

Please print clearly

Patient name: First _____ Middle _____ Last _____

Street Address _____ Town _____

Home phone _____ Work phone _____ Cell phone _____

Birth date _____ Marital status _____ Name of spouse (or parent) _____

Employer _____ Address (city) _____

Parent or guardian information: Name _____ Relationship _____

Address _____ Town _____

Preferred phone _____

	Yes	No
May we leave a message on your answering machine?		
May we speak with or leave a message with your spouse / parents? (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 _____

Secondary insurance company name _____

Insured name _____ Relationship to patient _____

Insured birth date (if different from above) ___/___/___ Insured employer _____

ID# _____ Group number _____

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 (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 _____

In case of emergency, please notify _____ Phone _____

PHARMACY OF CHOICE _____ TOWN _____

Reviewed by _____ (physician)

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

For office use only:

Signed form received from _____

Refused to sign:

Reason for refusal _____

Efforts to obtain _____

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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.