | <input type="checkbox"/> Loss of skin pigment  | <input type="checkbox"/> Thyroid disease          |
| <input type="checkbox"/> Breathing disorder        | <input type="checkbox"/> Hay fever                   | <input type="checkbox"/> Lung disease          | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Bruise easily             | <input type="checkbox"/> Headaches, chronic          | <input type="checkbox"/> Lupus                 | <input type="checkbox"/> Ulcers, skin             |
| <input type="checkbox"/> Cancer: _____             | <input type="checkbox"/> Heart problems              | <input type="checkbox"/> Malignant melanoma    | <input type="checkbox"/> Ulcers, intestinal       |
| <input type="checkbox"/> Cataracts                 | <input type="checkbox"/> Hepatitis                   | <input type="checkbox"/> Mitral valve prolapse | <input type="checkbox"/> Varicose veins           |
| <input type="checkbox"/> Colon/intestinal disorder | <input type="checkbox"/> Herpes simplex (cold sores) | <input type="checkbox"/> Neurological problems | <input type="checkbox"/> Vitiligo                 |
| <input type="checkbox"/> Convulsions/seizures      | <input type="checkbox"/> Herpes zoster (shingles)    | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Warts                    |
| <input type="checkbox"/> Depression                | <input type="checkbox"/> High blood pressure         | <input type="checkbox"/> Psoriasis             | <input type="checkbox"/> Wound healing difficulty |
| <input type="checkbox"/> Other: _____              |  |  |   |

• FEMALES:  Chronic vaginal infections  Taking Oral Contraceptives  
 Currently pregnant  Possibly pregnant  Date of last menstrual period: \_\_\_\_\_

**SURGICAL HISTORY:**

	Type of Surgery	When
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
*	Please see other side of form	

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**SOCIAL HISTORY:**

Has your weight changed in the last 6 months? Yes No Loss: \_\_\_\_\_ lbs Gained: \_\_\_\_\_ lbs

Do you use tobacco? Yes Never Quit If yes, how much per day? \_\_\_\_\_ For how long? \_\_\_\_\_  
 Do you drink alcohol? Yes Never Quit If yes, how much? \_\_\_\_\_ How often? \_\_\_\_\_  
 Do you use recreational drugs? Yes Never Quit If yes, how much? \_\_\_\_\_ How long? \_\_\_\_\_  
 Marital status: S M W D Children? Yes No If yes, how many? \_\_\_\_\_

**FAMILY HISTORY:** (Please check the following if they have occurred in your family)

- |  |   |
|--|---|
| <input type="checkbox"/> Allergies                 | <input type="checkbox"/> Hay Fever                    |
| <input type="checkbox"/> Arthritis                 | <input type="checkbox"/> Malignant melanoma           |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Psoriasis                    |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Skin cancer                  |
| <input type="checkbox"/> Collagen Vascular Disease | <input type="checkbox"/> Systemic lupus erythematosus |
| <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Tuberculosis                 |
| <input type="checkbox"/> Eczema                    |   |

**OTHER PERTINENT HISTORY:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

**PHYSICIAN'S NOTES:**

Date: \_\_\_\_\_

Initials: \_\_\_\_\_

Date: \_\_\_\_\_

Initials: \_\_\_\_\_

Date: \_\_\_\_\_

Initials: \_\_\_\_\_