Account#____________

Patient Information

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name: ___________________________ , _____________________________ , _____ "______________"
Last *First* *M.I.* *Nickname*

Date of Birth: _____/_____/_____ Age: _______ Sex: M F

Occupation:_______________________________________

As Mandated by Federal Government and Meaningful Use Criteria:

Race ____________________ Ethnicity _______________ Preferred Language ___________________

Tobacco Use: NO YES If yes, smoker or smokeless tobacco (circle one)

Referring Physician ____, _________________________
Doctor's Name Phone Number

CONTACT INFORMATION: Check preferred contact number

Mailing Address: ____, __________________, _____ ________
City State Zip

☐ Cell Phone: _________________________ ☐ Work Phone: __________________________

☐ Home Phone: ___________________________ Email: ________________________________

ARE YOU INTERESTED IN RECEIVING OUR E-NEWSLETTER? YES NO

EMERGENCY CONTACT

Name:____Relationship:______________________________

Phone #_______________________________________

INSURANCE COVERAGE

Name of Insurance Company: ____

Insurance ID # __________________________________ Insurance Group # ________________________

Name of Policy Holder: ____________________________ Policy Holder Date of Birth: ____/____/____

Relationship to Patient:_____________ Policy Holder Gender: M or F

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given a copy of the Notice of Privacy Practices uses and disclosures.

Patient or Responsible Party Signature __________________________________ Date_____/_____/_____

Print Name of Patient or Responsible Party ________________________________

CONTINUED INFORMATION ON BACK

PATIENT COMMUNICATION AUTHORIZATION

Do you give permission allowing DANV to leave clinical information on your voicemail? Please initial ________ yes _________ no

If you anticipate that you will need or want your medical information provided to family members, friends or caretakers/babysitters please indicate below. If you do not want any of your medical information provided to a family member please check no.

Spouse:____________________________ _____yes _____no

Parent:_____________________________ _____yes _____no

Other: _____________________________ _____yes _____no

Patient or Responsible Party Signature ________________________________ Date_____/_____/_____

Print Name of Patient or Responsible Party _____________________________

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, or credit card. In the event that your account must be turned over to collections, the patient responsibility is the actual cost of collections including but not limited to court/attorney fees. In the event that an appointment is not cancelled within 24 hours, you will be charged up to a $50.00 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ________________________________ Date_____/_____/_____

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).
I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims.
A copy of this authorization may be used in the place of the original.
I understand and agree that I am financially responsible for all charges not paid by my insurance company. This authorization may be revoked by either me or my insurance carrier at any time in writing.

Patient or Responsible Party Signature________________________________ Date_____/_____/_____

Please stop by after your appointment to let us know how your experience was today by filling out a review form located in the waiting room.

PATIENT RESPONSIBILITY AGREEMENT

I understand that I must provide my insurance card and photo ID for each visit before seeing the doctor, regardless of when I was last seen.

I understand that all copayments, coinsurance and or deductibles are due at the time of service.

I understand that if I have an outstanding balance, it must be paid before seeing the doctor unless other arrangements have been made with the billing department prior to the appointment.

I understand that if my insurance requires a referral, I must have it in hand at the time of the appointment.

I understand that if I fail to cancel/reschedule my appointment at least 24 hours in advance, I will be charged a $50 fee.

I understand that all cosmetic procedures must be *paid in full* at the time services are rendered. It is my responsibility to inquire about final costs before I choose to have procedures performed.

I understand that even though the office calls to confirm my appointment, it is ultimately my responsibility to remember my appointment.

I understand there is a $35 fee for any returned checks to the office.

I understand that, unless payment arrangements have been made, any outstanding balance not paid after 2 statements will be referred to an outside agency for collection. A 33 1/3% collection fee will be added to the total balance owed.

I understand there is a $50 fee to have the provider fill out any form at my request.

I understand that any culture or biopsy specimens sent to an outside lab will be billed separately by the lab.

Do you give permission allowing DANV to leave clinical information on your voicemail? Please initial
_______yes _______no

PATIENT CONSENT

I understand that providing proof of my insurance plan does not hold DANV, Inc. responsible for verifying this information. I accept financial responsibility for any lapse in my part in providing a referral, if necessary, and/or understanding my insurance benefits at the time services are rendered. I understand that it is my responsibility to notify the office of any changes to my insurance information such as new prefix to ID #, new group #, claim submission address, etc. or personal address or phone information.

I will cooperate with the billing department of DANV, Inc. to ensure payment for my services. I understand that I will be responsible for any costs associated with the collections of my account if I default on this agreement. I understand the terms of this financial policy may be amended at any time without prior notification to me, the patient. In the event that the patient is a minor, I am the parent/legal guardian of patient and agree that I am responsible for all payment for all services rendered to the patient herein.

If you would like a copy of this notice please inform the receptionist.

____
Printed Name of Patient/Parent/Guardian

____
Signature of Patient/Parent/Guardian

____
Date

SUMMARY OF PRIVACY PRACTICES

This summary of our privacy practices contains a condensed version of our Notice of Privacy Practices. Our full-length Notice follows this summary.

Effective Date: Immediately

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.

We understand that your medical information is personal to you, and we are committed to protecting the information about you. As our patient, we create medical records about your health, our care for you, and the services and/or items we provide to you as our patient. By law, we are required to make sure that your Protected Health Information is kept private.

How will we use or disclose your information? Here are a few examples (for more detail please refer to the Notice of Privacy Practices that follows this summary):

- For medical treatment
- To obtain payment for our services
- In emergency situations
- For appointment and patient recall reminders
- To run our Practice more efficiently and ensure all our patients receive quality care
- For research
- To avert a serious threat to health or safety
- For organ and tissue donation
- For workers' compensation programs
- In response to certain requests arising out of lawsuits or other disputes

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

You have certain rights regarding the information we maintain about you. These rights include:

- The right to inspect and copy
- The right to amend
- The right to an accounting of disclosures
- The right to request restrictions
- The right to a paper copy of this notice
- The right to request confidential communications

Feel free to contact the Practice Compliance Officer, Anita Neely for more information person or in writing.

ACCOUNT # ___________

Update Patient Information

☐ Name Change ☐ Address Change ☐ Insurance Change ☐ No Change

PLEASE UPDATE APPLICABLE INFORMATION:

NAME CHANGE: Name: ___________________________ , ______________________________ , _________
Last *First* *M.I.*

As Mandated by Federal Government and Meaningful Use Criteria:

Race ____________________ Ethnicity _______________ Preferred Language _____________________

ADDRESS CHANGE:

Mailing Address: ______________________________________ ______________________, _____ _________
City *State* *Zip*

CONTACT INFO CHANGE: Check preferred contact number

☐ Cell Phone: ____________________________ ☐ Work Phone: _________________________

☐ Home Phone:___________________________ Email:_______________________________

ARE YOU INTERESTED IN RECEIVING OUR E-NEWSLETTER? YES / NO

Emergency Contact:
Name: _________________________________ Relationship: ____________________________
Phone #: _______________________________

INSURANCE CHANGE: (RESPONSIBLE PARTY FOR INSURANCE)

Name: ____ Date of Birth: ____/____/____
Last *First* *M.I.*

Address: ____ _________________________, _____ ___________
City *State* *Zip*

INSURANCE CARRIER INFORMATION:
Primary Insurance Carrier: ____________________ ID#: ____________________ GROUP#: ________________

Secondary Insurance Carrier: ___________________ ID#: ___________________ GROUP#: ________________

PLEASE SIGN SO WE MAY HAVE YOUR INSURANCE AUTHORIZATION ON FILE
I authorize any holder of medical or other information about me to release to the above insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical benefits either to myself or the party who accepts assignment.

____ **Date:**_____/_____/______
Signature of Patient or Legal Guardian

I have been given a copy of the Notice of Privacy Practices uses and disclosures.

____ **Date:**_____/_____/______
Signature of Patient or Legal Guardian

Do you give permission allowing DANV to leave clinical information on your voicemail? Please initial
_______yes _______no

Revised 04/2015

ACCOUNT#___________

DERMATOLOGY ASSOCIATES OF NORTHERN VIRGINIA

WRITTEN ACKNOWLEDGEMENT FORM

- I am a patient of DERMATOLOGY ASSOCIATES OF NORTHERN VIRGINIA and hereby acknowledge receiving a receipt of Notice of Privacy Practices.

    Name [print]: ____

    Signature: ____

    Date: _______________

- If patient is a **minor**:

    I am a parent or legal guardian of __________________________ [patient name]. I hereby acknowledge receipt of DERMATOLOGY ASSOCIATES OF NORTHERN VIRGINIA Notice of Privacy Practices with respect to the patient.

    Name [print]: ____

    Relationship to Patient: ☐ Parent ☐ Legal Guardian

    Signature: ____

    Date: __________________

PATIENT COMMUNICATION AUTHORIZATION

Do you give permission allowing DANV to leave clinical information on your voicemail? Please initial:

_____________yes _______________no

If you anticipate that you will need or want your medical information provided to family members, friends or caretakers/babysitters, please indicate below. If you do not want any of your medical information provided to a family member, please check no.

Spouse:_______________________________ _____yes ______no

Parent:________________________________ ______yes ______no

Other:_________________________________ ______yes ______no

Patient or Responsible Party Signature_____________________________ Date_____/_____/_____

HIPPA NOTICE OF PRIVACY ACT

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.

Uses and disclosures of Health Information

Dermatology Associates of Northern Virginia may use and disclose the health information we have collected about you in order to provide you treatment, obtain payment for providing your care and to conduct health care operations. Your health information will be used and disclosed for other purposes only after we have obtained your written permission. Dermatology Associates of Northern Virginia has established the following privacy practices to guard against unnecessary uses and disclosures of your health information.

When Health Information can be used or disclosed without prior authorization

There are several situations where Dermatology Associates of Northern Virginia may use and/or disclose your health information without your prior authorization and they include the following.

1. Required Uses and Disclosures
   There are only 2 situations where Dermatology Associates of Northern Virginia is required to disclose your health information. The first is when you request to view the health information we have collected about you. The second is when the Secretary of Health and Human Services requests your health information for the purpose of determining our compliance with these privacy practices.

2. To provide treatment
   Dermatology Associates of Northern Virginia may use your health information to provide your medical care. This may include sharing your health information with other health care providers to whom you might be referred. We may also share your health information with other health care providers to coordinate your care; this might include, but is not limited to, pharmacists, suppliers of medical equipment or family members you have designated to receive such information.

3. To obtain payment
   Dermatology Associates of Northern Virginia may use and/or disclose your health information when submitting claims to your insurance companies or other third parties in order to receive payment for the health care we provide.

4. For health care operations
   We may also use and/or disclose your health information when conducting our own business operations and when this is necessary to provided quality care for our patients. Such health care operations may include, but is not limited to, quality assessments and improvement activities, activities designed to improve quality of care, professional review and performance evaluations, business planning or development and administrative activities.

5. When legally required
   Dermatology Associates of Northern Virginia will disclose your health information when required to do so by any Federal, State, or local law.

6. When there are risks to the Public Health
   Dermatology Associates of Northern Virginia may also disclose your health information for certain public health activities such as to prevent or control diseases, to report an injury, disease or death, to report adverse events to medications or treatments or to an employer when legally required.

7. To report abuse or domestic violence
   We may also report your health information to government or legal authorities if we believe, in good faith, that abuse or domestic violence has occurred. This disclosure of your health information will occur only if required by law to do so or after you have agreed to the disclosure.

8. To conduct health oversight activities
   Dermatology Associates of Northern Virginia may disclose your health information to a health oversight agency for the purpose of audits, inspections, licensure actions or criminal investigations. We may not disclose your health information if you are the subject of an investigation and your health information are not directly related to your receipt of health care or public benefits.

9. For judicial and administrative proceeding
   Dermatology Associates of Northern Virginia may disclose your health information in response to a court order or an authorized administrative tribunal. We will make reasonable efforts to notify you of such a request.

10. For law enforcement activities
    Dermatology Associates of Northern Virginia may disclose your health information to law enforcement officials as required by law for reporting of certain wounds (such as stab wounds), to help identify or locate a suspect, witness or missing person or if you are the victim of a crime or there is an emergency to report a crime.

11. To coroners, funeral directors or organ procurement organizations
    We may also disclose your health information to a coroner or medical examiner to determine a cause of death or for other duties; to funeral directors to help carry out their duties; and to organ procurement organizations for the purpose of facilitating donation and transplantation.

12. In the event of a serious threat
    Dermatology Associates of Northern Virginia may also disclose your personal health information if we believe in good faith that such disclosure is necessary due to a serious threat to your health or safety.

13. For specialized government functions
    Dermatology Associates of Northern Virginia may also disclose your health information for specialized government functions such as relating to national security, protecting the President and others, medical suitability determinations, inmates and law enforcement custody.

14. For Workman's compensation
    We may disclose your health information for workman's compensation or other similar programs.

Except for all the above circumstances, Dermatology Associates of Northern Virginia will not use or disclose your health information without first notifying you and obtaining your authorization to do so. If you do not agree to such uses or disclosure, Dermatology Associates of Northern Virginia will not use or disclose your health information for that purpose. If you agree to such a use or disclosure, you may revoke that authorization at any time by submitting a written request.

Patient Rights

All patients have the following rights:

1. Right to request restrictions
   You have the right to request restrictions on certain uses and disclosures of your health information but Dermatology Associates of Northern Virginia is not required to agree to such restrictions. If you would like to request a restriction, please contact our Privacy Officer and you will be given a form to complete requesting the restriction.

2. Right to confidential communication
   You also have the right to request that Dermatology Associates of Northern Virginia communicates with you in a particular way for example you may want to receive all communications about your health without any family members being present. Dermatology Associates of Northern Virginia will not require any reason for such a request and will do its best to honor your request. If you would like to make a special communication request, please contact our Privacy Officer and you will be given a form to complete.

3. Right to view and copy
   You have the right to inspect and copy your health information including the billing records. We may charge you a reasonable fee for assembling and copying your health information.

4. Right to amend
   You also have the right to amend your health care information if you believe it is incorrect or incomplete. A request to amend your records must be made in writing and describe the reasons why such an amendment is being requested. Dermatology Associates of Northern Virginia reserves the right to deny such a request if the information was not created by Dermatology Associates of Northern Virginia if the information is not part of our records, if you are not permitted to inspect or copy that part of the health information, or if Dermatology Associates of Northern Virginia believes the records are complete and accurate. If we deny the request for amending your health information, we will notify you in writing the reasons for the denial.

5. Right to an accounting of disclosures
   You have the right to request an accounting of the disclosures of your health information made by Dermatology Associates of Northern Virginia for any reason other than treatment, payment or health care operations. This request must be in writing, specify the time period for accounting and be limited to the last 6 years. The first request during any 12 month period will incur no charges but Dermatology Associates of Northern Virginia will charge a reasonable fee for additional requests.

6. Right to receive a paper copy of the Notice of Privacy Practices
   You also have the right to receive a copy of the Notice of Privacy Practice at any time, even if you have received it previously or have viewed it electronically.

To make any of the above mentioned requests, please contact our Privacy Officer at 703-222-2773 and 13890 Braddock Rd, Suite 310, Centreville, VA, 20121.

Dermatology Associates of Northern Virginia is very concerned about protecting your privacy and we are required by law to maintain the privacy of your health information and to provide you with a copy of this Notice of Privacy Practices. Dermatology Associates of Northern Virginia is required to abide by the terms set forth in this privacy notice but we reserve the right to change the terms and to make the new privacy notice effective for all the health information we maintain. If Dermatology Associates of Northern Virginia changes the privacy notice, we will post the new notice in a prominent location within our offices and provide you with a copy of the revised notice.

Complaints

You may complain at any time to our Privacy Officer or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. Any complaint should be made in writing. We encourage you to voice any concerns you have regarding our privacy practices and we will not retaliate against you for filing a complaint.

Contact Person

The contact person for Dermatology Associates of Northern Virginia to whom you may direct any privacy questions, submit special requests or file a complaint is our Privacy Officer. They may be contacted by calling 703-222-2773 or writing to the Privacy Officer of Dermatology Associates of Northern Virginia at 13890 Braddock Rd, Suite 310, Centreville, VA, 20121 or 21495 Ridgetop Circle, Suite 105 Sterling, VA 20166.

Effective Date: This Notice of Privacy Practices for Dermatology Associates of Northern Virginia is effective April 14, 2003.

Minor Consent Form

I, ___________________________________

(*Parent/Guardian Name*)

give permission for my son/daughter to be treated by Dermatology Associates of Northern Virginia without my presence. *Treatment includes assessing skin conditions and prescribing appropriate medications. It also includes minor surgical procedures, such as cyrotherapy, use of cantherone, corticosteroid injections, electrodessication, shave biopsies, and punch biopsies.* I do not hold the physician liable for any misunderstanding or miscommunication that might occur during my absence.

I also understand that copayment is due at the time of service, whether I am present or not. I will provide cash, check, or a credit card/number to the office to cover any costs incurred before my child is seen.

Contact Number: ________________________

____

Patient Name

____

Parent/Legal Guardian Signature

Date: _____________

Dermatology Associates of Northern Virginia, Inc.
DANV

Account # ____________

Medicare Patient Information

THIS SECTION MUST BE COMPLETED FOR ALL PATIENTS:

Name: ___________________________ ,____________________________ ,_____ "______________"
Last *First* *M.I.* *Nickname*

Date of Birth: ____/____/____ Age: _______ Sex: M / F

As Mandated by Federal Government and Meaningful Use Criteria:

Race ___________________ Ethnicity _______________ Preferred Language ___________________

Tobacco Use: NO YES If yes, smoker or smokeless tobacco (circle one)

Referring Physician ____, ______________________________
Doctor's Name Phone Number

CONTACT INFORMATION: Check preferred contact number

Mailing Address: ____, _______________________ ________
City State Zip

☐ Cell Phone: ________________________

☐ Home Phone: _________________________ Email: ___________________________________

ARE YOU INTERESTED IN RECEIVING OUR E-NEWSLETTER? YES NO

EMERGENCY CONTACT

Name:____Relationship:_________________________________

Phone #_______________________________________ Alternative Phone #____________________________

INSURANCE COVERAGE

Medicare ID Number (Social Security Number): __________________

Secondary Insurance Carrier: ___________________ ID#: ___________________ GROUP#:____________

Name of Policy Holder ____________________________ Relationship to Patient: _____________________

Policy Holder Date of Birth: ____/____/____

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given a copy of the Notice of Privacy Practices uses and disclosures.

__________________________________ _________________________________ Date_____/_____/_____
Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

PATIENT COMMUNICATION AUTHORIZATION

Do you give permission allowing DANV to leave clinical information on your voicemail? Please initial
__________yes _________no

If you anticipate that you will need or want your medical information provided to family members, friends or caretakers/babysitters please indicate below. If you do not want any of your medical information provided to a family member please check no.

Spouse:_____________________________ ______yes _______no

Child:_______________________________ ______yes _______no

Other:_______________________________ ______yes _______no

__________________________________ _________________________________ Date_____/_____/_____
Print Name of Patient or Legal Guardian Signature of Patient or Legal Guardian

Please Sign So We May Have Your Medicare Authorization On File:
I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Date: _____/_____/_____ Signature: ____

Please Sign So We May Have Your Supplemental Authorization On File:
I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits or the benefits payable for related services.

Date: _____/_____/_____ Signature: ____

Payment Policy
Medicare: **We are participating providers of the Medicare Program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the co-payment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be balance billed.**
Note: If you have recently joined (or changed) to a Medicare HMO, please let our staff know so we can update your records and advise you if we are participating providers

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, or credit card. In the event that your account must be turned over to collections, the patient responsibility is the actual cost of collections including but not limited to court/attorney fees. In the event that an appointment is not cancelled within 24 hours, you will be charged up to a $50.00 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature _______________________________________ Date _____/_____/_____

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).
I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims.
A copy of this authorization may be used in the place of the original.
I understand and agree that I am financially responsible for all charges not paid by my insurance company.
This authorization may be revoked by either me or my insurance carrier at any time in writing.

Patient or Responsible Party Signature _______________________________________ Date _____/_____/_____

I understand that in certain circumstances Medicare may decide that appropriate medical services are not medically reasonable or necessary under the Medicare law. I agree to be personally responsible for payment of these charges.

Patient or Responsible Party Signature _______________________________________ Date _____/_____/_____

Please stop by after your appointment to let us know how your experience was today by filling out a review form located in the waiting room.

Dermatology Associates of Northern Virginia, Inc. DANV

Minor Patient Registration Form

Minor's Name:____
First M.I Last

Date of Birth: _____/_____/_____ Age: _______ Sex: M F

As Mandated by Federal Government and Meaningful Use Criteria:

Race_____________________ Ethnicity____________________ Preferred Language______________________

Tobacco Use: No Yes If yes: smoker or smokeless tobacco (circle one only if minor is 13 or older)

Referring Physician: ____________________________________Phone #_________________________________

PARENT OR LEGAL GUARDIAN CONTACT INFORMATION

Name:____
Last First M.I

Address: ____
City State Zip

Check preferred contact number

- ☐ Cell Phone:____________________________ ☐ Work Phone: ___________________________
- ☐ Home Phone: _________________________ Email Address:_____________________________

ARE YOU INTERESTED IN RECEIVING OUR E-NEWSLETTER? YES NO

INSURANCE COVERAGE

Insurance Co. Name and ID # : ______________________________Group #_________________________________

Name of Policy Holder (insured) ____

Policy Holder (insured) Date of Birth: _____/_____/_____ Relationship to Patient: __________________________

Emergency Contact Information:

Emergency Contact: ________________________________ Relationship to Patient: __________________________

Phone: ______________________________________ Alternate Phone:____________________________________

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I have been given a copy of the Notice of Privacy Practices uses and disclosures.

Patient or Responsible Party Signature ___________________________________ Date_____/_____/_____

Print Name of Patient or Responsible Party ____

CONTINUED INFORMATION ON BACK

PATIENT COMMUNICATION AUTHORIZATION

Do you give permission allowing DANV to leave clinical information on your voicemail? Please initial
_________yes __________no

If you anticipate that you will need or want your medical information provided to family members, friends or caretakers/babysitters please indicate below. If you do not want any of your medical information provided to a family member please check no.

Parent:____ ______yes ______no

Other:____ ______yes ______no

Patient or Responsible Party Signature ________________________________ Date_____/_____/_____

Print Name of Patient or Responsible Party ____

Minor Consent

*(Please **ONLY** fill this part out if you allow your child to be seen without your presence)*

I, ____
(*Parent/Guardian Name*)
give permission for my son/daughter to be treated by Dermatology Associates of Northern Virginia without my presence. *Treatment includes assessing skin conditions and prescribing appropriate medications. It also includes minor surgical procedures, such as cyrotherapy, use of cantherone, corticosteroid injections, electrodessication, shave biopsies, and punch biopsies.* I do not hold the physician liable for any misunderstanding or miscommunication that might occur during my absence. I also understand that copayment is due at the time of service, whether I am present or not. I will provide cash, check, or a credit card/number to the office to cover any costs incurred before my child is seen.

Patient or Responsible Party Signature ____ Date _____/_____/_____

Payment Policy

The Adult/Guardian who brings in the child will be responsible for all co-payments and deductibles. We do not forward bills to other parties regardless of court rulings or divorce decrees.

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, or credit card. In the event that your account must be turned over to collections, the patient responsibility is the actual cost of collections including but not limited to court/attorney fees. In the event that an appointment is not cancelled within 24 hours, you will be charged up to a $50.00 fee. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ____ Date _____/_____/_____

I hereby authorize this physician to apply for benefits on my behalf for covered services rendered. I certify that the information I have reported with regard to my insurance coverage is correct, I further authorize the release of any necessary information, including medical information for this or any related claim, to my insurance carrier, (or in the case of Medicare part B benefits to the social security administration and healthcare financing administration).
I hereby authorize payment of all medical insurance benefits which are payable to me under the terms of my insurance policy to be paid directly to this physician for services rendered. I further authorize the release of any information needed for processing of my insurance claims. A copy of this authorization may be used in the place of the original.
I understand and agree that I am financially responsible for all charges not paid by my insurance company.
This authorization may be revoked by either me or my insurance carrier at any time in writing.

Patient or Responsible Party Signature ____ Date _____/_____/_____