SCSPHYSICIANS skin care specialty physicians | MOHS & SKIN SURGERY CENTER

PATIENT DEMOGRAPHICS

Please *CAREFULLY REVIEW* all of your information below, and *CORRECT OR FILL OUT* any missing areas.

ID #		Address		
Last Name		City		
First Name		State & Zip		
Birthdate		Cell Phone		
Email		Home Phone		
Age		Marital Status		
Hipaa Contact Name & Relationship		Race	Ethnicity:	Language:

PLEASE LET US KNOW IF YOU ARE INTERESTED IN COSMETICS	YES or NO

	EMERGENCY CONTACT		
NAME			
NUMBER			
RELATIONSHIP			
REFERRING PHYSICIAN		PRIMARY PHYSICIAN	

	PRIMARY Health Ins Company	Policy Number	Group Number
Info			
	Insured Party (Policy Holder)	Insured Party D.O.B.	Patient's Relationship to Insured Party
Info			
	SECONDARY Health Ins Company	Policy Number	Group Number
Info			

I, ____, have received, read and agree with the Notice of Privacy Practice and the Office and Financial Policies.

Patient Signature: ____ Date: __________________________

1447 York Road | Suite 301 | Lutherville | MD 21093 | 410.252.9090 I 410.494.7064 fax

1407 York Road | Suite 100A | Lutherville | MD 21093 | 410.252.9090 | 410.494.7064 fax

FRONT DESK FORMS

Abridged Notice of Privacy Practices - Please read through and check off & sign below

A. OUR COMMITMENT TO YOUR PRIVACY

We will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. Our practice will always post a copy of our current Notice of Privacy Practices in our offices in a visible location, and you may request a full version paper copy of our most recent Notice at any

time.

B. WE MAY USE AND DISCLOSE YOUR PHI IN THE FOLLOWING WAYS

The following categories describe the different ways in which we may use and disclose your PHI: Treatment, Payment, Health Care Operations, Appointment Reminders, Treatment Options, Health-Related Benefits and Services, Release of Information to Family/Friends, Disclosures Required by Law

C. USE AND DISCLOSURE OF YOUR PHI IN CERTAIN SPECIAL CIRCUMSTANCES

Our practice may disclose your PHI to public health authorities that are authorized by law to collect information for the purpose of: Public Health Risks, Health Oversight Activities, Lawsuits and Similar Proceedings, Law Enforcement, Deceased Patients, Organ and Tissue Donation, Research, Serious Threats to Health or Safety, Military, National Security, National Security, Inmates, Workers' Compensation

D. **YOUR RIGHTS REGARDING YOUR PHI**

You have the following rights regarding the PHI that we maintain about you: Confidential Communications, Requesting Restrictions, Inspection and Copies, Amendment., Accounting of Disclosures, Right to a Paper Copy of This Notice, Right to File a Complaint, Right to Provide an Authorization for Other Uses and Disclosures

If you have questions regarding this notice or our health information privacy policies, please contact:

SKIN CARE SPECIALTY PHYSICIANS

HIPAA Security Officer

1407 - 1447 York Road, Suite 100A & 301

Lutherville, MD 21093

(410) 252 9090

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Office Policies (Updated May 2021)

These policies may change without notice. Please call the office for updated information or if you have questions.
48 HOUR NOTICE REQUIRED FOR CANCELLATION: If an appointment must be cancelled or rescheduled, the patient is required to provide at least 48 hours' notice. Each time a patient misses an appointment without providing proper notice, another patient is prevented from receiving care.
FEE & PENALTY FOR LESS THAN 48 HOUR NOTICE: Failure to do so will result in a $50 (FIFTY DOLLARS) fees for each missed appointment. If this is a surgical or a Cosmetic appointment without at least a 48 hours' notice it will result in a $100 (ONE HUNDRED DOLLARS) fees. This fee is not covered by insurance and must be paid prior to scheduling your next appointment.
NO SHOW POLICY FOR INSURANCES NOT ALLOWING LATE PENALTIES: Insurances that do not allow late penalties will still allow us to revoke patient privileges after TWO NO SHOW APPOINTMENTS.
NO SHOW CANCELLATION FEE WAIVER REQUEST: If the patient has a valid excuse for missing their appointment, they may fill out the no show cancellation fee waiver request. The no show penalty will still be due but can be waived subject to management review of the waiver form.
LATE ARRIVALS: If a patient arrives more than 15 minutes after the scheduled appointment time, the appointment may need to be rescheduled and may result in a NO SHOW fee. Please call the office if you believe that you will not arrive in time for your appointment.
PATIENT IS RESPONSIBLE FOR THE INFORMATION WE HAVE: It is the patient's responsibility to notify the office of any changes, including insurance information, phone number, address, and email.
PATIENT RESPONSIBILITY FOR REFERRALS: If an insurance policy requires the patient to obtain a referral, it will be the patient's responsibility to do so. Please note that follow-up visits are considered separate visits and may require a separate referral.
APPOINTMENT RESCHEDULING REQUIRED IF REFERRAL NOT VALID: If you do not have a valid referral, you must reschedule your appointment. If you choose to be seen, we will not submit your claim to your insurer, and you will be held financially responsible for the full amount at the time of the visit.

Financial Policies (Updated May 2021)

PAYMENT AT TIME OF SERVICE: Copayments and account balances must be paid at the time of service.
CREDIT CARD POLICY: Our practice requires that you provide us with a valid credit card, HSA or FSA card to prevent carrying balances on your account. A $100 (ONE HUNDRED DOLLAR) deposit is required if you refuse our credit card policy. Once your insurance plans have paid their portion and notified us of the amount of your share, we will submit the patient responsibility to the credit card on file. The information will be held securely in a protected system as required by law.

- The current system uses P2PE (Point-to Point Tokenization & Encryption). This is considered the most secure way of saving cards.
- The card number is never stored on the Practice Management System. The card number is immediately encrypted and tokenized once it processed. The tokenization creates a random sequence of numbers (the Token) that replaces the actual card number in our system. We store the Token, and the Card is Stored on the Stripe Platform which is PCI Level 1 Data Center Compliant.

CREDIT CARD RECEIPT BY EMAIL: You will receive a copy of the charge by e-mail. This will in no way change or 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.
OUT OF OFFICE LAB SERVICES: If lab services such as biopsies and/or bloodwork, are required, you will receive a separate bill from the lab. Questions regarding your lab bills must be directed to the lab.
FINANCIAL HARDSHIP ARRANGEMENTS: If you are experiencing financial hardship and are unable to pay your balance in full, please contact the billing department for payment arrangements. Accounts that remain past due for 120 days will be turned over to a collection agency unless payment arrangements are made.
COLLECTION AGENCY FEES: Accounts turned over to a collection agency will be charged a $30 collection fee and be reported to the credit bureau. There will a $50 fee for all returned checks.

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PAYMENT FOR COSMETIC PROCEDURES: Payment for cosmetic consultations, services and products will be collected in full at the time of service. Cosmetic procedures and products will not be billed to your insurance company. Cosmetic consultations, services and products are non-refundable and non-returnable.
INSURANCE PAYMENT FOR COSMETIC PROCEDURES: If you believe that your insurance company will pay for cosmetic services, the office will provide you with any necessary documentation that may help you receive reimbursement. Requesting reimbursement for cosmetic services is the responsibility of the patient.
SELF PAY POLICY: Patients who do not have insurance coverage, will be required to pay for their visit prior to seeing the Clinician. Fees for office visits & procedures performed will vary & will be quoted at the time of service at the discretion of our Clinicians. These charges must be paid at the time of visit.
SELF PAY FOR OUTSIDE LAB SERVICES: If lab services such as biopsies and/or bloodwork, are required, you will receive a separate bill from the lab. Questions regarding your lab bills must be directed to the lab.
INSURANCE PAYMENT DENIALS: If your insurance company denies payment of your visit for any reason, including failure to obtain a referral, you will be held responsible for the balance due. Payment arrangements may be made by contacting the billing department.
PATIENT RESPONSIBILITY FOR ACCURATE INSURANCE INFORMATION: It's your responsibility as a patient to provide our office with your current up to date insurance information. Failure to do so could result in the full balance owed as your responsibility.

******SIGNATURE**: I have read and agree with the notice of the Abridged Privacy Practices (HIPAA) and the above Office and Financial Policies for Skin Care Specialty Physicians. A complete copy of either form is available on our website; www.scsphysicians.com, or in the office. I have read the above and understand that all account balances which I incur at Skin Care Specialty Physicians are ultimately my responsibility. I authorize Skin Care Specialty Physicians to process payments for balances on my account using the credit card information which I have provided.

Patient Acknowledgement

Please check the applicable boxes and enter your name in the signature box below:

I have read and agree with the Notice of Privacy Practices and the Office and Financial Policies. _____

I agree to receiving confirmations through text messaging. ______

I have read the above and understand that all account balances which I incur at Skin Care Specialty Physicians are ultimately my responsibility. I authorize Skin Care Specialty Physicians to process payments for balances on my account using the credit card information which I have provided. _____

I have read and agree with the notice of the Abridged Privacy Practices (HIPAA) and the above Office & Financial Policies for Skin Care Specialty Physicians. A complete copy of either form is available on our website www.scsphysicians.com or in the office.

I ____________________________________ agree to the above Credit Card Policy and the Office & Financial Policy.
print name

Email:____

Signature: ___________________________________ **DATE**: ____