University Dermatology, Inc.
Financial Policy and Patient Responsibilities

Thank you for choosing University Dermatology, Inc. as your medical provider. The following is a statement of our Financial Policy 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.

Co-Pays
All office ***co-pays*** are to be paid at the time of service. ***This is an insurance company policy.*** 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.

Deductibles & Co-Insurance vary among insurance plans and are to be paid at the time of service. Health insurance deductibles/co-insurances require the insured pay a certain amount out-of-pocket toward his/her health coverage before the insurance company has to begin paying under the policy. Please check with your insurance company to determine the amount of your plan deductible.

No Insurance or Self-Pay
Payment will be due 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
Any patient that does not show for their scheduled appointment and does not call within 24 hours to cancel the visit, will receive a $35 "no show" charge. Payment is due upon receipt of statement.
* This policy does not apply to patients who call to cancel their appointment at least 24 hours in advance of the scheduled visit.
_____ (Initial)

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

I have read, understand, and agree to the financial policies as outlined.
I acknowledge full financial responsibility for services rendered by University Dermatology, Inc. I understand that I am responsible for prompt payment of any portion of the charges including co-pays, deductibles and co-insurance amounts. I understand that payment of co-pays, deductibles and co-insurance amounts is expected at the time of visit. I agree to be responsible for all reasonable attorney fees and collection costs in the event of default of payment of my charges.

Print Patient Name: _____ Date_____

Signature of Patient or Responsible Party_____

PATIENT'S ACKNOWLEDGMENT OF RECEIPT OF THE UNIVERSITY DERMATOLOGY, INC. PRIVACY NOTICE

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 call the Privacy Officer at 401-444-7204.

_____ _____

Date Signature*

_____

Print Patient's Name

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

_____ _____

Relationship Signature

New Patient Information Sheet

University Dermatology, Inc.

Physician _____

Patient # _____

Date of First Visit _____

Please print all information

Name Male/Female		Date of Birth	SS #
Address			Primary Phone#
City	State	Zip	Secondary/Work #
Employer Address		Primary Physician Address/Phone #	
Pharmacy name: Address/Phone #		Emergency Contact Address Phone # Relationship	
Patient's Primary Health Insurance		Insurance ID# Group #	
Subscriber (person to whom policy was issued) Social Security # Employer Providing Insurance		Date of Birth Relationship to patient	
Patient's Secondary Health Insurance		Insurance ID # Group #	
Subscriber (person to whom policy was issued) Social Security # Employer Providing Insurance		Date of Birth Relationship to Patient	

Are you seeking treatment for an injury suffered at work?	Yes _____ No _____
If Yes, please provide the following information: Name and address of employer: Date of injury: Worker's Compensation Carrier: Address: File/Claim #:	
Are you seeking treatment for an automobile-related injury?	Yes _____ No _____
If Yes, please provide the following information: Insurance Company (Name & Address): Date of injury: Attorney: Address: File/Claim #:	
Is a liability Claim involved?	Yes _____ No _____
If Yes, please provide the following information: Insurance Company (Name & Address): Date of injury: Attorney: Address: File/Claim #:	

Payment is expected at the time of service. Necessary forms will be completed to expedite insurance payments, however, the patient is responsible for all fees including copayments, deductibles, and any non-covered services, regardless of insurance coverage.

I Hereby authorize University Dermatology, Inc. to furnish information to my insurance carrier(s) concerning my illness and treatments, and hereby assign the physician(s) all payments for medical services rendered to me or my dependents. I understand that I am responsible for any amounts not covered by insurance. I hereby authorize University Dermatology, Inc. to examine, test, and treat me for my medical condition.

Signature_____ Date_____

UNIVERSITY DERMATOLOGY, INC.

PEDIATRIC DERMATOLOGY NEW PATIENT QUESTIONNAIRE

Patient name _____DOB___/___/___ Age:_____

Preferred name of child_____

Child's pediatrician/primary care provider_____

Pediatrician/PCP address:_____

Who referred you to us for evaluation?

□Pediatrician □Dermatologist (name _____) □Self

□Hospital □Phone Book □Internet □Other _____

HISTORY

Please tell us about your child's skin problem_____

_____

_____

When did problem FIRST start?_____

List all medications and treatments tried for this problem_____

_____

HEALTH HISTORY

Does your child have any past or present medical problems? (list) _____

_____

_____

Any past surgeries? (please list)_____

_____

_____

Any past hospitalizations? (Please describe) _____

_____

FAMILY HISTORY

Please Indicate (√) If any family members have had the following problems?

(*GF=grandfather, GM=grandmother, Bro=brother, Sis=Sister, Other= aunts, uncles, cousins)*

	Mom	Dad	Sis	Bro	GF	GM	Other
Eczema							
Asthma							
Hay fever							
Psoriasis							
Skin Cancer							
Melanoma							
Abnormal mole							

SOCIAL HISTORY

Please list siblings and ages_____

_____

Child's primary caretaker (circle) Mom Dad Both Grandparent Other_____

Grade in school (circle) PreK K 1 2 3 4 5 6 7 8 9 10 11 12 College

Pets at home? _____ Day care: Yes No

SUN HISTORY

Please describe patient's skin as closely as you can:

□Burns, freckles easily never tans □Burns easily tans poorly □ Burns occasionally tans readily □Never burns, tans well

Sunscreen Use

□Never □Occasionally □Sometimes before spring or summertime outdoor activity

□Usually before spring or summer outdoor activity □Always before spring or summertime outdoor activity □Year-round

Sunscreen type and SPF _____Tanning bed use: Yes No

CURRENT MEDICATIONS

Please list_____

_____

MEDICATION ALLERGIES OR SERIOUS FOOD ALLERGIES

Please list and describe _____

_____

REVIEW OF SYSTEMS

Please indicate whether your child has experienced any of these symptoms by checking (√) YES (Y) or NO (N) for each

	Yes	No		Yes	No
Growth problems			Heart problem		
Eye problem			Joint pain		
Ear, nose, throat			Muscle or bone problem		
Seizure			Fever		
Wheezing, shortness of breath			"Swollen glands" lymph nodes		
Headaches			Learning disorder/school problem		
Jaundice or hepatitis			Poor appetite		
Weight change			Urinary problem		

Is there anything else you would like us to know?_____

_____

Signature of person filing out form_____Date___/___/___Relation to patient?___

MEDICAL TEAM USE ONLY

Signature of person reviewing form_____Date ___/___/___

UNIVERSITY DERMATOLOGY, INC.

Initial Visit Introduction

Thank you for choosing a member of the University Dermatology, Inc. for your dermatological needs. Our goal is to deliver the highest quality medical care for our patients.

As part of this effort there are two aspects of our practice we wish to acquaint you with:

1) **A COMPLETE YET DISCREET EXAMINATION OF THE ENTIRE SKIN SURFACE** is required on the 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. We also look for the earliest forms of skin cancer such as malignant melanoma and basal cell or squamous cell cancer.

2) In our role as teachers, (we are full-time faculty in Dermatology at the Brown Medical School) we are aided in our practice by physicians who have completed one or more years of post-medical school training. We feel that our daily association with the brightest young physicians increases the quality of care we deliver.

We hope you do not find either of these two aspects of our practice an inconvenience but rather something you would expect from high quality medical care. Also, our fees are determined by the level of exam required. Payment at the time of service is expected.

Attached you will find a form we would like for you to complete prior to your visit. **Please bring all completed forms with you on the day of your visit**. If you have any questions please do not hesitate to ask to speak to us. Thank You.

Patient Name: _____ Date of Appointment:_____

Your Primary care (or regular) doctor:

Full Name:_____
Address:_____
City/State/Zip:_____
Phone:_____

Referring Doctor (sent you here for consultation or treatment):

Full Name:_____
Address:_____
City/State/Zip:_____
Phone:_____