MORGAN DERMATOLOGY

3405 HIGHWAY 33
SECOND FLOOR
NEPTUNE, NJ 07753
TEL 732-508-9390
FAX 732-774-4028

Patient Name: _____Date: _____
First MI Last

DOB: ____/____/_____ Age: ____ SS# ____-____-_____ Gender: ___ Email: _____

Address: _____
Street APT # City State Zip Code

Home Phone: (_____) _____-_____ Mobile Phone: (_____) _____-_____

Occupation: _____ If retired, previous occupation: _____

Employer: _____
Name Address Phone

Race*: □ Asian □ Black/African American □ Caucasian □ Hispanic □ Other **Ethnicity***: □ Hispanic/Latino □ Not Hispanic/Latino

Preferred Language*: □ English □ Spanish □ Other _____*Please note these questions are asked to comply with U.S. Government requirements.

Responsible Party (if different from above):

Name: _____DOB: _____/_____/_____ Age: _____ Gender: _____
First MI Last

SS# _____-_____-_____ Home Phone: (____) _____-_____ Mobile Phone: (____) _____-_____

Address: _____
Street City State Zip Code

Primary doctor (name): _____ Practice name/ town: _____

Referring doctor (name): _____ Specialty/town: _____

Pharmacy (name): Pharmacy location:

Emergency Contact Person (name): _____

Relationship: Phone:

Primary Insurance Information

Name of your insurance: _____Policy #_____Group #_____

Subscriber of Insurance Information (if different): (Name): _____

Subscriber DOB: ___/___/_____ Subscriber SS#_____-_____-_____ Relationship: _____

Address (if different from above): _____

Secondary Insurance Information

Name of your insurance: _____Policy #_____Group #_____

Subscriber of Insurance Information (Name): _____

Subscriber DOB: ___/___/_____ Subscriber SS#_____-_____-_____ Relationship: _____

Address (if different from above):

Signature _____ Date _____

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ACKNOWLEDGEMENT OF THE RECEIPT OF NOTICE OF PRIVACY PRACTICES

WE ARE REQUIRED BY LAW TO MAINTAIN THE PRIVACY AND SECURITY OF YOUR PROTECTED HEALTH INFORMATION (PHI). WE ARE ALSO REQUIRED TO PROVIDE YOU WITH OUR NOTICE OF PRIVACY PRACTICES WHICH DESCRIBES OUR LEGAL RESPONSIBILITIES AND YOUR RIGHTS REGARDING THE USE OF YOUR PHI. YOUR SIGNATURE BELOW IS AN ACKNOWLEDGEMENT THAT YOU HAVE HAD AMPLE TIME TO READ THE NOTICE (POSTED IN THE WAITING ROOM) AND ASK QUESTIONS REGARDING ITS IMPLEMENTATION. A COPY OF THE PRIVACY PRACTICES IS AVAILABLE UPON REQUEST (PLEASE ASK FRONT DESK STAFF FOR A COPY)

Signature (Patient/ Authorized person) _____ Date _____

Designation of certain relatives, close friends and other caregivers

I agree that Morgan Dermatology, LLC may disclose certain elements of my health information to a family member, close personal friend or guardian because such a person is involved with my healthcare. In that case, Morgan Dermatology, LLC will disclose only information that is directly relevant to that person's involvement with my healthcare or payment relating to my healthcare.
I designate the following person(s) listed below as a person(s) involved in my healthcare or payment related to my healthcare for the purposes of Morgan Dermatology, LLC making the limited disclosures described above. I understand that I am not required to list anyone. I also understand that I may change this at any time in writing.
I agree that my protected health information (PHI) may be shared with the following people:

_____ _____

Signature (Patient/ Authorized person) _____ Date _____

Advanced Directive/Primary Decision Maker for patients aged 65 and older:

□ Self □ Name: _____ Relation: _____ Mobile: _____

Communication of test results:

Preferred method(s) of communication: □ Home phone □ Mobile phone □ Work phone

Is it OK to leave a detailed message on your answering machine? Yes _____ No _____

Information Release

I AUTHORIZE THE RELEASE OF MEDICAL INFORMATION TO MY REFERRING PHYSICIAN, TO CONSULTANTS IF NEEDED, AND AS NECESSARY TO PROCESS INSURANCE CLAIMS. I AUTHORIZE PAYMENT OF MEDICAL BENEFITS TO MORGAN DERMATOLOGY. I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT OF ANY AMOUNT NOT COVERED BY INSURANCE. I UNDERSTAND THAT MEDICARE AND MOST INSURANCE COMPANIES DO NOT COVER MEDICAL SERVICES THAT ARE CONSIDERED COSMETIC IN NATURE. THIS INCLUDES BUT IS NOT LIMITED TO PROCEDURES SUCH AS REMOVAL OF SKIN TAGS, UNSIGHTLY BLOOD VESSELS, BOTOX, JUVEDERM, AND RESTYLANE INJECTIONS. I ACKNOWLEDGE AND ACCEPT THE OFFICE NO-SHOW POLICY, WHICH IS A CHARGE OF $50 PER VISIT AND $150 PER SURGICAL APPOINTMENT MISSED WITHOUT 24 HOURS NOTICIFICATION.

Signature _____ Date _____

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Patient Name: _____Date_____
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Reason for visit? _____

Do you have any new or changing moles? _____

Allergies to medications _____ Food/ Latex Allergies _____

Current Medications _____

Do you take aspirin or blood thinners? _____

Do you smoke or use tobacco products? ☐ No ☐ Yes, how often? _____

Please list any previous surgeries _____

Past Medical History

Please mark any of the following conditions that you have or have had and SPECIFY BELOW:

☐ Heart murmur	☐ Artificial heart valve	☐ Artificial joint	☐ Metal prosthetic
☐ Pacemaker	☐ Other heart disease	☐ Bleeding disorder	☐ High blood pressure
☐ Liver disease	☐ Kidney disorder	☐ Thyroid disorder	☐ Cancer
☐ Asthma/ Hay fever	☐ Diabetes	☐ Neurologic condition	☐ Gastrointestinal condition
☐ Hepatitis B/C	☐ HIV/ AIDS	☐ Immune disorders	

ELABORATE HERE:

Dermatologic history: Do you have a history of any of the following skin condition? If so, please elaborate below:

☐ Skin cancer ☐ Basal cell carcinoma ☐ Squamous cell carcinoma ☐ Melanoma ☐ Other skin cancer

☐ Psoriasis ☐ Atopic dermatitis ☐ Keloids ☐ Abnormal moles

Family History:

Do you have any family history of skin cancer or skin conditions? _____

If so please explain: _____

Is there anything else we should know about your medical history? _____

Signature _____ Date _____

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PATIENT FINANCIAL LIABILITY STATEMENT AND PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

- I understand that I am personally and financially responsible for charges incurred for services rendered at Morgan Dermatology in the event that any of the following issues apply:
  - My health benefit plan requires prior authorization or referral by a primary care physician before receiving services at Morgan Dermatology
  - My health plan determines that the services I received at Morgan Dermatology are, in their opinion, not deemed medically necessary.
  - My health coverage has lapsed or expired at the time of services rendered at Morgan Dermatology
  - My health plan is not one that Morgan Dermatology has elected to participate with.
  - I have elected not to use my health insurance plan coverage or have no coverage.
- I also understand that I am responsible for all co-pays, co-insurances and deductibles under my health plan.
- I understand that I am responsible for any balances not paid by my insurance company and certify that all the information given by me is accurate for collection. I also authorize payment be made to the provider and any requested medical records required for payment of benefits be given to insurance company upon request.
- In the event of insurance denials, I hereby authorize Morgan Dermatology to act on my behalf to arbitrate with the insurance companies to resolve the issue.
- Any balances remaining unpaid by insurance for deductibles, co-payments, and co-insurances are the financial responsibility of that of the patient.

Signature _____ Date _____

CONSENT FOR PHOTOGRAPHY

I hereby consent to photographs to be taken for the purpose of medical record keeping and to be incorporated into the medical record. Photos will not be used for advertising without additional consent.

Signature _____ Date _____

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Cancellation Policy and No-Show Policy

For Doctor Appointments and Surgery

1. Cancellation/ No Show Policy for Doctor Appointment

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel and we are unable to schedule you for a visit, due to a seemingly "full" appointment book.

If an appointment is not cancelled at least 24 hours in advance you will be charged a fifty-dollar ($50) fee; this will not be covered by your insurance company.

2. Cancellation/ No Show Policy for Surgery

Due to the large block of time needed for surgery, last minute cancellations can cause problems and added expenses for the office.

If surgery is not cancelled at least 48 hours in advance you will be charged a one hundred- and fifty-dollar ($150) fee; this will not be covered by your insurance company.

3. Account balances

We will require that patients with self-pay balances do pay their account balances to zero (0) prior to receiving further services by our practice. All account balances must be current in order to receive any cosmetic treatments. Patients who have questions about their bills or who would like to discuss a payment plan option may call and ask to speak to a business office representative with whom they can review their account and concerns.

Signature _____ Date _____