PENNSYLVANIA DERMATOLOGY GROUP
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☐

☐ *Samuel L. Chachkin, M.D.* ☐ *Katherine G. Evans, M.D.* ☐ *David R. Enis, M.D., Ph.D.*

☐ *Francesca Wolfe-Burgi, MPAS, PA-C* ☐ *Hannah Rodriguez, MPAS, PA-C* ☐ *Emily Dando, M.D.*

☐ *Austin Liu, M.D.* ☐ *Thomas D. Regan, 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. **PLEASE ARRIVE 30 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT TIME.**
3. If you have a history of skin cancer, please bring your pathology reports at the time of your visit.
4. As of January 2023, our office has implemented a credit card on file policy for insurances that have a deductible of $300 or more. Prior to your appointment, please verify with your insurance carrier whether a deductible is part of your health plan.
5. 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.
6. 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-pays. If you do not have your co-pay, your appointment will need to be rescheduled.
7. There will be a **$50.00** charge for a cancel or missed appointment without 24 hours notice and a **$125.00** charge for cancelled or missed surgical appointments.
8. You may receive a courtesy call verifying the date and time of your appointment.

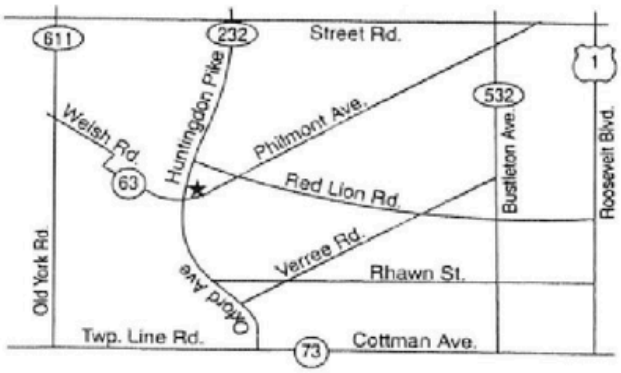
Thank you for your prompt response.

Sincerely,

Lynne Jastrzebski

Lynne Jastrzebski,

Office Manager Enclosures



PATIENT INFORMATION (PLEASE PRINT) DATE _____/_____/_____

Name_____
Last *First* *M.I.*

Address_____
Street *City* *State* *ZIP*

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

PREFERRED NUMBER (CIRCLE): HOME WORK CELL

DOB _____/_____/_____ Age _____ Sex _____ Marital Status _____ Spouse's Name_____

Email: _____

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

Primary Insurance: _____ Policy Number: _____ Group #:_____

Insurance Holder: _____
Name Date of Birth

Insurance Holder Address: _____
Street *City* *State* *ZIP*

Secondary Insurance: _____ Policy Number: _____ Group #:_____

Insurance Holder: _____
Name Date of Birth

Insurance Holder Address: _____
Street *City* *State* *ZIP*

Other family members that are patients:_____

Referred by:_____

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 to pay any unmet deductible, non-covered services and co-payments. **In the event that your account must be turned over to collections, a $50.00 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: _____

Past Medical History (please circle all that apply):

- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Bone Marrow Transplant
- ☐ Benign Prostatic Hyperplasia
- ☐ Breast Cancer
- ☐ Colon Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/AIDS
- ☐ High Cholesterol
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stroke
- ☐ Pacemaker
- ☐ NONE

Other:_____

Past Surgical History (please circle all that apply):

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

Other:_____

Skin Disease History (please circle all that apply):

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

Other:_____

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: Mother Father Sister Brother Daughter Son
Other:_____

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

Medications and Vitamins (Please enter all current medications and dosages):

_____

_____

_____

_____

Allergies:

_____

_____

_____

Pharmacy Name:_____

Street:_____

Zip Code:_____

Phone Number:_____

Prescription (Rx) Insurance Information

Plan Name:_____

RxBIN:_____

RxPCN:_____

RxGrp:_____

ID #:_____

Primary Care Physician: _____

Employer:_____

Occupation:_____ Field of Work:_____

Place of Birth:_____

PENNSYLVANIA DERMATOLOGY GROUP, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

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

Patient's Printed Name

_____ _____

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

With regards to telephone contact, may we:

YES NO Leave messages regarding test results on your answering machine, voice mail, or family member of your household.

YES NO May we give your test results to (please check):

☐ Spouse ☐ Parent ☐ Other designated family member

Their name:_____ Phone Number:_____

Emergency Contact:_____ Phone Number:_____

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

CONSENT TO MEDICAL PHOTOGRAPHY

Your doctor has determined that it may be in your best interest to obtain a photograph of your skin condition to assist with treatment. This will form part of your medical record and will be held and used strictly in accordance with your wishes which are defined below. Photographs will only be taken and used with your consent, which can be refused or limited by you. You can also change or withdraw this consent in the future. Please sign this form once you are satisfied that all of the above aspects have been explained fully to you.

	YES	NO
I consent to photographs being taken for my medical records so they may be used to identify lesions that are biopsied, should they require further treatment.		
I consent to the photographs being made available to other clinicians and clinical staff involved in my treatment.		
I consent to my photographs being used for teaching purposes, providing they are anonymous.		
I require the following restrictions to be applied to my images:		

Patient Signature:_____ Date:_____

Parent/Guardian/Caretaker Signature:_____

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 to 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 $50.00** 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.

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 of Parent or Legal Guardian

Account # _____

PENNSYLVANIA DERMATOLOGY GROUP, P.C.

EASY PAY FORM
CREDIT CARD ON FILE POLICY

Pennsylvania Dermatology Group (PDG) has simplified the collection of balances. We submit our bill (claim) to your insurance for services rendered. Once the insurance company responds with its determination of your portion of the bill, all balances will be paid by using your CREDIT/DEBIT/HSA/FSA card. Once your card numbers are entered into the system, they are held in a secure, encrypted gateway where they cannot be retrieved or changed by this office and payment is authorized only for charges submitted by this office. This policy is required and effective immediately. **Please choose one of the following options:**

- ☐ **I authorize PDG to charge my credit card for the full patient responsibility amount due once insurance processes my claim.**
- ☐ **I will pay my full patient responsibility amount due within 30 days of receipt of my statement from PDG, and if payment is not received within 30 days, I authorize PDG to charge my credit card.**

You will receive an Explanation of Benefits that details your responsibility directly from your insurance company. We will mail you a receipt confirming payment for your records.
Your email address:_____

Why is this policy necessary?
The health insurance business has gotten increasingly more difficult to understand. For example, many plans now have deductibles (the fixed amount you pay out of pocket before your health insurance plan begins to cover health care costs) and co-insurances (the amount owed after insurance processes your claim; for example, the insurance covers 80% of the allowed charges and the patient is responsible for the balance) that, unbeknownst to us, have been set by your insurance company to keep your monthly premiums lower. Rarely, services may not be covered or may be denied by your insurance company, leaving a balance on your bill. **Ultimately, it is your responsibility to know your insurance plan benefits and the extent of the coverage it provides.**

I HAVE READ AND UNDERSTAND THE CREDIT CARD ON FILE POLICY OF PENNSYLVANIA DERMATOLOGY GROUP AND AUTHORIZE USE OF MY CREDIT/DEBIT/HSA/FSA CARD TO PAY FOR CO-PAYMENTS, DEDUCTIBLES, CO-INSURANCE, AND SERVICES EITHER DETERMINED TO BE NON-COVERED OR DENIED BY MY INSURANCE.

Patient Signature:_____ Date _____/_____/_____

Signature of Parent or Guardian (if minor): _____

PENNSYLVANIA DERMATOLOGY GROUP, P.C.

2301 Huntingdon Pike, Suite 202
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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.

Pennsylvania Dermatology Group, P.C.
Insurance Network/Referral Acknowledgement

Patient's Name: _____

Patient's DOB: _____

Insurance plans vary, and patients are responsible for understanding their own insurance benefits.

I understand that it is my responsibility to verify whether Pennsylvania Dermatology Group, P.C. and my treating provider are in-network with my specific insurance plan.

Insurance information provided by the office is **not a guarantee of coverage or network status**.

If my insurance determines that the provider or services are out-of-network, **I understand that I am responsible for any resulting charges.**

If my insurance requires me to have a **referral**, I understand it is my responsibility to obtain one prior to my appointment, or **I will be responsible for any resulting charges.**

By signing below, I acknowledge that I have read and understand this policy.

Signature: _____

Date: _____

PATIENT INTAKE FORM

Every year, insurance companies require questions to be asked for improvement of the health care system. If you could please answer the following questions to help us comply with those measures.

Printed Name_____

DOB_____ MRN Number (For Staff)_____

1. What is your current smoking status?
    a. Former
    b. Current
    c. Never

2. How many times in the last year have you had 5 or more alcoholic drinks in a day?
    a. _____

3. Are you currently suffering from depression?
    a. Yes
    b. No
        i. If yes, are you currently seeking help for this? _____

4. This question is for females 65 and older only:
    a. Are you having any urine incontinence?
        i. Yes
        ii. No

Signature:_____ Date:_____