**Modly Dermatology**

# PATIENT INFORMATION

## CHART #:

Patient's Last Name: _____ First Name: _____ M.I. _____

Address: _____

Zip Code: _____ City: _____ State: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Date of Birth: _____ Gender: _____ Email Address: _____

Marital Status (circle one): SINGLE MARRIED DIVORCED WIDOWED OTHER: _____

Primary Care Physician: _____ Referred By: _____

Patient's Employer: _____

Initial if Correct: _____

### PERSON FINANCIALLY RESPONSIBLE FOR BILL

Responsible Party's Name: _____

Address: _____

Relationship to Patient: _____ Date of Birth: _____ Gender: _____

Email Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Responsible Party's Employer: _____

Initial if Correct: _____

### INSURANCE INFORMATION

**PRIMARY INSURANCE COMPANY:**

Policy Number: _____ Policyholder's Name: _____

Patient Relationship to Policyholder: _____

Group Number: _____ Policyholder's Date of Birth: _____

Copayment Amount: _____

**SECONDARY INSURANCE COMPANY:**

Policy Number: _____ Policyholder's Name: _____

Patient Relationship to Policyholder: _____

Group Number: _____ Policyholder's Date of Birth: _____

Initial if Correct: _____

### ASSIGNMENT OF BENEFITS

I hereby assign all medical and/ or surgical benefits, to include major medical benefits to which I am entitled to Modly Dermatology for services rendered by Charlotte E. Modly. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered valid as the original. I hereby assume financial responsibility for all charges whether paid by insurance or not. I hereby authorize said assignee to release all necessary information to secure payment. I understand that Modly Dermatology reserves the right to pursue a delinquent account via third party collection agencies or attorneys, and I am responsible for any collection fees incurred by Modly Dermatology.

Date: _____

Patient's Signature (or Responsible Party if under 18): _____

**Modly Dermatology**

## HIPAA PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing the consent. The terms of our Notice may change. If we change our Notice you may obtain a copy by contacting the Office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if do we shall honor agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and healthcare operations. You have the right to revoke this Consent in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected health operations may be disclosed or used for treatment, payment or health care operation.
2. The patient may forbid disclosure of information about a test or treatment for which the patient has paid out of pocket.
3. The Practice has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
4. The Practice reserves the right to change the Notice of Privacy Practices.
5. The patient has the right to restrict uses of their information, but the practice does not have to agree to these restrictions.
6. The patient may revoke the Consent in writing at any time and all future disclosures will then cease.
7. The Practice may condition receipt of treatment upon execution of this consent.

This consent was signed by _____

***Printed patient name or representative***

_____

***Signature*** ***Date***

Relationship to patient _____

Witness _____

***Printed name – practice representative***

_____

***Signature*** ***Date***

**Dr. Modly has my permission to leave messages via phone for appointment confirmations: Please circle YES or NO**

Modly Dermatology

# FINANCIAL AGREEMENT

Welcome to Charlotte Modly Dermatology. We are pleased to have you as our patient. We are dedicated to providing quality, accessible, and cost-effective health care services to our patients and we strive to make every visit a positive experience. This information was designed to provide our patients with detailed explanation of our financial policies. We realize this information may not always address your specific situation and encourage you to speak with our billing company, Medical Billing Solutions, Inc., whenever you have any questions or concerns regarding your account.

## Registration

The registration process is a vital link in your visit with us. The information gathered provides us with contact information as well as ensures your claims will be filed to the correct insurance company. Upon arrival at our office for each visit, you will be asked for basic information:

- Current patient information: name, address, and telephone number.
- Current patient insurance card(s)
- Drivers license or ID card.

All information obtained in the registration process is kept in your confidential medical record. For your convenience we accept cash, check, Visa, Mastercard and Discover. If you pay by credit card and there is a credit after your insurance processes your claim, we will refund your overpayment to the credit card you originally used.

## Co-payments

Co-payments will be collected at the time of your visit unless you are scheduled for a procedure. Please check with you insurance company for the requirements and provisions of your policy to determine the amount of your co-payment prior to your appointment. If you have an appointment for a procedure, we will not collect a co-payment at the time of your visit. We will bill your insurance company to determine if you owe a co-payment. After your insurance processes your claim, we will send you a statement for any balance due.

## Referrals

Referrals are required for some insurances in order for a visit to be covered or for better benefits to be applied. It is the patient's responsibility to be aware when their referral expires or that all their visits are used and to obtain a new one.

If your insurance requires a referral for your visit to be covered you must have a valid referral at your visit. If you do not have a valid referral your choice is to reschedule your appointment, or you may be a self-pay patient for this visit and pay the balance in full at the time of services. If you decide to be a self-pay patient a claim may not be submitted to your insurance.

If your insurance requires a referral in order to receive better benefits you will be responsible for any charges not covered if a valid referral was not provided at your visit. All referrals provided after your claim has been filed will be the responsibility of the patient to resolve with their insurance company.

**Modly Dermatology**

**FINANCIAL AGREEMENT** (cont)

## Balances

If there is any balance on your account after your insurance company processes your claim our billing company will send you a statement. The balance is to be paid within 30 days of the statement date. The statement will have a message explaining what your balance is for. If you believe your insurance company has made an error, please contact them prior to our billing company. If your insurance company is reprocessing your claim you need to provide our billing company with a reference number, the name of who you spoke with and the date of your phone call so that our billing company can follow up on your claim for you. If there is a discrepancy between the statement our billing company has sent you and your Explanation of Benefits please contact our billing company directly.

## Dependents

For your convenience, our statements show outstanding balance information for each responsible party in our system. This may include balances for family members who have the same responsible party listed.

## Returned Checks

There is a $25 returned check fee for any checks returned to our office. You a responsible for the original check amount plus the $25 returned check fee.

## No show/ Last minute cancellations

There is a $50 fee for cancelations for new patients, cosmetic appointments or scheduled procedures less than 24 hours' notice. All other appointments cancelled less than 24 hours' notice will incur a $25 fee. *Appointment reminders are a courtesy*, so please remember to put your appointment on your calendar.

## Collections

Statement balances not paid within 60 days will be reviewed by Dr. Modly for approval to send to a 3rd party collection agency. Your insurance also may be notified. In the event your account is turned over to a 3rd party collection agency you will be responsible for collection fees of 33% as well as interest of 1.5% per month or 18% annually.

## Self-pay/Cosmetic

If you do not have insurance, payment in full will be due at the time of service. Cosmetic visits are also due in full at the time of your service.

## General Insurance Policy

As a convenience to you our billing company will file a claim on your behalf provided, we have your current insurance information available. However, it is impossible for our staff to determine your coverage and payment levels since each insurance policy has different benefit coverage We cannot guarantee that your insurance will pay all or even part of your claim. Your insurance policy is a contact between you and your insurance carrier. Patients should resolve disputed coverage issues with their insurance carrier or employer. Is the patients responsibility to know the details of their insurance contact and if we are a network provider f or their particular plan.

**Modly Dermatology**

**FINANCIAL AGREEMENT** (cont)

If you do not bring the correct insurance information to your appointment and we file your claim to the incorrect carrier, we will bill you for the balance of your visit. Please be aware that there are timely filling limits for us to submit claims. If you supply the correct insurance information after the timely filing limit than the entire visit balance will be your responsibility.

**Participating Insurance:**

Charlotte Modly Dermatology reserves the right to determine which insurance companies or programs we participate with on a annual basis.

We are contracted with your insurance carrier and cannot write off or reduce your balance due to the terms of our contract. We realize unforeseen circumstances can come up so we ask you to contact our billing company to set up a payment plan if you are unable to pay in full.

Regarding Medicare, we accept Medicare assignment. This means we agree to accept Medicare's allowance on services provided to you. You will still be responsible for your annual deductible, co-insurance and non-covered services specified by Medicare. If you carry a supplemental plan to Medicare, please be sure we have your policy information so that a claim can be filed for you.

If you have signed up for a Medicare replacement policy, we need that insurance card at the Time of Service so that your claim is filed correctly.

**Non-Participating Insurance**

If Dr. Modly does not participate with your insurance, then your claim will go towards your out-of-network benefits. If your policy does not have any out-of-network benefits then you will be responsible for the entire balance.

**Questions regarding your Account**

If you have any questions regarding your account please contact Jessica A. at Medical Billing Solutions, Inc. at 410-876-1115 ext. 302.

I understand and accept the aforementioned policy.

Patient Name:_____

Responsible Party Signature:_____

Responsible Party Name (if different from patient):_____

Today's Date:_____

**Modly Dermatology**

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patients name: _____ DOB: _____ SS# _____

Patients Address: _____ City,State,Zip : _____

Phone #: _____

I hereby authorize Charlotte Modly, MD

( ) To release medical records to :

( ) To obtain medical records from:

( ) Verbal release only of medical information to ( family member/friend) Relationship: _____

Name of Person/Agency _____ Phone # _____ Fax # _____

Address: _____ City,State,Zip _____

The purpose/ need for such disclosure is _____

Dates of service: _____

_____ Is authorized to release the following: (Records may contain medical information pertaining to Mental health services, drug/alcohol diagnosis, and treatment).

( ) Abstract ( summary op reports, path consults, H&P)

( ) Alcohol/detox/drug abuse

( ) ER records

( ) XRAY,EKG,Labs

( ) Outpatient surgery

( ) PT/OT/Speech

( ) Discharge summary

( ) Nuclear medicine

( ) Admission H&P

( ) Clinic

( ) Consultation report

( ) Mental health/Psychiatry

( ) AIDS/HIV report

( ) Dr's office notes

Signature _____ Date _____

Witness _____ Date _____

Modly Dermatology

# HISTORY AND INTAKE

**PAST MEDICAL HISTORY:** (Please circle all that apply)

| | | |
|---|---|---|
| ANXIETY | CORONARY ARTERY DISEASE | THYROID PROBLEMS |
| ARTHRITIS | DEPRESSION | LEUKEMIA |
| ASTHMA | DIABETES | LUNG CANCER |
| ATRIAL FIBRILLATION | END STAGE RENAL DISEASE | LYMPHOMA |
| BONE MARROW | GERD | PROSTATE CANCER |
| TRANSPLANTATION | HEARING LOSS | RADATION TREATMENT |
| BREAST CANCER | HEPATITIS | SEIZURES |
| COLON CANCER | HIGH BLOOD PRESSURE | STROKE |
| COPD | HIV/AIDS | HIGH CHOLESTROL |
| NONE | COVID | |

OTHER _____

**PAST SURGICAL HISTORY**: (Please circle all that apply)

| | |
|---|---|
| APPENDIX | JOINT REPLACEMENT |
| BLADDER REMOVED | KIDNEY BIOPSY ( RIGHT,LEFT) |
| MASTECTOMY (RIGHT, LEFT, BILATERAL) | KIDNEY REMOVED(NEPHRECTOMY) |
| LUMPECTOMY (RIGHT, LEFT, BILATERAL) | KIDNEY STONE REMOVAL |
| BREAST BIOPSY (RIGHT, LEFT, BILATERAL) | KIDNEY TRANSPLANT |
| BREAST REDUCTION | OVARIES REMOVED: ENDOMETROSIS |
| BREAST IMPLANTS | OVARIES REMOVED: CYST |
| COLECTOMY: COLON CANCER RESECTION | OVARIES REMOVED: OVARIAN CANCER |
| COLECTOMY: DIVERTICULITIS | PROSTATE REMOVED: PROSTATE CANCER |
| COLECTOMY: IBD | PROSTATE BIOPSY |
| GALLBLADDER REMOVED | TURP (PROSTATE REMOVAL) |
| CORONARY ARTERY BYPASS | SPLEEN REMOVED |
| MECHANICAL VALVE REPLACEMENT | TESTICLES REMOVED (RIGHT, LEFT, BILATERAL) |
| BIOLOGICAL VALVE REPLACEMENT | HYSTERECTOMY: FIBROIDS |
| HEART TRANSPLANT | HYSTERECTOMY: UTERINE CANCER |
| JOINT REPLACEMENT, KNEE (RIGHT, LEFT, BILATERAL) | JOINT REPLACEMENT, HIP (RIGHT, LEFT,BILATERAL) |
| NONE | |

OTHER _____

**Modly Dermatology**

## HISTORY AND INTAKE (cont)

**SKIN DISEASE HISTORY** (Please circle all that apply)

ACNE

DRY SKIN

POISON IVY

ACTINIC KERATOSES

ECZEMA

PRECANCEROUS MOLES

ASTHMA

FLAKING OR ITCHY SCALP

PSORIASIS

BASAL CELL SKIN CANCER

HAY FEVER/ALLERGIES

SQUAMOUS CELL SKIN CANCER

BLISTERING SUNBURNS

MELANOMA

NONE

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)** _____

**Medications:** (Please write all current mediations)

_____

_____

_____

**Allergies**:_____

_____

**Modly Dermatology**

# HISTORY AND INTAKE (cont)

**SOCIAL HISTORY** (Please circle all that apply)

| | |
|---|---|
| Cigarette Smoking: | Alcohol use: |
| Currently smokes | ETOH -None |
| Has smoked in the past | ETOH-Less than 1 drink per day |
| Never smoked | ETOH- 1-2 drinks per day |
| Former smoker | ETOH-3 or more drinks per day |

**REVIEW OF SYSTEMS**

Are you currently experiencing any of the following? (Please circle if yes)

| | |
|---|---|
| Problems with bleeding | Bloody stool |
| Problems with healing | Bloody urine |
| Problems with scarring (keloids) | Joint aches |
| Rash | Muscle weakness |
| Blistering sunburns before puberty | Neck stiffness |
| Irregular menses | Headaches |
| Fever or chills | Seizures |
| Immunosuppression | Cough |
| HAY Fever | Shortness of breath |
| Chest pain | Wheezing |
| Night sweats | Anxiety |
| Unintentional weight loss | Depression |
| Thyroid problems | Blurry vision |
| Sore throat | Abdominal pain |

**ALERTS**: (Please circle all that apply)

| | |
|---|---|
| Allergy to Adhesive | MRSA |
| Allergy to Lidocaine | Pacemaker |
| Allergy to topical antibiotics | Require antibiotics before procedures |
| Artificial joint replacement | |

Rapid heartbeat with epinephrine

Blood thinners

Defibrillator

Pregnant

Currently trying to get pregnant

**FAMILY HISTORY** (Only first-degree relatives)

_____

_____

_____

**Preferred Language:** _____

**Race:** _____ **Ethnic Group:** _____

**Preferred Pharmacy Name:** _____

**Phone #:** _____

**City or Zip Code:** _____