## New Patient Registration

| **Patient Information** | | Date: |
|---|---|---|
| Full Name: | | Date of Birth: |
| Street Address: | City: | State: Zip: |
| Home Phone: | Cell Phone: | Work Phone: |
| Email: | | Patient Gender: ☐ M ☐ F |
| SSN: | | Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed |

| **Emergency Contact Information** | | |
|---|---|---|
| Name: | | Relationship to Patient: |
| Primary Phone: | Secondary Phone: | I give UDERMIC Health permission to speak with this person in detail about my healthcare. ☐Yes ☐ No **Signature:_____** |

Signature:_____ Date: _____

## Patient Health History Questionnaire

| **Allergies and Sensitivites** | | **Past Hospitalizations/Surgeries** | |
|---|---|---|---|
| **Type** | **Reaction** | **Description** | **Date** |
| *i.e. Latex* | *Rash* | *i.e. Knee Replacement* | *Oct. 2019* |
| 1. | | 1. | |
| 2. | | 2. | |
| 3. | | 3. | |
| 4. | | 4. | |
| 5. | | 5. | |

| **Current Medications** | | | |
|---|---|---|---|
| **Name** | **Dosage** | **Frequency** | **Reason** |
| *i.e. Advil* | *200mg* | *2x daily* | *Back Pain* |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| 5. | | | |
| 6. | | | |
| 7. | | | |
| 8. | | | |

| **Preferred Pharmacy:** | **Location:** | **Phone:** |
|---|---|---|

**I acknowledge that I do not have any known drug allergies: Initials: _____**

**Any other health conditions?**

**Have you ever had skin cancer?** ☐No ☐ Yes; which type? Basal Cell Carcinoma Squamous Cell Carcinoma Melanoma Unknown Type

**Where was the skin cancer located?** **What year were you diagnosed?**_____

**Were you treated?** ☐ No ☐ Yes

**If yes, what type of treatment? (please circle one)** Excision MOHS Surgery Medication Scraping
Freezing Chemotherapy Radiation Therapy

**Have you ever had pre-skin cancer?** ☐ No ☐ Yes; Type:_____ Location:_____

**Have you ever had abnormally pigmented lesions or moles?** ☐ Yes ☐No

If unable to reach me by phone, I give permission to the physicians or staff of UDERMIC Health to release my test results to my (initial all that apply):
Spouse_____Parent_____Child_____Answering Machine_____ Other_____

## Lab services

It is your responsibility to inform our staff which lab is preferred by you and/or your insurance company at the time services are rendered that require lab services. *We typically use the following labs: LabCorp, DermPath Diagnostics, Clinical Pathology, SkinPath, or Cutaneous Pathology.* If your insurance requires a different or a particular laboratory, please let us know. **If you do not specify which laboratory during the time services are rendered that require lab services and UDERMIC Health sends the specimen to a nonpreferred lab by your insurance company, you will be responsible for any bills you receive from that lab. UDERMIC Health will not be financially responsible or held liable for any bills you receive from a nonpreferred lab.**

**Initial:**

## MISSED APPOINTMENT POLICY

Your appointment time has been reserved especially for you. If you cannot keep your appointment, please call at least 24 hours in advance to cancel or reschedule. We also reserve the right to reschedule your appointment if you are more than 15 minutes late; however, we will do our best to work you back in your provider's schedule; however, you may have an extended wait time. You may also be given an option to see another provider that may be able to see you quicker.

**Initial:**

# UDERMIC Health

## Financial Policy & Patient Responsibility Agreement

At UDERMIC Health, we are committed to providing high-quality dermatologic care while maintaining clear and transparent billing practices. We understand that medical billing and insurance can be confusing, and we appreciate the trust you place in our office.

By signing below, you acknowledge that you have read, understood, and agreed to the following policies.

### Insurance & Patient Responsibility

Your health insurance policy is a contract between you and your insurance company. While we will gladly file claims on your behalf, you are ultimately responsible for all charges related to your care.

Please bring your current insurance card(s) to every appointment. If we are unable to verify your insurance coverage at check-in, your appointment may need to be rescheduled, or you may be treated as a self-pay patient and required to pay in full prior to services being rendered.

If your insurance changes or becomes inactive, it is your responsibility to notify our office immediately.

We participate with many major insurance plans, but not all. If we are not contracted with your insurance company, we will still submit claims as a courtesy; however, you remain responsible for any unpaid balance.

Please note:
• Insurance benefit estimates are not guarantees of payment or coverage.
• Any estimates provided by UDERMIC Health are based on information available at the time and are not guarantees of insurance payment or patient responsibility.
• Your insurance company determines what services are covered and what portion of charges you are responsible for.
• Services deemed “non-covered,” “not medically necessary,” cosmetic, excluded by your plan, or denied by your insurance company remain your responsibility.

### Co-Pays, Deductibles & Coinsurance

Co-pays are required by your insurance plan and must be paid at the time of service. If you are unable to pay your co-pay, your appointment may be rescheduled.

Most insurance plans also include deductibles and/or coinsurance responsibilities. These amounts are determined by your insurance company and may apply to office visits, biopsies, injections, freezing treatments, excisions, surgeries, and other procedures.

Because many insurance companies apply services toward deductibles, you may receive a bill even after paying your co-pay at the time of your visit.

We reserve the right to collect all or part of your estimated deductible, coinsurance, or patient responsibility at the time of service.

If you have a deductible or coinsurance plan, you may be responsible for the full contracted rate of your visit and/or procedures until your deductible has been satisfied.

By electing to proceed with recommended treatment or procedures during your visit, you acknowledge financial responsibility for any applicable charges not covered by insurance.

### Referrals & Prior Authorizations

If your insurance requires a referral or prior authorization, it is your responsibility to ensure that all required approvals are obtained before your appointment or procedure.

If an authorization or referral is missing, invalid, expired, or denied, you may be financially responsible for all or part of the charges incurred.

**Billing Statements & Payments**

All insurance claims for services rendered will be submitted by our office. If there is a balance remaining after insurance processing, statements will be mailed by our local third-party billing company, Physician Technologies ("Phy-Tech").

Statements will arrive in a "Phy-Tech" envelope. It is your responsibility to:
- Maintain a current mailing address with our office
- Monitor your mail and insurance Explanation of Benefits (EOBs)
- Contact our office or Phy-Tech if your EOB shows patient responsibility and you have not received a statement

Payment is due as stated on your billing statement.

We accept cash, checks, debit cards, credit cards, and CareCredit.

Returned checks or declined payments are subject to a $35 returned payment fee.

Please note that UDERMIC Health is not responsible for payments lost in the mail.

**Cosmetic Services**

Cosmetic services are generally not billable to insurance unless otherwise specified and payment is due at the time services are rendered. Patients are encouraged to inquire about pricing prior to receiving cosmetic services or treatments.

**Self-Pay Patients**

Self-pay fees may be collected prior to your visit.

Current self-pay office visit rates:
- New Patient Visit: $265
- Established Patient Visit: $215

Office visit charges do not include procedures performed during your visit. Additional charges may apply for services such as biopsies, injections, freezing treatments, excisions, or other procedures.

Many procedures may require multiple treatments, each of which may result in additional charges. Procedure pricing may be requested prior to treatment.

Payment in full is expected at the time services are rendered.

We reserve the right to submit self-pay visits to your insurance if active coverage is identified.

**Credits & Refunds**

If an overpayment is made on your account, the credit will remain on your account for future visits unless a refund is requested. Refunds are issued on the first Wednesday of each month.

Refunds may be issued provided there are no outstanding balances owed to UDERMIC Health. Any available credit may be applied toward unpaid balances before a refund is processed.

**Insurance Processing Errors**

If your insurance company incorrectly processes or adjudicates a claim, our office will make reasonable efforts to assist in resolving the issue. This process may require your assistance if our office has exhausted all efforts.

However, if your insurance company ultimately does not correct the error or denies payment, you remain responsible for the outstanding balance.

**Outstanding Balances & Payment Arrangements**

Outstanding balances must be resolved before future appointments may be scheduled.

Payment arrangements may be made through our billing department; however, it is your responsibility to maintain those arrangements. Reminder calls for scheduled payments may not be provided.

Failure to make required payments at check-in may result in your appointment being rescheduled. Unfortunately, exceptions cannot be made based on prior billing history or insurance status.

**Delinquent Accounts & Collections**

Failure to pay outstanding balances may result in:
- Rescheduling or cancellation of future appointments
- Non-emergent appointments being postponed until account balances are resolved
- Dismissal from the practice
- Referral of your account to an outside collection agency
- Legal action to recover unpaid balances

Patients referred to collections may incur an additional 25% collection fee added to the balance owed.

Patients with accounts in bad debt status may not schedule future appointments until balances are paid in full. A delinquency notice ("Dunning Letter") will be sent prior to referral to collections whenever applicable.

Patients agree that:
- Any legal action related to unpaid balances may be filed in Columbia County, Georgia
- Any legal fees, court costs, collection costs, or related expenses incurred by UDERMIC Health in collecting unpaid balances will become the responsibility of the patient in addition to the outstanding debt

**Questions Regarding Billing**

If you have questions regarding:
- Insurance coverage
- Statements
- Procedure pricing
- Payment arrangements
- Outstanding balances

Please contact our Billing Department directly, as providers do not manage billing matters.

Our goal is to provide transparent billing and work collaboratively with our patients regarding financial responsibilities. If you have questions, please contact our Billing Department and we will be happy to assist you.

By signing below, you acknowledge that you have read, understand, and agree to the Financial Policy & Patient Responsibility Agreement in its entirety.

Patient Name: _____

Patient/Legal Guardian Signature: _____

Date: _____

Staff Initials: _____