

Patient Registration Form

First Name _____ Last Name _____

Date of Birth _____ Email _____

Address _____ Apt# _____

City _____ State _____ Zip _____

Home # _____ Office # _____ Cell # _____

Gender (optional): _____ Occupation _____

Primary Care Physician(name, address, phone#) _____

Referred By: _____

Emergency Contact

Name _____ Relationship _____

Home # _____ Office # _____ Cell # _____

****Please Provide us your insurance card****

**I have reviewed list of insurance plans the Doctors accept as per NYS Surprise Bill Law
(See Attachment)**

Please sign _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____ (name of insurance co.) and assign directly Kathleen Vine, MD PC all medical benefits. I understand that I am financially responsible for all charges that are not paid by my insurance. I hereby authorize the doctor to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of insured/guardian _____ **Date** _____

HIPAA PRIVACY NOTIFICATIONS

I, the undersigned, have been issued the HIPAA NOTICE OF PRIVACY PRACTICES. I fully understand that Kathleen Vine, MD PC is required by law to maintain the privacy of my medical and health information. I acknowledge the practice will use and disclose my health information for purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of insured/guardian _____ **Date** _____

Patient Health Information

Name: _____ Date: _____

Please state the reason for your visit today: _____

Please list all allergies to medications: _____

Current medications including any aspirin and/or vitamins: _____

Pharmacy Name and Tel # _____

Please circle any of the following conditions which you have had or been treated for:

Stomach or Intestinal Problems

Liver or Gallbladder Disease, Hepatitis

Lung Disease (COPD, TB, Asthma)

Heart Disease, Rheumatic Fever

High Blood Pressure

Stroke, Heart Attack

Kidney Disease

Blood Disorder (specify): _____

Arthritis, Lupus, Joint Replacement

Diabetes

HIV/AIDS

Eye Disease (Glaucoma Corneal Transplant)

Depression

Anxiety/Thyroid Abnormalities

Cancer (Type) _____

Neurological Disorder (specify): _____

Do you smoke? Yes No

Do you have a Pacemaker or defibrillator? Yes No

Do you take antibiotics before a routine dental procedure? Yes No

Is there a history of skin cancer in your family? Yes No (specify): Melanoma, BCC, SCC

Have you previously had a skin problem? Yes No (specify): _____

Prior Hospitalization and Surgery (give dates) _____

For Women (circle): *Inform physician if you are planning or become pregnant during treatment*

Are you pregnant? Yes/No Are you breastfeeding? Yes/No Taking Birth Control? Yes/No

Patient/Guardian's Signature _____ Date _____

Patient Financial Policy

Insurance and Insurance Collection

- If you are unable to present an insurance card at the time of service, or if you are covered by an insurance company with which we are not contracted, we require that you pay for services at the time of service. If we tell you that we do not take your insurance or we are unsure if we do and you insist on being seen with your insurance, if the claim is denied then you are responsible for paying the full amount of the visit.
- Having more than one insurance does not necessarily mean that your services are covered 100%. Depending on your plan's benefits, the secondary insurers will pay as a function of what your primary insurer pays. We will bill your secondary insurer as a courtesy. You are responsible for any balances after your insurers have processed our claims. We cannot tell you beforehand how much you will have to pay.
- Important reminder for Medicare enrollees: If you qualified for Medicare and decided to enroll in a Medicare + Choice/Medicare Advantage plan (example: Empire Medibluе HMO), you may need to get a referral from your PCP before your visit with us will be covered. Please call the number on your insurance card for information for that plan.

Know Your Plan Benefits - Non Covered Services Are Your Responsibility

- Each and every insurance company, including Medicare, has different plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should understand what services are covered under your specific plan. Your insurer, not us, can assist you with any questions you have relative to your own benefits. All copayments, co-insurance, and/or deductibles are your responsibility. Co-payments are due at the time of service for every single visit. We may decline to see patients if copayments are not made at the time of the visit.
- If you are told by us or any provider that insurance covers the visit *this does not mean you do not have to pay anything*. All deductibles, co-insurance, and copayments still apply. Your insurance company will not fully pay for any visit until you have fully paid and met your deductible and out of pocket. This will be later billed to you once all claims have been processed.
- Please be aware that the physicians practicing under Kathleen Vine MDPC may provide services that may not be covered as a benefit of your specific insurance plan. Patients or Guarantors are financially responsible for any and all services provided that may not be covered by your insurance plan.
- Some procedures you may undergo will involve removing tissue. The charges for this process are known as tangential biopsy of skin and will appear on your bill if performed. Kathleen Vine MDPC sends specimens to an outside laboratory for special staining purposes, pathologic interpretation, and/or to obtain a second opinion. Kathleen Vine MDPC is not responsible for any outside laboratory charges that may be incurred. If you have a specific laboratory you would like your specimen sent to, please make the provider aware before the procedure.
- Dermatologists cannot bill for preventative care. Any copayments/deductibles/co-insurances apply for annual skin checks.

Referrals

- Some insurance companies require that patients get referrals from their primary care provider to see specialists. As a courtesy we typically let patients know if a referral is required but it is not our responsibility. Please be aware of any referrals your insurance may need, expiration dates, and amount of visits.

Return Check Fee

- There is a \$25 banking fee for all returned checks. This sum is used to offset the fees incurred by Kathleen Vine MDPC by our bank.

Missed Appointments

- There is a \$75 missed appointment fee if you cancel or reschedule an appointment with less than 24-hour advance notice, or if you fail to arrive for your scheduled appointment. Please do not rely on our automated appointment reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service, or that the phone number provided is accurate or functional for this purpose.

Cosmetic Services

- ALL cosmetic services must be paid immediately after the appointment is concluded, while physically in the office. This cannot be billed to you. You cannot leave and pay later that day. Please make sure to confirm with the provider regarding the cost of any cosmetic procedure *before* getting anything done. We offer a variety of payment options including Cash, Check, Venmo, Zelle with no fee, as well as Apple Pay/Debit/Credit Cards, which does incur a processing fee of 4%.

Patient Acknowledgement and Authorizations

I authorize Kathleen Vine MDPC to conduct examinations, and perform procedures as are medically required to administer treatment and medications as deemed necessary or advisable.

Kathleen Vine MDPC is hereby authorized to release a complete report of services rendered, diagnosis, findings, and details of treatment and progress for the purpose of receiving payments for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, Social Security Administration, or other intermediaries responsible for payment of services rendered.

Kathleen Vine MDPC will bill all primary and secondary insurances, but I am ultimately responsible for payment of services rendered.

Patient Financial Policy

Thank you for choosing Kathleen Vine MDPC (and any providers under this practice) as a healthcare provider. We are committed to your treatment being a successful experience. Please help us maintain accurate records by filling out forms legibly, and inform us if any changes need to be updated on your account (for example: address, phone number, insurance). Copayments are due at the time of service. Kathleen Vine MDPC reserves the right to send out specimens to an outside laboratory. Kathleen Vine MDPC is not responsible for any outside laboratory charges that may be incurred. It is your responsibility to know and understand your specific insurance plan and what benefits are provided. There is a \$75 fee if appointments are not canceled or rescheduled within 24 hours of your appointment. We accept all Cash, Check, Venmo, Zelle with no fee and Apple Pay/Debit/Credit cards with 4% processing fee.

I have read and agree with the Patient Acknowledgment and authorizations and Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.

PATIENT NAME (PRINTED): _____ **DOB:** ____/____/____

PATIENT OR GUARDIAN SIGNATURE: _____

DATE: ____/____/____