PENNSYLVANIA DERMATOLOGY GROUP, P.C.

2301 Huntingdon Pike, Suite 202
Huntingdon Valley, PA 19006
Telephone (215) 947-7500
Fax (215) 947-7501
www.paderm.com

Dear

This is to confirm your appointment at our office on: _______________ *at:* _______ ☐ *AM* ☐ *PM*

☐ *Barry S. Friter, M.D.* ☐ *Samuel L. Chachkin, M.D.* ☐ *David R. Enis, M.D., Ph.D.*

☐ *Katherine G. Evans, M.D.* ☐ *Thomas D. Regan, M.D.* ☐ *Austin Liu, M.D.*

1. Enclosed are new patient forms for you to fill out and return to the office.

2. Please bring your valid Insurance Card and photo ID at the time of your visit.

3. If you have a prior history of skin cancer, please bring your pathology reports at the time of your visit.

4. Should your insurance carrier require a referral, please contact your primary doctor's office to request a referral. **Our NPI # is 1942357454**. Upon arrival, if we have not received your referral we will have to reschedule your appointment.

5. Co-pays are most often to be paid at the time of your visit. We accept cash, checks and credit cards. We do not bill for co-payments. If you do not have your co-payment, your appointment will need to be rescheduled.

6. There will be a $40.00 charge for cancelled or missed appointments without 24 hours notice and a $125.00 charge for cancelled or missed surgical appointments.

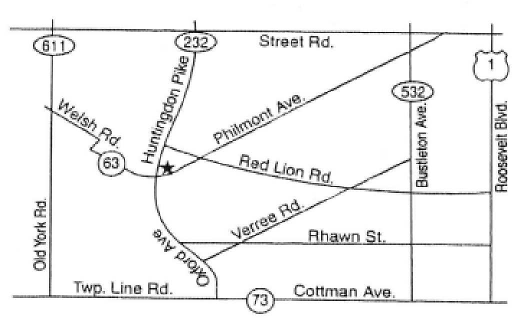
7. You may receive a courtesy call verifying the date and time of your appointment.

Thank you for your prompt response.

Sincerely,

Lynne Jastrzebski

Lynne Jastrzebski, Office Manager
Enclosures



PATIENT INFORMATION *(PLEASE PRINT)* Date ___ / ___ / ____

NAME ____
(Last) *(First)* *M.I.*

ADDRESS ____
City *State* *Zip*

Home Phone ( ) _____________ Work ( ) _____________ Cell ( ) _____________

S.S.# _______ - ____ - _______ D.O.B. _____ / _____ / _______ E-Mail Address _______________

Age ________ Sex _________ Marital Status ______________ Spouse Name _______________

INSURANCE POLICY HOLDER (If Different from information above)

Name ____
(Last) *(First)* *M.I.*

Address ____
City *State* *Zip*

Home Phone ( ) _____________ Work ( ) _____________ Cell ( ) _____________

S.S.# ______ - ____ - ______ D.O.B. ____ / ___ / _____ Age _____ Sex _____ Mar. Status _____

INSURANCE INFORMATION *(Please present insurance card at time of visit)*

Primary Insurance Name	**Secondary** Insurance Name
Policy Holder Name	Policy Holder Name
Date of Birth	Date of Birth
ID # GROUP #	ID # GROUP #
Relationship to Patient	Relationship to Patient
Employer Name	
Employer Add.	
Employer Phone	

Other Family Members that are patients ______________________________

Pharmacy of Choice ______________________________ Phone ______________

In case of Emergency, who should be notified? ______________________ Phone ______________

Referred ____

Family Physician______________________ Address ______________________

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient Signature ______________________________ **Date** _____ / _____ / ______

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable co-payments and deductibles will be collected. We accept payment in the form of **CASH, CHECK** and **CREDIT CARD**. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked pay any unmet deductibles, non-covered services and co-payments. In the event that your account must be turned over to collections, a $10.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient Signature ______________________________ **Date** _____ / _____ / ______

History and Intake Form

Patient Name: ______________________________ Date of Birth: ____________________

Address: ____

Home # _______________ Cell # _________________ Work # __________________

Email: ____

In case of Emergency, who should be notified?__________________ Phone # _________________

Past Medical History: (please circle all that apply)

Anxiety	Depression	Leukemia
Arthritis	Diabetes	Lung Cancer
Asthma	End Stage Renal Disease	Lymphoma
Atrial fibrillation	GERD	Prostate Cancer
Bone Marrow Transplantation	Hearing Loss	Radiation Treatment
BPH	Hepatitis	Seizures
Breast Cancer	High Blood pressure	Stroke
Colon Cancer	HIV/AIDS	Pacemaker
COPD	High Cholesterol	NONE
Coronary Artery Disease	Thyroid Problems [Hyper or Hypo]	

Other: ____

Past Surgical History: (please circle all that apply)

Coronary Artery Bypass	Joint Replacement, Hip (Right, Left, Bilateral)
Mechanical Valve Replacement	Joint Replacement within last 2 years
Biological Valve Replacement	Kidney Transplant
Heart Transplant	NONE
Joint Replacement, Knee (Right, Left, Bilateral)	

Other: ____

Skin Disease History: (please circle all that apply)

Acne	Dry Skin	Poison Ivy
Actinic Keratoses	Eczema	Precancerous Moles
Asthma	Flaking or Itchy Scalp	Psoriasis
Basal Cell Skin Cancer	Hay Fever/Allergies	Squamous Cell Skin Cancer
Blistering Sunburns	Melanoma	NONE

Other ____

PLEASE SEE OTHER SIDE

Reason for Visit: ____

Do you wear Sunscreen? Yes No
If yes, what SPF? __________

Do you tan in a tanning salon? Yes No

Family Skin Disease History: (please circle all that apply, SPECIFY IF OTHER)

Melanoma	Mother	Father	Sister	Brother	Daughter	Son	Other
Non-Melanoma Skin Cancer	Mother	Father	Sister	Brother	Daughter	Son	Other

Do you live in a Nursing Home, Assisted Living, or Retirement Home? Yes No

Medications: (please enter all current medications and dosages)

____
____
____
____

Allergies: (please enter all allergies)

____
____
____
____

Pharmacy Name: ____
Street: ______________________________ Zip Code: ______________
Primary Care Physician: ____
Employer: ____
Occupation: ______________________ Field of Work: ______________
Place of Birth: ____

PENNSYLVANIA DERMATOLOGY GROUP, P.C.

Acknowledgment of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgment

I ______________________________ have received a copy of this office's Notice of Privacy Practices, and have been provided an opportunity to review it.

Patient's Signature
(Or Legal Guardian if under 18)

______________________________ ____________________

(Patient's Printed Name) (Date)

With regards to telephone contact, may we:

YES NO Leave a message regarding your appointment on your answering machine, voice mail or with your spouse, a parent or other member of your household or at work, if this is the number you provide us with.

YES NO Leave a message regarding test results on your answering machine, voice mail, with your spouse, a parent or other member of your house hold. Or at work, if this is the number you provide us with.

YES NO May we give your test results to:

Spouse Parent Other designated family member

Name: ______________________________ Phone Number: ____________________

Emergency Contact: ______________________________ Phone Number: ____________________

****YOU ARE RESPONSIBLE TO NOTIFY US OF ANY CHANGES OF YOUR PRIVACY FOR THE FUTURE****

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign
Communication barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgment
Other (Please specify)______________________________

PENNSYLVANIA DERMATOLOGY GROUP, P.C.

OFFICE POLICIES FOR APPOINTMENTS

All patients are seen by appointment only. Appointment times reflect the health issues provided to the receptionist at the time your appointment is scheduled (e.g. is the visit for acne, wart treatment, total skin examination, a surgical procedure or a consultation regarding a specific skin concern). We make every effort to see you at your scheduled time. Lengthy delays most often result from patients asking for additional time to address issues other than those originally scheduled. Please be considerate of how this may impact others whose appointments follow yours. If there are multiple dermatologic concerns, which need to be addressed, you may be asked to schedule a follow up appointment so that adequate time can be allocated for each problem.

LATE ARRIVALS

Anytime you suspect you may arrive late for your appointment, please call to inform us as much in advance as possible. If you are more than 15 minutes late, it will be at the discretion of the front staff and providers to determine if there will be adequate time to see you without impacting patients whose appointments follow yours. We certainly take traffic and weather conditions into consideration, and we will always try to accommodate as we all run late sometimes. Those patients that need to reschedule their appointment will incur a cancellation fee.

CANCELLATIONS

If you are unable to attend your appointment, you are responsible for calling the office to give us a minimum of 24 hours notice. This courtesy on your part will make it possible to give the time set aside for you to another patient who needs it. Anything less than 24 hours does not allow us adequate time to ensure another patient can be scheduled. We do try and help remind you with a courtesy reminder call; however, your appointment is considered confirmed when it is made and the final responsibility for keeping scheduled appointments is yours. If appropriate notice is not given in time, you will incur a cancellation fee of $40.00 for any type of medical dermatology appointment and $125.00 for any type of surgical appointment, to cover a portion of the overhead expense incurred for each visit. A cancellation fee will also be incurred if we cannot see you because you failed to provide and/or bring with you any of these required items:

- Valid insurance card
- Photo id
- Co-pay as required by your insurance carrier
- Valid referral if required by your insurance carrier
- Custodial parent, legal guardian or written authorization to treat if the patient is a minor
- Means for full payment for self-pay patients

We reserve the right not to reschedule patients who repeatedly miss appointments.

Please sign to indicate you are aware of and agree to comply with these policies.
Print Patient Name: ________________________________ Date: ____ / _____ / _____

Signature (Parent or Guardian if minor): ______________________________________

PENNSYLVANIA DERMATOLOGY GROUP, P.C.
2301 Huntingdon Pike, Suite 202
Huntingdon Valley, PA 19006
Telephone (215) 947-7500
Fax (215) 947-7501
www.paderm.com

Barry S. Friter, M.D.
Samuel L. Chachkin, M.D.
Katherine G. Evans, M.D.
David R. Enis, M.D., Ph.D.
Thomas D. Regan, M.D.
Austin Liu, M.D.

MINOR PATIENT APPOINTMENTS

A parent or legal guardian must be present for every minor who is being seen in our office. If a parent or legal guardian is unable to accompany the minor, the patient cannot be seen. If another family member is permitted to accompany a minor, a written letter of permission will be accepted.

An authorization note will be accepted if signed by a parent or legal guardian giving permission for a patient who is 16 or older to be seen by the physician

____
Signature parent or legal guardian

PENNSYLVANIA DERMATOLOGY GROUP, P.C.

2301 Huntingdon Pike, Suite 202
Huntingdon Valley, PA 19006
Telephone (215) 947-7500 Fax (215) 947-7501

SUMMARY OF NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY. THE PRIVACY OF YOUR MEDICAL INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state laws to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003 and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including medical information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We may use and disclose your protected health information about you for treatment, payment, and health care operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditations, certifications, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or disclose it to any one for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Friends and Family: We may disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition or death. If you are present, then prior to use or disclosure of your health information we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat of your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose health information to authorized federal officials required for lawful intelligence, counterintelligence and other national security activities. We may disclose to correctional institutions or law enforcement officials having lawful custody of protected health information of inmates or patients under certain circumstances.

Test Results: We will provide test results and other medical information directly to the patient ONLY unless patient authorizes us to leave a voice message, authorizes us to provide this information to a spouse, parent, family member or caregiver.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, such as voicemail messages, postcards or letters.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your protected health information with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you requested unless we cannot practicably do so. You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based free for expenses such as copies, we will charge you $0.50 fee for each page, $20.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternate format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes other than treatment, payment, health care operations and certain other activities for the last six (6) years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or alternative locations. You must make your request in writing. Your request must specify the alternative means or location, and provide satisfactory explanation how payment will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. Your request must be in writing and it must explain why the information should be amended. We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our website or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our Privacy Practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, you disagree with a decision we made about access to your health information or to have us communicate with you by alternative means or alternative locations, you may complain to us using the contact information listed at the end of this Notice. You may submit a written complaint to the U.S. Department of Health and Human Services.

We support the right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with the U.S. Department of Health and Human Services.

Contact Officer:	Dr. Barry S. Friter
Telephone:	215-947-7500 Fax: 215-947-7501
Address:	2301 Huntingdon Pike, Suite 202 Huntingdon Valley, PA 19006