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 The Warren Alpert Medical School of Brown University 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.

New Patient Information Sheet

Brown 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 Brown 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 Brown Dermatology, Inc. to examine, test, and treat me for my medical condition.

Signature_____ Date_____

BROWN 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 __/__/__