NIAGARA DERMATOLOGY ASSOCIATES, LLC

PATIENT INFORMATION FORM (Please Print Clearly and Complete All Information)

Patient Information:

Name (Last, First):_____ Date: _____

Address: _____
Street City State Zip Code

Phone (Home):_____ (Work): _____ (Cell): _____

Birth Date: _____/_____/_____ Sex: (M / F) Email: _____

Alternate Email: _____

Employer (of insured party): _____ Employer Phone: _____

Address: _____
Street City State Zip Code

Insurance Information:

Primary Insurance: _____ Secondary Insurance: _____

Policy #: _____ Policy #: _____

Group #: _____ Group #: _____

Policy Holder Name: _____ DOB: _____ SSN: _____-_____-_____

Patient Relationship to Policy Holder: _____

Physician Information:

Name of Referring Physician: _____ Phone: _____

Address: _____ City: _____ State: _____

Name of Primary Care Physician: _____ Phone: _____
(If different than referring physician)

Address: _____City: _____ State: _____

Emergency Contact:

Name: _____

Phone (Home): _____ (Cell): _____

Relationship to Patient: _____

NIAGARA DERMATOLOGY ASSOCIATES, LLC

PATIENT FINANCIAL PAYMENT POLICY

The Patient Financial Payment Policy has been developed to help our patients understand their financial responsibilities related to their healthcare and to answer any questions regarding patient and insurance responsibilities. If there are any questions regarding your healthcare benefits, you should contact your health plan with the phone number located on your insurance card. We will keep a copy of your current insurance identification card(s) in your medical chart. You are responsible to notify us of any changes to your health plan coverage.

We accept cash, checks, and all major credit cards for any payments required below. If there is any financial hardship and you are unable to make payments at the time of service, we will discuss payment options available to you. ***There will be a $25 charge for any checks returned to us.***

CO-PAYMENTS: All co-payments must be paid at the time of service.

DEDUCTIBLE PLANS: All deductibles must be paid at the time of service. We will electronically verify the current deductible amount with your health plan. If your deductible has not been met or the information is not available, you will be asked to make a ***$100*** payment if you are a new patent and a ***$75*** payment if you are an established patient toward the deductible. You will be billed for the balance after the insurance is processed.

Elective Procedures Not Covered by Insurance: You are responsible for full payment at the time of service.

Self-Pay/Uninsured: You are responsible for full payment at the time of service. The initial visit fee is ***$100***, and the follow-up visit fee is ***$75***.

No Show/Missed Appointments: If appointments are canceled ***less than 24 hours***, there will be a ***$25*** charge for any missed appointments and a ***$100*** charge for procedure appointments. This cannot be billed to your insurance carrier.

Referrals: If your benefits require referrals, it is your responsibility to make the office aware of this and verify that the referral is in place, prior to the visit, or you will be responsible for the visit.

Collection Process: All past due accounts of 120 days or more will be turned over to a collection agency unless arrangements have been made previously. The additional fees associated with the collection agency will be the responsibility of the patient. I grant permission and consent to Niagara Dermatology Associates, LLC and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations):

(1) to contact me by phone at any number associated with me, if provided by me or another person on my behalf.

(2) to leave messages for me and include in any such messages the amounts owed by me.

(3) to send me text messages or emails using any email address I provided, or any phone number associated with me, if provided by me or another person on my behalf; and

(4) to use prerecorded/artificial voice messages and/or an automated telephone dialing system (an autodialer) as defined by the Telephone Consumer Protection Act in connection with any communications made to me as provided herein or any related scheduled services and my account. I further agree to provide updated contact information to avoid unintended disclosures of my information and I accept and acknowledge that Niagara Dermatology and its agents, assignees, and contractors (which may include third-party debt collectors for past due obligations) will treat any email address or phone number I provide as my private email or phone number that is not accessible by unauthorized third parties. I understand that communication attempts will be made to my cellular phone during permitted calling hours based upon the time zone affiliated with the cellular phone number provided unless notified otherwise. I understand that my refusal to provide the information described in this paragraph will not affect, directly or indirectly, my right to receive healthcare services.

If you have any questions on the Patient's Financial Policy, please ask to speak to the Office Manager, Alyssia Vaughn, MHA.

Please understand that your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. Not all services are covered benefits in all contracts.

I have read, understand, and agree to the above policy.

_____ _____

Patient/ Guarantor Signature Date

NIAGARA DERMATOLOGY ASSOCIATES, LLC

PATIENT RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

A. I understand that I am financially responsible for my health insurance deductible, coinsurance, or non-covered service.
B. Co-payments are due at the time of service.
C. If you have a deductible plan, we will collect $100 (New Patient) and $75 (Established Patient) as a down payment for your visit.
D. If my plan requires a referral, I must obtain it prior to my visit. If no referral is on file, we will bill the patient for the office visit.
E. If my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
F. If I am uninsured, I agree to pay for the medical services rendered to me at the time of service as a self-pay patient.
G. I understand that although my insurance plan may be in-network with Niagara Dermatology, I may have contractual patient responsibility under my insurance carrier plan.
H. If your insurance carrier denies our charges, fails to pay us on time, or your account becomes delinquent, we reserve the right to refer your account to a collection agency and report it to the credit bureau. Patients who have an outstanding balance of more than 120 days must make payment arrangements prior to scheduling appointments.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to Niagara Dermatology Associates, LLC on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize Niagara Dermatology Associates, LLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to another medical provider.

_____ _____
Signature of Patient, Authorized Representative, or Responsible Party Date

_____
Print Name of Patient, Authorized Representative, or Responsible Party

_____
Relationship to Patient

NIAGARA DERMATOLOGY ASSOCIATES, LLC

NOTICE OF PRIVACY PRACTICES/HIPAA & ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have had an opportunity to review and/or receive Niagara Dermatology Associates LLC's "Notice of Privacy Practices."

1. I consent to Niagara Dermatology Associates LLC's use and disclosure of my personal health information to carry out. treatment, payment, and healthcare operations.
2. I understand this means Niagara Dermatology Associates LLC may call and leave a message on voice mail or in person in reference to any items that assist in meeting my healthcare needs, such as appointment reminders, insurance items, laboratory results, and clinical care information among others. I also understand Niagara Dermatology Associates, LLC may also mail items to my home or other designated location such as appointment reminders, statements, brochures, and other items.
3. I understand I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon prior consent. I understand if I do not sign this consent, Niagara Dermatology Associates, LLC may decline to provide treatment to me.

Patient Signature:_____ Date: _____

AUTHORIZATION FOR RELEASE OF INFORMATION TO FAMILY MEMBERS

_____ _____

Print (Name of Patient) (Date of Birth)

Many of our patients allow family members such as their spouse, parents, or others to call and request medical or billing information. Under the requirements of HIPAA, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to family members, you must sign this form. By signing this form, we will only give information to family members indicated below.

I authorize Niagara Dermatology Associates, LLC to release my medical and/or billing information to the following individual(s):

1. _____ Relationship to Patient: _____
2. _____ Relationship to Patient: _____
3. _____ Relationship to Patient: _____

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Patient's Signature:_____ Date: _____

NIAGARA DERMATOLOGY ASSOCIATES, LLC

AUTHORIZATION FOR RELEASE/DISCLOSURE OF HEALTH INFORMATION

_____ _____

(NAME / Date of Birth) (STREET ADDRESS)

_____ _____

(PHONE) (CITY, STATE, ZIP)

I AUTHORIZE:	TO RELEASE/DISCLOSE PROTECTED HEALTH INFORMATION TO:
Niagara Dermatology Associates 5320 Military Road, Suite 104 Lewiston, NY 14092 Phone: 716-205-8324 Fax: 716-205-8593	PHYSICIAN NAME
	STREET ADDRESS
	CITY, STATE, ZIP

Please release the following information:

- Surgery Notes ☐
- Last Two Office Visit Notes ☐
- Pathology Reports ☐
- All Medical Records ☐
- Other – Please Specify ☐ _____

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Niagara Dermatology Associates, LLC. Unless otherwise revoked, this authorization will expire on the following date/event or condition:

_____

I understand that any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules. If I have questions about the disclosure of my health information, I may contact Niagara Dermatology Associates.

Patient Signature:_____ Date: _____

If the patient is minor or unable to sign:

Signed by:_____ Date: _____

Relationship:_____ Date: _____

Witnessed by:_____ Date: _____

NIAGARA DERMATOLOGY ASSOCIATES, LLC

MEDICATION LIST

Patient Name:_____Date of Birth: _____

Medication Name	Dose	Frequency	Date Started