Advanced Dermatology and Mohs Surgery
1049 East Wilson Street · Suite 190 · Batavia, IL 60510
Sharon L. Horton, M.D.

PATIENT _____
FIRST MI LAST
DATE OF BIRTH _____/_____/_____ **MARITAL STATUS**: ☐ *Single* ☐ *Married* ☐ *Widowed* ☐ *Divorced* **(Please check one)**

☐ Male ☐ Female **GENDER IDENTITY:** _____ **PREFERRED PRONOUN:** _____

ADDRESS _____ **CITY/STATE** _____ **ZIP** _____

HOME PHONE #_____ Permission to leave a detailed message **(Please type Yes or No) :** _____

WORK PHONE #_____ Permission to leave a detailed message **(Please type Yes or No) :** _____

CELL PHONE # _____ Permission to leave a detailed message **(Please type Yes or No) :** _____

CELL PHONE # _____ Permission to text you **(Please type Yes or No):** _____

EMAIL: _____ Permission to email you **(Please type Yes or No) :** _____

The following is government mandated for medical offices to ask: Preferred Language: _____

Race: □ White/Non-Hispanic □ Hispanic/Latino □ Black or African American □ Prefer not to answer
Ethnicity (list multiple) *ex/ Swedish, Russian, Mexican, Japanese* _____
Primary Care Physician: _____ Office Phone #:_____

Were you referred to this office? □ If yes, please specify: **Referring Physician** _____ Phone #: _____

EMERGENCY CONTACT Name _____Relationship _____Phone: _____

Insurance Information: MUST be filled out completely for your insurance to pay.

Primary Insurance Company: _____
Insured's Name _____ Relation to Patient _____ D.O.B. _____/_____/_____
Is insurance through an Employer? ☐Yes ☐ No Employer's Name _____ Phone # _____

Secondary Insurance Company *(if applicable):* _____
Insured's Name _____ Relation to Patient _____ D.O.B. _____/_____/_____
Is insurance through an Employer? ☐Yes ☐ No Employer's Name _____ Phone # _____

MEDICARE PATIENTS- Please complete this section

Yes	No	
☐	☐	Have you joined a Medicare HMO or Medicare Advantage (PFFS)? If yes, identify _____
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
☐	☐	Are you covered by a HMO/PPO which makes Medicare secondary?
☐	☐	Are you receiving Medicaid?

I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Advanced Dermatology and Mohs Surgery for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits related services

_____ _____
Signature Date

PATIENT SIGNATURE_____
DATE_____

PARENT/GUARDIAN SIGNATURE_____
DATE_____

Patient Name_____Age:_____Date of Birth_____

Referred By: (*Please select referral source):*

□ Physician – Please provide NAME & ADDRESS: _____

□ Insurance □ Telephone Book □ Newspaper □ Website □ Physician Referral Line

Please list your **Pharmacy Preference** (include name, phone number and address):_____

_____

Please list any medication **ALLERGIES**:_____

Please list or attach a list of all **MEDICATIONS** and **DOSAGES** you are taking by mouth (Include Aspirin, Ibuprofen, Vitamin E and Herbal Supplements):

_____

_____

_____

Please list any medications or products you are currently using on your skin:_____

_____

Chief Complaint: Problem #1 Problem #2

What is the reason for your visit? _____ _____
Where is the location of your problem? _____ _____
How long has it been present? _____ _____
Does it itch, hurt, bleed or other? _____ _____
Have you used any treatment for it? _____ _____

ROS – REVIEW OF SYMPTOMS (Please circle if you are presently experiencing any trouble with the following)

☐Fever ☐Swollen Lymph Nodes **Problems with your** – ☐Eyes ☐Ears ☐Nose ☐Mouth ☐Heart ☐Lungs ☐Stomach/bowels ☐Urinary Tract ☐Joints ☐Blood ☐Nerves ☐Mood

FOR WOMEN: Are you or could you be pregnant now? □ YES □ NO
Are you breast feeding? □ YES □ NO

PMH – PAST MEDICAL HISTORY

(Please circle any conditions you have or had)

SKIN CANCER: ☐ *Basal Cell* ☐ *Squamous Cell* ☐ *Melanoma*

Skin cancer location(s): _____

☐Keloids	☐Artificial Valve	☐Artificial Joint	☐Liver/Hepatitis	OTHER DISEASES:
☐Eczema	☐Pacemaker	☐Organ Transplant	☐Blood/Anemia	_____
☐Psoriasis	☐Defibrillator	☐Diabetes	☐Lung Disorder	_____
☐Cold Sores	☐Heart Problems	☐AIDS	☐Kidney Disorder	_____
☐Psychiatric	☐High Blood Pressure	Lupus	☐Neurologic	_____

Other Cancers:_____

History of Radiation: _____

PSH – PAST SURGICAL HISTORY: Please list any other prior surgeries, including cosmetic surgery:

_____

FH – FAMILY HISTORY: (Please circle any conditions anyone in your family has had)

☐Skin Cancer ☐Abnormal Moles ☐Hay Fever ☐Eczema ☐Asthma ☐Psoriasis

What family member has / had the condition? _____

SH – SOCIAL HISTORY: *Please* list your occupation: _____

Do you smoke? □ YES □ NO Do you drink alcohol? □ YES □ NO □ SOCIALLY

Advanced Dermatology and Mohs Surgery

1049 East Wilson Street, Ste. 190; Batavia, IL 60510
630-482-3700

STATEMENT OF FINANCIAL POLICY

Thank you for choosing us as your health care provider! We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our Statement of Financial Policy, which we require all of our patients to read, understand, and sign prior to any non-emergent treatment or care.

In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card at **each** visit. Please cooperate with our Reception Staff in providing this information.

When is Payment Due:
Payment is due at the time services are rendered in the office. To see how this affects your specific insurance situation, please discuss with the registration staff or your insurance company. ***We accept Cash, Checks, Visa, Discover and Mastercard***.

About Your Insurance Coverage:

- Commercial / Indemnity Insurance - Your policy is a contract between you and your insurance company. Since we are not a part to the contract, your account balance is your responsibility whether your insurance pays or not. As a courtesy, we will file a claim on your behalf. However, if your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow up with your insurance directly.
- Managed Care Plan (HMO, POS, PPO) - You are responsible for paying any **co-payments, deductibles, and non-covered services** at the time services are rendered. It is the patient's responsibility to verify a physician's participation in their health plan prior to making an appointment. If your plan requires a referral for **ANY** service beyond your Primary Care Physician's office, you must contact our office staff. This will allow you to obtain the necessary information and authorization for your visit. Please understand that if you fail to do so, your insurance carrier may **NOT** authorize the visit. We must comply with your insurance company's rules and will **NOT** issue a retroactive referral for services already provided by another provider.
- Medicare - As required, we will file claims with Medicare. (We are a participating provider in the Medicare program). You are responsible to pay all Medicare co-payments and for services not covered under the Medicare program (such as cosmetic services). If Medicare does not forward claim information to your secondary insurance carrier, our office will do so and attach the primary explanation of benefits.
- Self-Pay or Self-Filing - Patients who do not have insurance coverage, who are unable to provide us with valid insurance information, or who wish to file their own insurance claims are responsible to pay 100% of charges at the time services are rendered.

We offer you the opportunity to provide us with your credit card information so that we can automatically charge your account for any remaining balance AFTER INSURANCE PAYMENTS.

About our Staff:
Our staff has been trained to understand many insurance company policies, but they **DO NOT** have all the answers about your specific benefits. Please contact your employer for a copy of your *Benefits Guidebook*, or call your customer service number located on the back of your insurance I.D. card to obtain detailed information about your plan coverage. **It is your responsibility to know if we are under your insurance plan.**

Past Due Account Balances:
If your account balance becomes past due, appropriate action will be taken to collect the amount due. If you have issues that prevent you from paying the full balance due, please contact our office so we can help find a solution. If your account is in Collections, this may result in dismissal from the practice.

Returned Checks and Missed Appointments:
The fee for each check returned for insufficient funds is $25. This fee will be automatically charged to your account when your check is returned from the bank. We understand that emergencies, though rare, do occur, and are taken into consideration; however, we have invested substantial resources to provide care for you and had staff members waiting for your arrival. The courtesy of a cancellation phone call 1 business day, Monday through Friday, prior to your appointment time would be most helpful to provide care to other patients waiting to be seen. We require the 1 business day cancellation, or a $50 missed appointment fee will be charged for office visit appointments. If a surgical procedure is cancelled without 2 business day notice, a $100 fee will be charged. Due to the amount of time involved in coordinating any reconstructive surgeries, a $100.00 fee will be charged for rescheduling outside closure MOHS appointments. These fees must be paid before any future appointments can be scheduled.

Thank you for reading and understanding our Statement of Financial Policy. Please let our Practice or Office Staff know if you have any questions or concerns.

I HAVE READ THE STATEMENT OF FINANCIAL POLICY. I UNDERSTAND AND AGREE TO THE POLICY

_____
Patient's Name (Please Print)

_____ _____
Signature of Patient or Guarantor Date

ADVANCED DERMATOLOGY
AND MOHS SURGERY

1049 East Wilson Street, Suite 190
Batavia, Illinois 60510
Telephone (630) 482-3700
Fax (630) 761-8724

Credit Card Authorization

Please read this time saving policy!

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance(s) have paid their portion and notified us of the amount of your share. **At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.**

This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us, as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down. The American Medical Association estimates it costs $7 to $12 to collect $20 dollars.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-Pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, please do not hesitate to ask.

Please list other family members who are also patients in our office to include on this authorization: (ex., Son, Daughter, Husband, etc…)

Sincerely,

Sharon L. Horton, M.D.

I authorize Advanced Dermatology and Mohs Surgery to charge outstanding balances on my account to the following card:

☐ Visa ☐ MasterCard ☐ Discover

Account Number _____ Expiration Date _____

Cardholder's Name (Please print) _____

Security Code _____ Zip code: _____

Signature: _____ Date: _____

ADVANCED DERMATOLOGY AND MOHS SURGERY

CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment and continuing medical care at ADVANCED DERMATOLOGY AND MOHS SURGERY, that I authorize and consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of SHARON L. HORTON, M.D. and her assistants or her designee as is necessary in her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees will be made to me as the result of treatments or examinations by Sharon L. Horton, M.D.

MINORS must be accompanied by a parent/legal guardian for medical care. The parent/legal guardian may sign a release giving permission to Dr. Sharon L. Horton or her designee to treat the minor in the absence of the parent/legal guardian.

Outside Laboratory Charges: There may be a charge from an outside laboratory for ordered lab work and biopsies performed in our office. This bill will not come from Advanced Dermatology and Mohs Surgery and should be paid directly to the performing laboratory.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

TO BE SIGNED:

I have received and have been presented with the opportunity to review the ADVANCED DERMATOLOGY AND MOHS SURGERY Privacy Notice during this visit/prior visit. I understand that I may obtain a copy of any future revised Notices.

_____ _____

Patient / Parent / Spouse / Legal Guardian Date

Reason that Notice was not accepted or patient / representative did not acknowledge receipt:

___ ____Patient indicates received on prior visit _____ Patient declined to sign Other _____

_____Patient / Representative initials declined _____ Employee initials (if patient / representative did not accept notice)

ASSIGNMENT OF BENEFITS

In consideration of these medical services I hereby assign, transfer and set over to Advanced Dermatology and Mohs Surgery, all my rights, title, and interest to medical reimbursement benefits under my insurance policy(s) as indicated below.

AUTHORIZATION TO RELEASE INFORMATION

I authorize Sharon L. Horton, M.D. DBA Advanced Dermatology and Mohs Surgery to furnish any consulting physician or insurance company and its representative, any information or copies of all hospital, medical records including photographs, consultation and prescriptions relating to illness or injury. A copy of this authorization shall be effective and valid. This authorization may be revoked at any time.

AUTHORIZATION TO LEAVE MESSAGE

I authorize my health care provider, or a business associate of theirs, to contact me at any of the numbers or email addresses using an automatic telephone dialing system, using a pre-recorded voice or other third-party automated outreach and messaging system as well as to use my protected health information, or other personal or identifying information, during such contact for any administrative or healthcare matter. I consent to the practice, my provider, or their business associate contacting me via unencrypted email and text messaging.

PAYMENT AGREEMENT

I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient to Advanced Dermatology and Mohs Surgery. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. An assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waver of the Provider's right to require payment directly from the undersigned. The Provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to reimburse us the fees of any collection agency, which may be based on a percentage at a minimum of (40%) of the debt, and all costs and expenses, including reasonable attorney's fees we incur in such collection efforts. If the undersigned is more than one person, every obligation hereunder shall be joint and several.

All deductibles and co-pays are due at the time of service. We accept cash, checks or Visa, Discover, or Mastercard. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with that company. Necessary forms will be completed to expedite claims.

I understand and agree to the above statements. A copy of this consent/s shall be considered as valid as the original.

_____ _____

Signature of Patient / Parent / Guardian Date

Revised February 2, 2015

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AND MOHS SURGERY

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Fax (630) 761-8724

HIPAA RELEASE

(Patient Sticker)

I hereby give my consent for ADVANCED DERMATOLOGY AND MOHS SURGERY to disclose protected health information (PHI) to person(s) as designated below:

_____ / _____ / _____
NAME RELATIONSHIP PHONE NUMBER

_____ / _____ / _____
NAME RELATIONSHIP PHONE NUMBER

_____ / _____ / _____
NAME RELATIONSHIP PHONE NUMBER

_____ / _____ / _____
NAME RELATIONSHIP PHONE NUMBER

_____ _____
Patient Signature / Authorization **Date**

*** If you would like to request a restriction on certain uses or disclosures of your information please ask for an additional form. (I.e., Communicable diseases, HIV or Aids.)**