Dermatology Associates
of Western Connecticut, PC

Date of Appointment: _____ **Account #:** _____

PLEASE PRINT CLEARLY

Patient Information:

Prefix: Mr. Mrs. Miss Ms. Title: _____

First Name: _____ Middle Initial: _____ Last Name: _____

Home Address: _____

City, State, Zip Code: _____

P.O. Box: _____City, State, Zip Code: _____

SSN #: _____ Date of Birth: _____ Age: _____

Gender: _____ Marital Status: _____

Home #: _____ Work #: _____ Ext. _____ Mobile #: _____

Preferred Contact (please circle): Home Work Mobile Email: _____

In case of EMERGENCY, Please call:

First Name: _____ Last Name: _____ Relationship to Patient: _____

Emergency Contact's Home #: _____ Work #: _____ Mobile #: _____

Is the patient a student? _____ If Yes, Name of School: _____

Patient's Employer: _____

Race: _____ Ethnicity: _____ Preferred Language: _____

Full Name of the person who referred you: _____

Physician ___ Friend ___ Relative ___ Self ___ Other: _____

If Physician provide address: _____ Telephone #: _____

Primary Care Physician: _____ Telephone #: _____

Address: _____

City, State, Zip Code: _____

Pharmacy Name: _____ Pharmacy Telephone #: _____

Pharmacy Address: _____

Can we leave a message? YES NO – I give DAWC permission to leave a message on my answering machine:

If Yes, Please circle one: Home / Work / Mobile

HIPAA (must be completed):

I give DAWC permission to speak with the following person(s) regarding **any of my medical condition, lab results, or financial information:**

***** If you wish we only discuss your information with you only, please check box ☐ & Initial:** _____

First Name: _____ Last Name: _____

Relationship to Patient: _____

First Name: _____ Last Name: _____

Relationship to Patient: _____

Insurance Information: **Is Patient Self Pay? Yes No**

Does patient have Private Insurance? Yes No

Account #: ___

Must complete in order to ensure proper billing – If the patient is the POLICYHOLDER circle SELF, no need to fill out.

Primary Insurance Information:

*Insurance Company Name: _____

*Policyholder Name: _____ *Relationship to Patient: _____ / **SELF**

*Date of Birth: _____ Driver's License #: _____ SSN #: _____

*Policyholder's Address: _____

*City, State, Zip: _____

*Policyholder's Employer: _____ If unemployed, Check box ☐

*Home #: _____ Work #: _____ Ext. _____ Mobile #: _____

Secondary Insurance Information (if applicable):

*Insurance Company Name: _____

*Policyholder Name: _____ *Relationship to Patient: _____ / **SELF**

*Date of Birth: _____ Driver's License #: _____ SSN #: _____

*Policyholder's Address: _____

*City, State, Zip: _____

*Policyholder's Employer: _____ If unemployed, Check box ☐

*Home #: _____ Work #: _____ Ext. _____ Mobile #: _____

Payment/Financial Policy

Please read carefully!

We accept: VISA, MASTERCARD, AMEX, DISCOVER, CASH AND CHECKS.

For HMO, PPO, Medicare or other managed care insurance plans: You will be responsible for paying any deductibles, coinsurance, copay and charges for any non-covered cosmetic services.

Payment of copay is required at the time of service. A $10.00 surcharge will be charged to any patient that does not pay the copay at the time services are rendered.

Private Insurance Patients: Patients who are covered by private commercial plans in which our physicians are not providers will be required to pay the total bill at the time of service. An insurance claim form will be mailed to you to use for submission of the bill to your insurance carrier.

Patients with No Insurance: Full payment is required at the time of service.

For Cosmetic Or any Medically Un-necessary Procedures: Full payment is required at the time of service. If a deposit is required for a cosmetic procedure, please note that cosmetic deposits are non-refundable and will be forfeited if not used within 6 (six) months of date of deposit.

Cancellation/NO Show Policy: We require 24-hour notice for cancellations. If you fail to cancel your medical appointment within this time frame, a fee of $50.00 will be charged to your account. Cancellation/No Show of a cosmetic appointment within the 24 hour time frame will result in a $150.00 fee charged to your account. No Show/Cancellation of a Mohs appointment within the 24 hour time frame will result in a $150.00 fee charged to your account.

Returned Checks (bounced/insufficient funds): Returned checks will result in a $25.00 insufficient check charge to be added to your account balance.

Authorization, Release & Confidentiality

My signature below authorizes any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or any carrier, any information needed for this or a related Medicare or other insurance 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. I understand that DAWC may, at times, send me emails promoting health education and/or in-office promotions. I may request in writing that I do not want to receive any such emails from DAWC.

Further, my signature indicates that I understand and accept the financial policy described above. All therapeutic communications, records, and contacts with the Dermatology Associates of Western Connecticut staff will be held in strict confidence in accordance with the Health Insurance Portability & Accountability Act (HIPAA). I can request my medical records in writing via mail or FAX. If I have any questions, your staff is trained to assist me.

****

Our Notice of Privacy Practice (NPP) provides information about how we may use and disclose protected health information (PHI) about you. It discusses your rights as a patient and Dermatology Associates of Western Connecticut's duties with respect to your PHI. You have the right to review our policy before signing this acknowledgement. If we change our Notice you may obtain a revised copy by contacting our office or from our website: www.dermwestconn.com. Your signature acknowledges your receipt of our NPP. Your signature also acknowledges your receipt of our prescription refill policy.

_____ _____

Signature of patient or legal guardian Date

Patient Name: Acct#:
D.O.B: Date:

Confidential Medical History

Do you have now, or have you ever had any of the diseases or conditions listed below? (Please check YES or NO)

	YES	NO		YES	NO		YES	NO
Anxiety	☐	☐	Heart Attack	☐	☐	Parkinson's Disease	☐	☐
Arthritis/Joint Deformity	☐	☐	Heart Disease	☐	☐	Prostate Issues	☐	☐
Asthma	☐	☐	Heart Murmur	☐	☐	Prosthetic Heart Valve	☐	☐
Bell's Palsy	☐	☐	Heart Surgery	☐	☐	Reflux	☐	☐
Bipolar Disorder	☐	☐	Hepatitis	☐	☐	Rheumatic Fever	☐	☐
Bladder Issues	☐	☐	High Blood Pressure	☐	☐	Seasonal Allergies (Hayfever)	☐	☐
Bleeding Disorder	☐	☐	High Cholesterol	☐	☐	Seizures	☐	☐
Blood Clots	☐	☐	HIV (AIDS)	☐	☐	Stents	☐	☐
Cancer	☐	☐	Irregular Heartbeat	☐	☐	Stomach Issues / Ulcers	☐	☐
Type: _____			Joint Replacement	☐	☐	Stroke	☐	☐
Chest Pain	☐	☐	Kidney Issues	☐	☐	Thyroid Disorder	☐	☐
Colon / Bowel Disease	☐	☐	Lyme Disease	☐	☐	Tuberculosis	☐	☐
Congestive Heart Failure	☐	☐	Mitral Valve Prolapse	☐	☐	List any other diseases or conditions we should know about:		
Defibrillator	☐	☐	Multiple Sclerosis	☐	☐			
Depression	☐	☐	Neurological Disorders			1. _____		
Diabetes	☐	☐	Type: _____			2. _____		
Emphysema (COPD)	☐	☐	Osteoporosis	☐	☐	3. _____		
Eye Disorder	☐	☐	Pacemaker	☐	☐	4. _____		

Please list **ALL** (prescription and over the counter) medications (internal or topical) you are taking or have taken in the last 7 days:

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

	YES	NO	
Are you allergic to any medications or local anesthetics?	☐	☐	If yes, please list below:

1. _____ 2. _____ 3. _____

Please list any surgical procedures you have had in the last 6 months: _____

	YES	NO		YES	NO
Have you had any raised scarring after injury or surgery?	☐	☐	Do you pre-medicate for any medical procedures?	☐	☐

Skin History:

	YES	NO	
Have you ever had a skin cancer?	☐	☐	If yes, what type? _____
Has anyone in your family had a skin cancer?	☐	☐	If yes, who? _____
Has anyone in your family had a malignant melanoma?	☐	☐	If yes, who? _____
Have you had any specific skin diseases or skin problems?	☐	☐	If yes, please list: _____
Do you use sunscreen?	☐	☐	If yes, what type and SPF? _____

UV Exposure (check all that apply):

Avoid sun	☐
Frequently in the sun	☐
Some sun exposure	☐
Past history of tanning bed use	☐
Currently using tanning bed	☐

Sunburn History (choose one):

No history of sunburn	☐
Less than 5 sunburns	☐
More than 5 sunburns	☐
1 or more blistering sunburns	☐

Other History:

	YES	NO	
Do you drink alcohol?	☐	☐	If yes, how much? _____
Do you smoke or have a history of smoking?	☐	☐	If current, how much? _____
			If a former smoker, list start and quit date: _____
(Women) Are you pregnant?	☐	☐	If yes, due date: _____

Patient Signature: _____

Dermatology Associates
of Western Connecticut, PC

Alicia D. Zalka, M.D. Jeffrey D. Knispel, M.D. Beth A. Buscher, M.D. Kimberly M. Eickhorst, M.D.
Laurence A. Sibrack, M.D. Peter W. Heald, M.D. Carmela J. Luzi, PA-C

Credit Card on file consent form

DAWC has implemented a new policy to make paying your balance easier for you as well as us. We will collect credit card information at the time of check in. The information will be held securely until your insurance processes and pays their portion and notifies us of the amount of your share. We will then mail you a statement for the amount due by you. If your statement is not paid 30 days after it is mailed to you the balance of your account, up to $500.00 will be charged to your credit card. A copy of the charge (receipt) will be mailed to you. This will in no way compromise your ability to dispute a charge or question your insurance company's determination of payment.

DAWC requires patient to have a credit card on file with our office. Failed appointment fees will be charged automatically to that card. Per our cancellation policy if you fail to cancel an appointment 24 hours before the scheduled appointment you will be charged $50 for dermatologic appointments, $100 for cosmetic appointments and $150 for Mohs appointments.

Dermatology Associates staff will securely swipe your credit card into our system and only be able to view your name, DAWC patient account number and the last 4 digits of your debit/credit card number.

I understand that this signed form gives DAWC authorization to apply patient balances to the credit card listed below and a receipt will be mailed to my home address or email address depending on my preference.

Patient Name: _____

DAWC Patient Account Number: _____

Cardholder name: _____

Credit card type (circle one): Mastercard Visa Amex Discover

Circle one: HSA(Health Savings Account) Traditional Credit/Debit card

Email address: _____

Last 4 digits of credit card account number: _____

Cardholder signature: _____ Date: _____

Credit Card Encryption and Security Information

Dermatology Associates of Western Connecticut securely processes and stores credit and debit card information through NMI's encrypted and secure payment processing Customer Vault Interface.

NMI's Customer Vault allows DAWC to transmit their patient's payment information through a Secure Sockets Layer (SSL) connection for storage in their Level 1 PCI certified data facilities. Once the record has been securely transmitted DAWC can then initiate transactions remotely without having to access the cardholder's information directly. This process is accomplished without DAWC storing the patient's payment information in our EMR or Servers.

For more information about NMI, visit www.NMI.com

170 Mount Pleasant Road, CT 06470 • (203) 792-4151 • Fax: (203) 792-4155
120 Park Lane Rd Suite A-203 New Milford, CT 06776 • (860) 350-4152 • Fax (860) 354-3804
10 South Street Suite 204 Ridgefield, CT 06877 • (203) 438-1101 • Fax (203) 894-8357
77 Main Street North Suite 107 Southbury, CT 06488 • (203) 264-3903 • Fax (203) 264-3907