Skin & Laser Center of NJ

Patient Information Sheet

Name: _____ Date of Birth: _____ Height:_____ Weight: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Mobile #: _____ Work #: _____

Email address: _____

Referring Doctor or How You Found Us: _____

Primary Physician (PCP): _____ PCP Address: _____

City: _____ State: _____ Zip Code: _____

Emergency Contact Name: _____ Phone #: _____

Employer: _____

Language: _____ Hispanic or non-Hispanic: _____ Race: _____ Marital Status: S M W D Sep

Gender at birth: M F Has your gender since changed? Yes No

PRIMARY INSURANCE COVERAGE:

Insurance Co: _____ Policy #: _____

Group #: _____ Specialist Copayment: _____ Subscriber's Employer:_____

Subscriber name: _____ Subscriber DOB: _____ Relationship: _____

Subscriber's address: _____ City: _____ State/Zip: _____

SECONDARY INSURANCE COVERAGE:

Insurance Co: _____ Policy #: _____

Group #: _____ Specialist Copayment: _____ Subscriber's Employer:_____

Subscriber name: _____ Subscriber DOB: _____ Relationship: _____

Subscriber's address: _____ City: _____ State/Zip: _____

We will bill your insurance company if we participate with that company. You are responsible for **any and all** charges that your insurance company does not cover. You are responsible for notifying us of any changes to your insurance. Treatments performed by the doctor (not covered by insurance) are to be paid at the time of the visit. Payments are payable at time of service. Parents are responsible for payments on minor's account. Subscribers will be billed for deductible and/or co-insurance and any additional charges as indicated by EOB. I authorize the insurance payments to go directly to physician and for release of necessary medical records to the insurance company. I understand that all tissue removed will be sent for pathologic examination at additional cost.
Managed care participants: *Although we will try to assist you as best we can, it is your responsibility to obtain referrals from your primary care physicians for each visit to our office. Even if a return visit is made for you by our office, your referral may have expired. If you are uncertain if one is current, please call our office to check at least 48 hours before your visit.*
I certify that I understand the above and that the information I have given is correct to the best of my knowledge.

X _____ Date: _____
(Patient signature; if minor then parent/guardian must sign)

Updated 8.2022

Skin & Laser Center of NJ

PATIENT HISTORY AND INTAKE FORM

Name: _____ Date of Birth: _____

Pharmacy name: _____ Pharmacy address: _____

City: _____ State: _____ Pharmacy Phone #: _____

What is the primary problem that brings you to the office today? _____

How long have you had this problem? _____

Have you been treated by another doctor for this problem? If yes, who? _____

Allergies to medications: (Please enter all known allergies AND the reaction)

_____

_____

Prescription medications: (Enter all current medications; attach list if more space is needed)

_____

_____

_____

Over-the-counter medications: (vitamins, herbs, minerals, supplements)

_____

_____

Topical skin medications / creams: (prescription and over-the-counter)

_____

_____

Did you receive the pneumonia vaccine? NO YES

Did you receive the shingles vaccine? NO YES

Did you receive the flu vaccine this year? NO YES

Did you receive the COVID vaccine? NO YES

FAMILY Skin Disease History (circle all that apply and write which relative)

Actinic keratosis (pre-cancer) _____	Allergies/Asthma _____
Abnormal moles _____	Eczema _____
Basal cell skin cancer _____	Lupus _____
Squamous cell skin cancer _____	Psoriasis _____
Melanoma _____	OTHER _____

Social History (circle answers)

Sun exposure:	Minimal	Tanning salons	NO YES IN THE PAST
	Occasional	Sunscreen routinely	NO YES
	Moderate	Number of children	_____
	Frequently	Occupation	_____
Smoking:	Current smoker – daily	**Alcohol history:**	None/Never
	Social smoker – not daily		Occasional
	Former smoker		Moderate
	Never smoker		Heavy
# years smoked	_____		

Name: _____ Date of Birth: _____

Past Surgical History (circle all that apply to you, **indicate the year it was performed**):

Appendix removal _____ Mastectomy (left or right) _____

Angioplasty/heart stent placement _____ Joint replacement _____

Bladder/Kidney surgery _____ Organ transplantation _____

Cardiac surgery _____ Skin lesion removal surgery_____

Cosmetic surgery _____ Valve replacement _____

Gynecology surgery _____ OTHER_____

Gynecologic History (**FEMALES** circle yes or no):

Do you have regular periods	NO YES	Do you take birth control pills	NO YES
Are you breastfeeding?	NO YES	Are you trying to get pregnant?	NO YES
Are you currently pregnant?	NO YES	Have you gone through menopause?	NO YES

Past Medical History (circle all that apply to you, and give details):

Anxiety _____	Diabetes_____	Radiation treatments_____
Arthritis _____	GERD/heartburn_____	Rheumatologic illness _____
Allergies/Asthma _____	High blood pressure_____	Seizures _____
Atrial fibrillation _____	High cholesterol _____	Shingles _____
Cancer (type) _____	Kidney disease _____	Stroke_____
Treatment/Year_____	Liver disease _____	Thyroid disease _____
Cardiac/heart disease _____	Low blood pressure _____	OTHER _____
Chicken Pox_____	Lung disease _____	_____
COPD/Emphysema_____	Lupus _____	_____
Depression _____	Psychiatric illness _____	_____

Skin History (circle all that apply to you, and give details)

Acne _____ Psoriasis _____

Actinic keratosis (pre-cancer) _____ Eczema_____

Asthma/allergies_____ Lupus_____

Abnormal mole _____ Sunburns in the past _____

Cosmetic procedures _____ Tanning salons (now or in the past) _____

Basal cell skin cancer (provide year and treatment)_____

Squamous cell skin cancer (provide year and treatment)_____

Melanoma (provide year and treatment) _____

Do you wear sunscreen? NO YES SPF:_____ Other skin history _____

I attest that all information provided on this form is true to my knowledge.

X _____ Date: _____

(Patient signature; if minor then parent/guardian must sign)

SKIN & LASER CENTER OF NJ

FINANCIAL POLICY

It is the **patient's responsibility** to provide all insurance information, obtain referrals, and check that the doctor is in-network, before seeing the physician. If you have provided us with a secondary insurance, we will automatically file a claim with them as soon as the primary carrier has paid. We will **not** submit to a third insurance. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. You are financially responsible for any services provided but not covered by your insurance plan as detailed on your insurance Explanation of Benefits.

It is the policy of Skin & Laser Center of NJ to treat all patients equitably related to account balances. **The practice will not waive, fail to collect, or discount** co-payments, coinsurance, deductible, or other patient financial responsibility in accordance with **State and Federal Law**, as well as participating agreements with insurance carriers.

- **INSURANCE CARDS** - must be presented at every visit. If no card is presented, you cannot be seen until the card is presented and / or proof of coverage is verified by the office.

- **CO-PAYMENTS** - By law we **MUST** collect your carrier designated copay at the time of service. Please be prepared to pay that copay at each visit upon check in. If you do not have your co-payment, your appointment may be rescheduled.

- **HIGH DEDUCTIBLES -** If your plan has a high deductible, it is our policy to request your credit card information which we will keep in a secure file until we receive the explanation of benefits (EOB) from your insurance company. We will then run your credit card to pay the balance of your responsibility as shown on the EOB.

- **REFERRALS** - If your plan requires a referral from your primary care physician it is **your** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. For subsequent visits, you can call our office in advance and we will gladly check the status of your referral. **If you do not have your referral, you will be required to reschedule your appointment.**

- **NON-PLAN PATIENTS OR COSMETIC PROCEDURES** - Payment is expected at the time of service. If applicable, you can attach the itemized receipt to your insurance form and send it to your carrier, who **MAY** reimburse you directly.

- **OUTSTANDING BALANCES** – Balances over 90 days past-due will be sent to a collection agency. Collection accounts will be subject to a 30% collection fee which will be added to the past due balance. It is the patient's responsibility to pay their balance.

- **ARRIVING LATE** – You will be given a 15 minute grace period for arriving to your appointment. If you arrive more than 15 minutes late, you will be considered a NO SHOW, and you will need to reschedule your appointment.

- **RESCHEDULING, CANCELLING APPOINTMENTS, AND NO SHOWS:**
  - No showing, rescheduling or canceling a medical appointment with less than 24 hour notice **- $50 fee**
  - No showing, rescheduling or canceling a 20 minute appointment with less than 24 hours notice - **$100 fee**
  - No showing, rescheduling or canceling a surgery/excision appointment with less than 24 hours notice - **$150 fee**
  - No showing, rescheduling or canceling a 30+ minute appointment with less than 24 hours notice - **$150 fee**

- **$50 administrative fee for patient checks returned by the bank**

- We **DO NOT** participate with **Medicaid**. **<u>If you have a Medicaid plan please advise front desk staff immediately.</u>**

You are responsible for the timely payment of your account. WE ACCEPT CASH, CHECKS, DEBIT AND CREDIT CARDS.
THANK YOU for taking the time to review our policies. Please feel free to ask any questions or share with us any concerns.

X _____ Date: _____
(Patient signature; if minor then parent/guardian must sign)

_____ Date: _____
(Patient name printed)

Updated 8.2022

SKIN & LASER CENTER OF NJ

PROTECTED HEALTH INFORMATION – USE AND DISCLOSURE FORM

With my consent, Skin & Laser Center of NJ may use and disclose protected health information to carry out treatment, payment, and healthcare operations. My provider has my consent to contact other medical professionals in an effort to provide optimal medical care.

I have the right to review the Notice of Privacy Practice prior to signing this form. Skin & Laser Center of NJ 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 Skin & Laser Center of NJ's Compliance Officer.

I allow my protected health information to be shared with the following people:

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

Name: _____ Relationship: _____ Phone number: _____

I have the right to request that SLCNJ restrict how it uses or discloses my protected health information. However, under certain circumstances, SLCNJ would not be 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 the above use and disclosure of my protected health information to carry out treatment and payment operations. I also have been given the opportunity to read the privacy policy.

I, **_____, acknowledge that I have read and understand the above.**
(patient name)

_____ Date: _____
(Patient signature; if minor then parent/guardian must sign)

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, SLCNJ may decline to provide treatment to me. If you have any questions about our Notice of Privacy Practice, please contact the office at 201-500-7525.