# A David Gerstein MD, PC

*Dermatology and Dermatological Surgery*
*www.meridiandermatology.com*

*8801 N Meridian St.*
*Suite 107*
*Indianapolis, IN 46260*

*Phone 317-848-3408*
*Fax 317-843- 2242*

## Financial Policy and Patient Liability

The physicians and staff are committed to providing you with the finest care possible. It is our feeling the energies and personnel functions of this office must be geared toward patient centered medical care, not financial record keeping. To achieve this goal, it is important you have a clear understanding of our financial policy.

*IT IS IMPORTANT YOU UNDERSTAND THE FOLLOWING*:

Your insurance plan is a legal document between YOU and your insurance company. All fees incurred with this office are your responsibility for payment. Insurance is a means of payment and not a transfer of personal responsibility. We cannot render services on the assumption our charges will be paid by an insurance company. All services are charged directly to the patient, and he or she remains personally responsible for payment. As a courtesy, however, we will prepare and submit any necessary claim forms, reports, and itemizations to assist in making collections from insurance companies and will credit such collections to the patient's account.

In order to better serve you, we have contracts with a number of insurance companies and health plans to provide services at specific reimbursement rates. We also accept Medicare assignment. However, these plans include co-pays, co-insurance and annual deductibles, which are due at time of service. We are happy to bill you your co-pay amount, however, this service will require an invoicing fee of $20.00. If you disagree with your insurance company's settlement of your claim you will need to pay the balance due and appeal directly to your carrier. Delays in payment of more than 30 days will result in service charges at the rate of $15.00 per month. Should we reach a point where we must seek the assistance of a collection agency to satisfy your debt, you will be responsible for any collection and attorney fees incurred.

If temporary financial problems affect your ability to pay, and there is no alternative except to set up a payment program, we reserve the right to establish the minimum of payment and the date on which the account is to be paid in full.

We understand your schedule may sometimes change and you will need to cancel or re-schedule your appointment with us. Please call us as soon as possible and we will make every effort to accommodate your schedule. In keeping with our desire to provide quality care to all our patients, you will be charged $50.00 for a "No Show" standard office visit and $100.00 for a "No Show" surgery appointment.

We are always happy to prepare copies of your medical record file. However, this again requires staff time and equipment. Therefore a prepaid fee of $25.00 applies to this task. It is in your best interest to make the written notification of your request as early as possible allowing the staff 7 days to complete your request.

*I have read and understand the financial policy of A. David Gerstein, MD, PC. I realize all medical and surgical charges incurred by me for services rendered are my financial responsibility. I am also aware and may obtain at any time a copy of the Privacy Practice used in relationship to my medical information obtained during my visits*

_______________________________ _________________________________

*Patient Signature* *Date*

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## Confidential Patient Registration

*Please **PRINT ALL** information for the patient and the insured*
***We must have the insured information for filing insurance claims***

### Patient Demographics

Patient Last Name ______________________________ First Name ______________________________ M.I.__________

Date of Birth____________________ Patient SS #______________________________ Sex: Male Female

Patient Address ______________________________________ City____________________ State_________ Zip__________

Primary Phone Number ( _____)_______-________________ Alternate Phone Number (_____)_______-______________________

Email ____________________________________________________ Marital Status Single Married Divorced Widowed
(Please provide if we may email personal medical and account information to you)

Student: Y/N Full Time Part Time How did you hear about our office: Physician _________________________ Other___________________

Patient Employer ___________________________________ Employer Phone Number (_____) _____-_____________________

**Responsible Party Name** Last__________________________________ First__________________________________ M.I.______
(if different from patient)

Address________________________________________ City_________________ State_____ Zip_________ SS#_____________

DOB___________________ Relationship to Patient _____________________ Phone Number (_______) __________-___________

Email _______________________________________________________ Employer_____________________________________
(Please provide if we can e-mail personal medical and account information to responsible party)

**Emergency Contact Name** _________________________________ Phone Number (_______) ___________-________________

Relationship to Insured ______________________________________

### Insurance Coverage Information

Primary Insurance Carrier __________________________________ Subscriber Name _________________________________

Date of Birth____________________________ Relationship to Patient ____________________________________________

Patient Signature ___________________________________ Parent or Guardian Signature ______________________________
(if patient is under 18)

***Initial here if it is acceptable to leave messages regarding your health care on your voice mail or answering machine. This includes, but is not limited to biopsy results. _______________***

***Initial here if it is acceptable to leave messages regarding your health care with your spouse ____________***

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## ***GENERAL MEDICAL INFORMATION***

Why are you seeing the doctor today?

_______________________________________________

Is your general medical health GOOD FAIR POOR

Have you ever been diagnosed with skin cancer NO YES
Describe _______________________________________________

Are you diabetic? NO YES

Have you ever had a bleeding problem? NO YES

Do you smoke? NO YES

Have you ever had high blood pressure? NO YES

Have you ever had a stroke? NO YES

Have you ever had trouble with:

| | | |
|---|---|---|
| a. Ear, Nose, Throat | NO | YES |
| b. Stomach for digestive tract? | NO | YES |
| c. Heart? | NO | YES |
| d. Circulation? | NO | YES |
| e. Kidney or urinary tract? | NO | YES |
| f. Liver? | NO | YES |
| g. Lungs? | NO | YES |
| h. Teeth or gums? | NO | YES |
| i. Are you allergic to Latex? | NO | YES |

What medicine do you take on a regular schedule? (use back of form for more space)

_______________________________________________

_______________________________________________

Are you allergic to any medication or food? NO YES
If yes, please list

_______________________________________________

Have you had any previous surgery not related
to your present concern? NO YES
If yes, please list

_______________________________________________

List any infection you have had in the last month, such as cold, flu, kidney, skin, dental, etc:

_______________________________________________

List all current medical problems

_______________________________________________

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Signature of Patient ______________________________ Date _____________________

## Skin Consult Intake Form

Name___________________________________ Today's Date__________________

**Which concerns apply to you? (Please mark all that apply)**

___Uneven skin tone
___Enlarged or clogged pores
___Acne
___Hyperpigmentation (brown spots)
___Exposed blood vessels
___Excessive oiliness
___Wrinkles
___Stretch Marks
___Upper lip lines
___Blackheads/whiteheads
___Dry patches
___Scarring
___Other:_________________________________________________________________

**What is your skin type? (Please Circle)** Normal Dry Oily Combination

**Do you have any of the following chronic skin disorders? (Please mark all that apply)**

___Psoriasis ___Dermatitis ___Eczema ___keloid scarring ___Fever blisters
___Cold sores ___Herpes Simplex/Blisters

**Have you ever undergone any of the following treatments? (Please mark all that apply)**

___Microdermabrasion ___Acid Peel ___Cosmetic Surgery ___Accutane ___Botox
___Restylane ___Juvederm

**Are you currently using any topical creams, lotions, or oral antibiotics for acne, skin cancer, anti-aging or hyperpigmentation?**

Please list:

_____________________________________________________________________________

**Additional Comments:**

_____________________________________________________________________________

_____________________________________________________________________________

_____________________________________________________________________________