

Patient name: First \_\_\_\_\_ Middle \_\_\_\_\_ Last \_\_\_\_\_

Street Address \_\_\_\_\_ Town \_\_\_\_\_

Preferred phone (is this cell, work or home?) \_\_\_\_\_

Secondary phone (is this cell work or home?) \_\_\_\_\_

Email \_\_\_\_\_ SS# \_\_\_\_\_

Birth date \_\_\_\_\_ Marital status \_\_\_\_\_ Name of spouse (or partner) \_\_\_\_\_

Employer \_\_\_\_\_ Address (city) \_\_\_\_\_

(if minor) parent / medical guardian name: \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_ Town \_\_\_\_\_

|  | Yes | No |
|--|-----|----|
| May we leave a message on your answering machine?  |     |    |
| May we speak with or leave a message with your spouse / parents?<br>(if so, please list names) |     |    |
| May we contact you by cell phone?  |     |    |

**Primary** insurance company name \_\_\_\_\_

Insured name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured birth date (if different from above) \_\_\_ / \_\_\_ / \_\_\_\_\_ Insured employer \_\_\_\_\_

ID# \_\_\_\_\_ Group number \_\_\_\_\_ SS# \_\_\_\_\_

**Secondary** insurance company name \_\_\_\_\_

Insured name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Insured birth date (if different from above) \_\_\_ / \_\_\_ / \_\_\_\_\_ Insured employer \_\_\_\_\_

ID# \_\_\_\_\_ Group number \_\_\_\_\_ SS# \_\_\_\_\_

I understand that I am financially responsible for all charges for services provided to me, including the balance remaining after payment of insurance benefits. I authorize payment for medical services rendered and authorize release of any medical information necessary to process this claim.

Signed \_\_\_\_\_ Date \_\_\_ / \_\_\_ / \_\_\_

## *Eastern Connecticut Dermatology*

Patient name \_\_\_\_\_ Age \_\_\_\_\_ Today's date \_\_\_ / \_\_\_ / \_\_\_

Referring doctor \_\_\_\_\_ Referring doctor's town \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Medications \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Drug allergies \_\_\_\_\_

| Do you have, or have members of your family ever had diseases or conditions of any of the following (please explain)? |     |                                |
|---|-----|--------------------------------|
|   | YOU | FAMILY MEMBERS<br>(WHO, WHAT?) |
| Eyes  |     |                                |
| Ears/Nose/Throat  |     |                                |
| Heart   |     |                                |
| Liver   |     |                                |
| Lungs   |     |                                |
| Stomach/Bowels  |     |                                |
| Kidneys   |     |                                |
| Arthritis/Muscles/Joints  |     |                                |
| Blood pressure  |     |                                |
| Headaches/Seizures  |     |                                |
| Psychological problems  |     |                                |
| Thyroid/Diabetes  |     |                                |
| Blood/bleeding disorders  |     |                                |
| Allergic/Immunologic  |     |                                |
| Cancer  |     |                                |
| Melanoma  |     |                                |
| Psoriasis   |     |                                |
| Eczema  |     |                                |

Females only: are you pregnant, breast feeding or trying to get pregnant? (yes / no)

Do you have an artificial heart valve, joint pacemaker? Yes / No

Number of children \_\_\_\_\_ ages \_\_\_\_\_

Occupation \_\_\_\_\_ Hobbies \_\_\_\_\_

Best phone to reach you (day) \_\_\_\_\_ (night) \_\_\_\_\_

In case of emergency, please notify \_\_\_\_\_ Phone \_\_\_\_\_

PHARMACY OF CHOICE \_\_\_\_\_ TOWN \_\_\_\_\_ Reviewed by \_\_\_ (MD)

**PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE**

*Eastern Connecticut Dermatology  
491 Gold Star Highway, Suite 310  
Groton, CT 06340  
(860) 445-8020*

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PAYMENT POLICY:**

Medicare: We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% co-payment. We file with secondary/supplemental carriers. Medicare does not cover cosmetic procedures.

HMO, PPO or other managed care patients: You will responsible for paying your annual deductible, copayment and charges for any non-covered or cosmetic procedures.

Commercial Patients: Patients who are covered by private, commercial plans in which our physicians are not providers will be required to pay the bill at the time of service. The office may agree to bill insurance first in the case of expensive surgical procedures. The entire unpaid balance left after payment from your insurance will be billed to you regardless of the benefits and payment policies of your carrier.

Patient, legal guardian, or responsible party signature \_\_\_\_\_ Date: \_\_\_\_\_

**MEDICARE PATIENTS ONLY:**

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

*I authorize any holder of medical or other information about me to release to the Social Security Administration and the Centers for Medicare and Medicaid Services or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original , and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.*

Signature as it appears on Medicare Card \_\_\_\_\_ Date: \_\_\_\_\_

If you have a supplemental policy and it is MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

*I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.*

Signature as it appears on MEDIGAP card \_\_\_\_\_ Date: \_\_\_\_\_

## Acknowledgement of Notice of Privacy Practices

*Eastern Connecticut Dermatology*  
491 Gold Star Highway, Suite 310  
Groton, CT 06340  
(860) 445-8020

Patient Name \_\_\_\_\_

I hereby acknowledge that I have been offered a summary or full copy (my preference) of the Eastern Connecticut Dermatology Notice of Privacy Practices. I understand that I may request a copy of any amended Notice of Privacy Practices at any time.

Signed \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Printed name \_\_\_\_\_ Phone \_\_\_\_\_

If not signed by the patient, please indicate your relationship to the patient

\_\_\_\_\_

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For office use only:

Signed form received from \_\_\_\_\_

Refused to sign:

Reason for refusal \_\_\_\_\_

Efforts to obtain \_\_\_\_\_

***Eastern Connecticut Dermatology***  
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**For patient with high deductible plans or health savings accounts  
(Lumenos, Pequot Plus, United Healthcare)**

Due to the increased popularity of HSA/high deductible insurance policies, we have initiated a policy to cover these deductibles. Much like a hotel asks for a credit card which is later used to pay your bill, we have a similar policy.

You will be asked for a credit card number at the time of check in. Your information will be held securely until your insurance(s) have paid their portion and notified us of the amount of your share. At that time, you will be sent a statement which you have 30 days to pay. If the bill remains unpaid after 30 days, we will bill your card.

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

Co-pays due at the time of service will continue to be due at the time of service.

If you have any questions, do not hesitate to ask.

Sincerely,  
Eastern Connecticut Dermatology

I understand I am responsible for the balance of my bill after processing by my insurance. I authorize Eastern Connecticut Dermatology to charge the outstanding balance on my account to the following credit card:

Visa    Mastercard    Discover

Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

Name on card (please print) \_\_\_\_\_

Address \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

-or-

Please bill my credit card immediately for any balances due after processing my insurance.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Privacy Summary

***Eastern Connecticut Dermatology***  
***491 Gold Star Highway, Suite 310***  
***Groton, CT 06340***  
***(860) 445-8020***

Federal rules regarding the privacy of your medical records are complex. The law creates new restrictions on how medical information can be used and transmitted and requires documentation that you have been informed of these rules.

The primary intent of the HIPAA (Health Insurance Portability and Accountability Act) privacy rule is to limit the use and disclosure of your medical record. The law was prompted by the lack of unifying standards regarding protections, by concerns over internet security and by several marketing scandals created by the sale and distribution of patient mailing lists to various manufacturers.

This is a summary of our privacy policy; it does not amend or replace the full statement. The bulk of the policy statement lists the legally required exceptions to your rights to restrict information (we have an obligation to obey court orders, release of information in an emergency situation, etc.). However, there are specific rights you should know about. In general, you have a right to:

- a copy of our full Notice of Privacy Practices
- certain restrictions on how we use your medical information
- restrict communications (e.g.: don't call me at home or only call me at home...). We reserve the right to leave messages on your answering machine or send appointment reminders to your home unless you request otherwise.
- inspect or copy your medical record
- request a correction of any information which you believe to be incorrect
- specifically authorize release of information for purposes other than treatment, payment and operations (e.g.: to apply for life insurance, to participate in research or marketing activities...)
- an accounting of any disclosures of your medical record which lie outside the normal operations of our office
- complain about privacy policy issues to our Privacy Officer or to the Secretary of the Department of Health and Human Services

In general, HIPAA allows the use of your personal health information for all the immediate needs of providing care. For example, we don't need your permission to communicate with a referring physician or emergency room, for using dictation services, for billing your insurance company or for research where personal identifying information has been deleted. HIPAA requires a specific authorization for any non-approved use. Marketing activities (disclosing your name and address to a pharmaceutical or marketing firm) are specifically restricted. Since our office has never participated in this sort of marketing, we don't see that this part of the law affects us.

Please see our full Notice of Privacy Policy for more details.