Brown Dermatology, Inc.
Financial Policy and Patient Responsibilities

Thank you for choosing Brown Dermatology, Inc. as your medical provider. The following is a statement of our Financial Policy and Patient Responsibilities, which we require you to read and sign prior to receiving any services.

Insurance

Our practice participates with most health insurance plans. Insurances vary in their coverage and it is the ***patient's responsibility*** to understand his/her medical benefits. Please bring your insurance card and a photo id with you at the time of your appointment, it will be copied and the information entered into our system. This is to ensure that the information we have is correct and that your insurance plan is current. If there are any issues concerning eligibility, coverage policies, or other problems not related to our billing practice, you will be responsible for all charges incurred.

Insurance Referrals

You are responsible for all referrals required to comply with your insurance plan. **Please obtain your Primary Care Physician's referral prior to your appointment.** If your claims are denied for lack of referral or it the referral is rejected by your insurance company, you are responsible for all charges.

Co-Pays, Deductibles, Co-Insurance, & Self-Pays

All office ***co-pays, deductibles, co-insurance, and self-pay visits*** are to be paid at the time of service. Please check with your insurance company to determine the amount of your plan deductible. We accept cash, check, Visa and MasterCard. **A $15.00 fee will be applied if the co-pay is not paid at the time of service.** If you are unable to pay your balance in full, we will gladly arrange a payment plan. Arrangements must be made with our Billing Department prior to your appointment.

The following fees will not be filed with your insurance carrier; they are the direct responsibility of the patient:

No-Show Fee

Any patient who does not show for their scheduled appointment and has not called with 24 hour notice to cancel the visit, will receive a $35 "no show" charge. Payment is due upon receipt of statement and no further appointments may be made until the charge has been paid.

Finance Charge

A 1% finance charge will be added to the amount due if payment is not received within 30 days of being billed.

Returned Check Fee

There is a $30 returned check fee.

I have read, understand, and agree to the financial policies as outlined.

Your signature below indicates that you understand and acknowledge the financial responsibility for services rendered by Brown Dermatology, Inc. Further, your signature authorizes Brown Dermatology to release such medical information necessary to process your insurance claims.

Print Patient Name: _____ Date _____

Signature of Patient or Responsible Party _____

Brown Dermatology, Inc.
Initial Visit Consent

I understand that as part of my care the staff of Brown Dermatology, Inc. originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment.

HIPAA Privacy Policy

I have been offered or received a copy of the Privacy Notice. It describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time. To receive a copy of any revised Notice, please ask a front desk staff person or call the Privacy Officer at 401-444-7204.

Teaching Practice

Our physicians are full-time, teaching Dermatologists at Brown Alpert Medical School and in our role as teachers you may be seen by a resident, who is a physician that has already completed one or more years of post-medical school training, before being seen by your attending physician.

Photo Consent

I consent to be photographed regarding the medical dermatological condition or treatment for which I am seeing my provider at Brown Dermatology, Inc. for. These photographs may be used for my own medical and dermatologic care by my provider or a representative(s) for medical education or research. If any of these photographs are published in professional journals or used for any other educational purpose, which my provider may deem appropriate, I understand that I will not be identified or compensated in connection with the use or publication of these photographs. I understand that all slides and photographs are property of Brown Dermatology, Inc. _____(Initial)

First Visit

A COMPLETE YET DISCREET EXAMINATION OF THE ENTIRE SKIN SURFACE is strongly suggested on your first visit and after a prolonged (years) absence. We often find clues from areas of the skin other than your major concern that can help us care for you better.

Yes, I would like a medical assistant present during my visit _____(Initial)

No, I do not require a medical assistant present during my full-skin exam _____(Initial)

Print Patient Name: _____Date: _____

Signature of Patient or Responsible Party: _____

_____ _____

Relationship* Print Representative Name*

*As the representative of the above individual, I acknowledge receipt of the Notice on his/her behalf.

Brown Dermatology, Inc.

New Patient Information Sheet

Physician _____

Patient MR# _____

Date of First Visit _____

Please print all information

Patient Information:

Patient Name: _____ Age: _____ Date of Birth: _____

Mailing Address: _____ Sex: M F Marital Status: S M W D

City: _____ State: _____ Zip: _____ Preferred Phone #: _____

Secondary Phone #: _____ Email: _____

Parent/Legal Guardian's Name if Patient is a minor: _____

Patient/Parent Employer: _____ Work #: _____

Consent:

Brown Dermatology, Inc. has my permission to call my Preferred Phone Number to confirm appointments and may leave messages pertaining to my visits on my answering machine/voicemail or with the person answering the phone. ☐ Yes ☐ No

The Practice will not disclose patient information to anyone other than the people listed below.

If no names are given, no patient information will be discussed with anyone other than the patient.

_____

Insurance Information:

Primary Insurance Carrier: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: ☐ Self ☐ Spouse ☐ Child

☐ Other _____

Secondary Insurance Carrier: _____ Policy #: _____

Subscriber Name: _____ Date of Birth: ☐ Self ☐ Spouse ☐ Child

☐ Other _____

Medical Information:

Primary Care Physician: _____ Address: _____

Referring Physician: _____ Address: _____

Pharmacy: _____ Address: _____ Phone #: _____

Do you have any allergies? ☐ No ☐ Yes If yes, please list them. _____

_____

Reason for today's visit (please include location and for how long, if possible)

_____

_____

List all medications you are currently taking including aspirin, vitamins, and any over-the-counter medications:

_____

_____

Review of Systems: *Check yes or no if you have or had any of the following symptoms/conditions:*

Eczema	☐ No ☐ Yes	Thyroid Disease	☐ No ☐ Yes	Anxiety/Depression	☐ No ☐ Yes
Psoriasis	☐ No ☐ Yes	Raynaud's Disease	☐ No ☐ Yes	Mental Health Problems	☐ No ☐ Yes
Blistering Sunburns	☐ No ☐ Yes	High Blood Pressure	☐ No ☐ Yes	Convulsions/Seizures	☐ No ☐ Yes
HIV/AIDS	☐ No ☐ Yes	Irregular Heartbeat	☐ No ☐ Yes	Kidney Disease	☐ No ☐ Yes
Hepatitis	☐ No ☐ Yes	Heart Murmur	☐ No ☐ Yes	Bladder	☐ No ☐ Yes
Bad Scars/Keloids	☐ No ☐ Yes	Heart Attack, Disease	☐ No ☐ Yes	Stomach	☐ No ☐ Yes
Asthma Hay	☐ No ☐ Yes	Chest Pain	☐ No ☐ Yes	Bowel	☐ No ☐ Yes
Fever	☐ No ☐ Yes	Pacemaker/defibrillator	☐ No ☐ Yes	Lupus/Tissue Disease	☐ No ☐ Yes
Diabetes	☐ No ☐ Yes	Bleeding Problems	☐ No ☐ Yes	Loss of Vision	☐ No ☐ Yes
Fever	☐ No ☐ Yes	Artificial Heart Valve	☐ No ☐ Yes	Glaucoma	☐ No ☐ Yes
Weight Loss	☐ No ☐ Yes	Damaged Heart Valve	☐ No ☐ Yes	Muscle Aches	☐ No ☐ Yes
Diarrhea	☐ No ☐ Yes	Lung Disease	☐ No ☐ Yes	Arthritis/Joint Problems	☐ No ☐ Yes
Hearing Loss	☐ No ☐ Yes	Poor Circulation	☐ No ☐ Yes	Easy Bruising	☐ No ☐ Yes
Throat Pain	☐ No ☐ Yes	Cold Intolerance	☐ No ☐ Yes	Headaches	☐ No ☐ Yes
Anemia	☐ No ☐ Yes	Female		Fainting	☐ No ☐ Yes
Male		Breastfeeding	☐ No ☐ Yes	Artificial Joints	☐ No ☐ Yes
Penis Discharge	☐ No ☐ Yes	Breast Mass	☐ No ☐ Yes	If yes, what joint(s)_____	
Lesions	☐ No ☐ Yes	Discharge	☐ No ☐ Yes	Cancer	☐ No ☐ Yes
				If yes, type_____	

Personal history:

Skin Cancer ☐ No ☐ Yes

If yes, what type? _____ Location: _____When:

Type? _____ Location: _____When:

History of skin biopsies and/or surgeries:

Where/What/When: _____

Where/What/When: _____

Where/What/When: _____

Has anyone in your family had: ☐ skin cancer ☐ melanoma ☐ psoriasis ☐ asthma/hay fever/eczema?

What is your occupation? _____

Do you have any hobbies? _____

Are you currently pregnant? ☐ No ☐ Yes If yes, how many weeks?: _____

Do you have any children? ☐ No ☐ Yes If yes, how many?: _____

Do you have any pets? ☐ No ☐ Yes If yes, what kind?: _____

Do you use sunscreen? ☐ No ☐ Yes

Do you use a tanning booth? ☐ No ☐ Yes If yes, how often?: _____

When you are exposed to the sun, do you ☐ tan ☐ tan and burn ☐ burn?

Do you use tobacco products? ☐ No ☐ Yes Amount _____

Do you drink alcohol? ☐ No ☐ Yes Amount _____

Reviewed by _____