Elmhurst Dermatology

103 N. Haven Rd., Ste. 7, Elmhurst, IL 60126

Patient Demographics

Patient Name:				
Mailing Address:				**Apt No.:**
City:		**State:**		**Zip Code:**
Referred By:	☐ **Physician:**		☐ **Patient:**	
	☐ **Insurance Website**	☐ **Yellow Pages**	☐ **Newspaper**	☐ **Other:**
Pharmacy Name:		**Intersection and Town:**		
Financially Responsible:		*Self unless under the age of 18.*		
Social Security Number:		*If the patient is under the age of 18 list SSN of financially responsible.*		

Receipt of Notice of Privacy Practices (I received the Privacy Practices Brochure)

By signing below you acknowledge that you received a copy of our Notice of Privacy Practices

X ____ ____________________

Signature of Patient or Authorized Representative Date

Confidential Voice Mail (Ok to leave me a message)

☐ Elmhurst Dermatology has my permission to leave a confidential voice mail (e.g. lab, path or test results, prescription information) using the following phone number:__________________________

☐ Elmhurst Dermatology does **NOT** have my permission to leave a confidential voice mail

Health Data Exchange using Carequality and Commonwell Health Alliance networks (Ok to share my health info)

I give my consent for Elmhurst Dermatology to receive my health data from other providers who have treated me, and to share my health data with others that are providing me with treatment in the future. I understand that these sharing networks benefit me by improving coordination of the health care I receive. ☐ Yes ☐ No

X____ ____________________

Signature of Patient or Authorized Representative **Date**

Disclosure of Information (Other folks who I trust with my confidential information)

In the event that Elmhurst Dermatology is unable to contact me, I give full permission to Elmhurst Dermatology to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not be limited to information regarding pathology reports, laboratory tests, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Elmhurst Dermatology for the disclosure of information to the individual(s) designated below.

Name	**Date of Birth**	**Phone Number**
________________________	________________	____________________
________________________	________________	____________________

X____ ____________________

Signature of Patient or Authorized Representative **Date**

OR

I do **NOT** agree to allow Elmhurst Dermatology to disclose any medical information regarding myself to any individual other than myself.

____ ____________________

Signature of Patient or Authorized Representative Date

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Financial Policy

Thank you for selecting Elmhurst Dermatology, P.C. for your dermatologic care. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or any laboratory fees, the following information is provided:

HMO/PPO/Other Insurance Coverage: If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a driver's license. **All co-payments are due prior to seeing the physician.** If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provider all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services by your insurance carrier as not medically necessary and/or not covered.

Medicare: Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory: Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients (Will Pay): For patients with no insurance, payment in full is due at the time of service/visit.

Cosmetic Patients: The balance of the charge is required prior to the procedure being performed.

Payments: Payments can be made by cash, check, VISA, MasterCard, or Discover.

Appointment Cancellation Fee: If you are unable to keep your appointment, please call at least 24 hours in advance and speak with a front desk representative or leave a message. If you do not give sufficient notice you may be subject to a $35 fee.

Financial Policy:

Financial Information: Either your social security number or credit card on file is required. Subsequent to your visit a claim will be processed thru your insurance. Any remaining balance (resulting from deductible, co-insurance, etc.) is then billed to you or charged to your credit card. Balances under $250 will be a one-time charge per date of service. For balances over $250, monthly increments of $250 will be charged until the balance is paid in full. All patient balances are due and payable within 30 days after insurance explanation of benefits has been received. Unpaid balances will be turned over to a collection agency after 60 days. The patient or patient guarantor, if patient is a minor, is responsible for all collection costs including agency fees of $20, attorney's fees and any costs incurred by Elmhurst Dermatology in collecting for services rendered.

Returned Checks and Collections: A charge of $40 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay the 50% fee for collections cost and/or any reasonable attorney fees.

My signature below indicates my understanding and full responsibility for the balance on my account for any professional services.

____ ____________________

Signature of Patient or Authorized Representative Date

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Credit Card on File

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time you check in. That information will be held securely until your insurances have paid their portion and notified us how much, if any, is your portion. **Any remaining balance after insurance pays that is less than $250 will be charged to the authorized card. Monthly increments of $250 will be charged for any larger balances until account is paid in full.**

This will be an advantage to you, because you will no longer have to write out and mail us a check. It will be an advantage to us as well, because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

You can think of this as much like when you check into a hotel or rent a car; you are asked for a credit card which is imprinted and later used to pay your bill.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Elmhurst Dermatology

I authorize Elmhurst Dermatology to charge outstanding patient portion balances for me and my dependents to the following credit card:

Signature ____ Date ___________________

Full name on card (please print) ____

Patient name (if other than cardholder) ____

This form is considered PATIENT SPECIFIC. If you want to cover your entire family, please request another form for each member of your family.

Bottom portion is shredded after entry into encrypted password-protected file.

☐ Visa ☐ MasterCard ☐ Discover (please select one)

Account number __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Expiration Date __ __ / __ __ Security Code __ __ __