MORGAN DERMATOLOGY

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

Patient Name: _____Date: _____
First M Last

DOB: ____/____/_____ Age: ____ SSN _____ Sex: ____ Email: _____

Address: _____
Street APT # City State Zip Code

Preferred Phone: _____ Alternate Phone: _____
[Mobile/Home/Work] [Mobile/Home/Work]

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 M Last

Email: _____ SSN _____-_____-_____
(Required if Insurance Subscriber)

Relationship: _____ Home Phone: _____ Mobile Phone: _____

Address: _____
Street City State Zip Code

Emergency Contact Person (name): _____
Relationship: Phone:

Primary Physician: _____ Practice name/town: _____
Ref. Physician: _____ Specialty/town: _____
Pharmacy: _____ Tel: _____ Location: _____

***Primary Insurance Information**

Name of insurance: _____Policy #_____Group #_____
Subscriber of Insurance Information (Name): _____
Subscriber DOB: ___/___/_____ Subscriber SSN_____-_____-_____ Relationship: _____

Secondary Insurance Information

Carrier _____ Policy #_____ Group #_____
Subscriber of Insurance Information (Name): _____
Subscriber DOB: ___/___/_____ Subscriber SSN_____-_____-_____ Relationship: _____

Signature _____ Date _____

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HIPAA ACKNOWLEDGEMENTS AND AUTHORIZATIONS

ACKNOWLEDGEMENT OF THE RECEIPT OF HIPAA 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 HIPAA 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 our reception) and ask questions regarding its implementation. A copy of the HIPAA Notice of Privacy Practices is available upon request at any time.

Signature (Patient/ Authorized person) _____ Date _____

Release of Medical History, Treatment, and Billing Information

I agree that Morgan Dermatology, LLC may disclose certain elements of my health information to a family member, certain relatives, close personal friend, guardian, and/or other caregivers 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 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:

Name _____ Relation _____DOB _____ Phone _____

Name _____ Relation _____DOB _____ Phone _____

Signature (Patient/ Authorized person) _____ Date _____

If you are 65 or older, do you have an Advance Directive (Living Will)? ☐ No/Self ☐ Refuse to answer

☐ Yes, Name _____ Relation _____ Mobile _____

Communication of test results: Preferred method/s of communication: □ Preferred phone □ Alternate phone

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

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, injectables such as neurotoxins and fillers. I acknowledge and accept the office no-show policy, which is a charge of $50 per appointment and $150 per surgical appointment missed without a 24-hour notification.

Signature _____ Date _____

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Patient Name _____Date_____DOB_____
First M Last

Reason for visit? _____

Do you have any new or changing moles? _____

Allergies to medications? _____ Reaction: _____

Food/Latex Allergies? ☐ No ☐ Yes, _____

Are you currently taking any medications? ☐ No ☐ Yes, _____

Do you take aspirin or blood thinners? ☐ No ☐ Yes, _____

Please list any prior surgeries _____

Past Medical History: (select all that apply and specify)

☐ Anxiety	☐ Cancer	☐ HIV/ AIDS	☐ Radiation Therapy
☐ Anemia	☐ Chemotherapy	☐ High Cholesterol	☐ Renal (Kidney) Disorder
☐ Artificial Joint Replacement	☐ Depression	☐ Hypertension	☐ Seizures / Epilepsy
☐ Artificial Cardiac Valve	☐ Diabetes	☐ Liver disease	☐ Stroke
☐ Asthma / Allergic Rhinitis	☐ Gastrointestinal disorder	☐ Metal prosthesis	☐ Thyroid disorder
☐ Autoimmune disorders	☐ Hepatitis B/C	☐ Neurologic condition	☐ Other heart disease
☐ Cardiac murmur	☐ Hemophilia	☐ Pacemaker	☐ Other: _____

ELABORATE HERE: _____

Dermatologic/Skin History: Do you have a history of any of the following skin conditions?

☐ Abnormal moles	☐ Contact Dermatitis	☐ Melanoma	☐ Hives
☐ Acne	☐ Dysplastic Nevus	☐ Psoriasis	☐ ELABORATE: _____
☐ Actinic Keratosis	☐ Eczema	☐ Pruritis of scalp	_____
☐ Atopic Dermatitis	☐ Herpes Simplex (cold sores)	☐ Squamous cell carcinoma	_____
☐ Basal cell carcinoma	☐ Keloids	☐ Severe sunburn	_____

Family History:

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

Do you have a family history of Melanoma? ☐ No ☐ Yes, _____

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

Have you had any falls within the past year? ☐ No ☐ Yes, how many falls? _____

If yes, were you injured? ☐ No ☐ Yes, please describe: _____ ☐ I do not wish to discuss this matter

Do you smoke cigarettes or use tobacco products? ☐ Never smoked ☐ Quit – former smoker ☐ Yes, _____

Alcohol use: ☐ Non-drinker ☐ Fewer than once/week ☐ 1-2 drinks ☐ 3+ drinks/day ☐ Daily ☐ Socially

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Patient Name _____ DOB _____

First M Last

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

- 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 insurance/benefit plan requires prior authorization or referral by a primary care physician before receiving services at Morgan Dermatology.
    - My health insurance/benefit 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
- I understand that I am required to provide the office with the most current and updated information for myself and my insurance, and I will be responsible for any charges incurred if the information provided is not correct or updated.
- 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
- I understand that I may incur, and am responsible for, the payment of additional charges. These charges may include, but are not limited to; A charge for returned checks, charges for missed appointments
- I understand payment is due at time of service, payable by cash, check, and major credit cards, including HSA & FSA cards
- I understand that I am ultimately responsible for the payment of my treatment and care, including Lab/Pathology fees, which are separate from typical Practice fees.

Signature _____ Date _____

CONSENT FOR PHOTOGRAPHY

I hereby consent that photographs taken at the time of my appointment for the purpose of medical record keeping will be considered a part of my medical record and will be used solely for the purpose of my treatment and medical care. Photos will not be used for anything other than treatment and medical care without additional consent.

Signature _____ Date _____

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ELECTRONIC COMMUNICATIONS

- Patient Portal - For your convenience, our practice offers secure electronic communications between you and your office via the Patient Portal. Secure messages and information can be read only by someone who knows your password to log in to the Portal site. The communications are automatically encrypted and, for those who want to participate, this secure communication can be a valuable tool to provide administrative and clinical information.

  ☐ No, I do not wish to participate ☐ Yes, my email is provided on Page 1: _____
- Appointment Reminders - As an added convenience, we offer appointment reminder phone calls and texts via an automated service. The reminders are sent using our EMR software service and cannot be used as a way for you to communicate back to us. Should you need to reach us, please call our main number (732−508-9390). If at any time you change your mind about reminders, you can opt out by following the prompts in the voice calls or texts.

  ☐ No, I do not wish to participate ☐ Yes, my phone # is provided on Page 1: _____

Signature _____ Date _____

CANCELLATION POLICY AND NO-SHOW POLICY

- **Cancellation/ No-Show Policy for Provider 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 fee will not be covered by your insurance company.
- **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 24 hours in advance you will be charged a one hundred- and fifty-dollar ($150) fee; this fee will not be covered by your insurance company.

Signature _____ Date _____

ACCOUNT BALANCES

- We will require that patients with 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 consultations or 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 our billing dept. representative with whom they can review their account and concerns.
- Kindly note that cosmetic visits may still require copay collection at the time of service, depending on the nature of the appointment and your insurance coverage. If a cosmetic consultation or visit leads to a medical evaluation, diagnosis, treatment or treatments plan/options, a claim may be submitted to your insurance provider. You will be financially responsible for any associated copays, coinsurance, and/or deductible amounts in accordance with your insurance plan.

Signature _____ Date _____