# Skin Cancer & Mohs Surgery, LLC

82 East Allendale Road Suite 8A Saddle River, NJ 07458

## PATIENT INFORMATION

Name: _____ Date: _____
Last Name First Name Middle Initial

Address: _____

City: _____ State: _____ Zip: _____ Occupation: _____

Birthdate: _____/_____/_____ Email: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____

SSN: _____ Sex (Circle): **M F O** Age:_____ Race:_____

Emergency Contact Name: _____ Phone: (_____) _____-_____

How did you hear about our practice?: _____

## PRIMARY INSURANCE

Subscriber Name: _____

Relation to Patient: _____ Birthdate: _____/_____/_____ SSN: _____

Address (If different from patient's): _____ Phone: (_____) _____-_____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____

Group #: _____ Subscriber #: _____

## SECONDARY INSURANCE

Subscriber Name: _____

Relation to Patient: _____ Birthdate: _____/_____/_____ SSN: _____

Address (If different from patient's): _____ Phone: (_____) _____-_____

City: _____ State: _____ Zip Code: _____

Insurance Company: _____

Group #: _____ Subscriber #: _____

## ASSIGNMENT OF BENEFITS / FINANCIAL AGREEMENT

If under age 18, Responsible Party Name: _____

I hereby give lifetime authorization for payment of insurance benefits to be made directly to _____, and any assisting physicians, for services rendered. I understand that I am financially responsible for all charges whether they are covered by insurance or not. In the event of default, I agree to pay all costs of collection, and reasonable attorney's fees. I hereby authorize this healthcare provider to release all information necessary to secure the payment of benefits. I further agree that a photocopy of this agreement shall be as valid as the original.

_____ _____/_____/_____
**Signature** of Patient, Parent, Guardian or Responsible Party Date

_____ _____
**Printed** Name of Patient, Parent, Guardian or Responsible Party Relationship to Patient

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## HEALTH HISTORY

Name: _____ Birthdate: _____ /_____ /_____

| | | |
|---|---|---|
| Do you smoke? | **YES** | **NO** |
| Do you drink excessive alcohol? | **YES** | **NO** |
| Are you prone to scars or keloids? | **YES** | **NO** |
| Have you received the flu vaccine this year? | **YES** | **NO** |
| Have you received the pneumonia vaccine? (Patients 65+) | **YES** | **NO** |
| Do you have an Advance Care Plan/Directive? (Patients 65+) | **YES** | **NO** |

**If yes**, please name your surrogate decision maker: _____

Patient's Height: _____ feet & _____ inches Weight: _____ lbs.

**FEMALES**: Date of Last Menstrual Cycle: _____ Are you Pregnant? **YES** **NO**

## ADDITIONAL INFORMATION

PCP (Primary Care Physician): _____

Phone: (_____) _____-_____ Fax: (_____) _____-_____

PCP Address: _____

Referring Physician Name:

_____

Referring Physician Address:

_____

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Patient Name:_____ DOB:____/____/___ Date:___/____/___

Yearly Patient Update Questionnaire

1. Do you have any allergies? Yes No

   Please list:_____

2. Do you have diabetes? Yes No
3. Do you have hypertension? Yes No
4. Do you have any heart valve, hip, or knee replacements? Yes No

   How many years ago? _____

5. (Please put a check if applicable) Do you_____ or family member_____ have a history of skin cancer____ or melanoma____?
6. Do you have a pacemaker? Yes No
7. Add a check if you currently have the following: HIV___ Herpes___ Hepatitis A/B/C_____
8. Do you take any blood thinners? Aspirin Coumadin Warfarin Eliquis

   Other:_____

9. Please list all your current medications including strength, dose, and frequency or provide us with your list so we can make a copy:

   1_____2_____

   3_____4_____

   5_____6_____

   7_____8_____

   9_____10_____

10. Pharmacy Name and phone #:_____
11. Pharmacy Address:_____

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## GENERAL MEDICAL HISTORY (CIRCLE ANY THAT APPLY)

| | | |
|---|---|---|
| Anxiety | Depression | Seizures |
| Asthma | End Stage Renal Disease | Stroke |
| Arthritis | Hearing Loss | Stomach Ulcer |
| Benign Prostate Hyperplasia | High Cholesterol | Thyroid Issues (Hyper or Hypo) |
| Bone Marrow Transplant | Heart Failure | Tuberculosis |
| Breast Cancer | Lymphoma | Other: _____ |
| Colon Cancer | Lung Cancer | |
| Coronary Artery Disease | Leukemia | |
| Gastroesophageal Reflux Disease | Parkinson's Disease | |
| COPD (Pulmonary Disease) | Prostate Cancer | |

Past Surgical History:

_____

_____

## SKIN DISEASE HISTORY

| | Patient | | Patient's Family | |
|---|---|---|---|---|
| Acne | **YES** | **NO** | **YES** | **NO** |
| Actinic Keratosis | **YES** | **NO** | **YES** | **NO** |
| Blistering Sunburn | **YES** | **NO** | **YES** | **NO** |
| Dry Skin/Flaky Scalp | **YES** | **NO** | **YES** | **NO** |
| Hay Fever/Allergies | **YES** | **NO** | **YES** | **NO** |
| Poison Ivy | **YES** | **NO** | **YES** | **NO** |
| Psoriasis | **YES** | **NO** | **YES** | **NO** |
| Precancerous Moles | **YES** | **NO** | **YES** | **NO** |
| Eczema | **YES** | **NO** | **YES** | **NO** |

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## CONSENT TO RELEASE INFORMATION & COMMUNICATION INSTRUCTIONS

Date: _____ /_____ / _____ Patient Name: _____

I, (Name) _____ give my permission for:

Skin Cancer & Mohs Surgery, LLC makes every effort to keep your information confidential. We comply with all applicable State and Federal privacy laws. We have a **Notice of Privacy Practices** on our website. We also have this available in our offices. You have the right to receive a paper copy of this notice. Please ask us at any time to give you a copy of this notice.

You may wish to check with us from time to time as the **Notice of Privacy Practices** may be revised. We have found that most of our patients that request email confirmation with our office want to receive unencrypted email. We have also found that some of our patients prefer text messages. These texts are not on an encrypted or secure device.

Do we have permission to use your (Circle & Fill-in the following):

Home answering machine: **YES NO** Phone: (_____) _____-_____

Cell phone Voicemail: **YES NO** Phone: (_____) _____-_____

Unencrypted email: **YES NO** Email: _____

Unsecure text: **YES NO** Phone: (_____) _____-_____

I hereby give permission to Advanced Laser and Skin Cancer Center to speak with anyone (Spouse, Children, Parents/Guardian) regarding my care **UNLESS** written otherwise below:

Name(s): _____

_____

If you change your preference at any time, please let us know.

Patient Name: _____

Patient Representative: _____

I wish to have my medical results left on any answering machines, voicemails, or email:

_____ _____ /_____ /_____

**Signature** of Patient, Parent, Guardian or Responsible Party Date

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## INTERNAL FINANCIAL POLICY AND WHAT ACCEPTING INSURANCE MEANS

To our patients,

You **must** present your current insurance card(s) and a **Government Issued Photo ID** at the time of service. All co-pays and other balances are due prior to treatment. **Self-pay patients are required to make full payments up front at the time of your visit.** We accept cash, check, or credit cards (Visa, AmEx, Discover, or MasterCard). **A $30 fee will be applied to any account with a returned check for insufficient funds**.

**No enrollment forms** will be accepted if your benefits cannot be verified on the day of your visit. If you do not have your insurance card and we cannot check your eligibility, you will have to reschedule, If you are a college student and you are under your parent's or guardian's insurance policy, please provide a copy of full time school schedule to your insurance company, (Note: Most insurance companies **will not process** any claim if they do not have a record of full time status from school).

You are responsible for knowing your insurance requirements including referrals, authorization numbers and medical claim forms (if applicable). **YOU ARE TO HAVE THIS ON HAND BEFORE YOU ARE SEEN BY THE DOCTOR**. If you are **seen without a referral**, there will be an **administrative fee of $200.00** applied to your account.

You are liable for deductibles, co-payments, and non-covered services for **any** type of consultation done by the doctor, as they are part of your contract between you and your insurance company. If your insurance company refuses to pay or ignores our claims, you will also be responsible for payments. If your insurance company goes bankrupt, you are responsible for your balance.

For established patients, **any personal changes that occur; (i.e. name, address, insurance name, guarantor, phone number, etc.) you must fill out new forms. You will also need to update your personal information on a yearly basis.** Any incorrect information may cause your insurance company to delay or decline payments.

Any requested documents such as: disability papers, medical necessity letters medical records, etc. will be completed within 30 business days from the time we received them. **You will have to pick up this documentation. We are not responsible for mailing or submitting any documentation.** To release any medical records and in accordance with HIPAA, a valid record release form must be on file prior to initiation of this process. The release could be signed with your new physician or in our office, with the new information of the new physician.

Note: It is important to know what laboratory your insurance will allow you to participate with. Failure to provide this information may result in fees being billed to you. Laboratory fees for analyzing biopsies, cultures, bloodwork, etc. will be billed to your insurance company by the performing laboratory. Our office (Advanced Laser & Skin Cancer Center, LLC) has no authority over billing policies of these laboratories.

If you have any questions about your medical policy, call your insurance company. They have final determination on all matters. Our office only receives quotes, not a guarantee of payment.

I, (Name) _____ hereby understand the above premises and I am aware that I will be fully responsible for any non-payment from my insurance company and payment will be made in full within 30 days of the billing statement In the case I cannot make full payment, I will let the office of **Gangaram Ragi, M.D.** arrange a payment plan. I understand that I will be legally responsible for all collection costs, reasonable attorney fees, and all other expenses incurred with collection if I default on this agreement.

Thank you for understanding our Financial Policy.

_____ _____/_____/_____

**Signature** of Patient, Parent, Guardian or Responsible Party Date

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To Our Patients:

**In our efforts to go green and keep the cost of healthcare down we have implemented the following policy.**

If we are providers for your insurance company, you will be asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and notified us of your financial responsibility. At that time, any remaining balance due to Skin Cancer & Mohs Surgery, LLC will be charged to your credit card. If we are NOT providers for your insurance plan, the office policy remains the same: you will pay in full at the time of your visit. **It is in your best interest to understand your insurance plan.**

This credit card policy will be an advantage to you as you will no longer have to prepare and mail us checks. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and post in the mail. This policy benefits everybody by keeping the cost of healthcare down, and by allowing us to concentrate first and foremost on your medical needs.

Our credit card on account policy in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays, Co-insurances, and deductible amounts will, of course, still be due at the time of your visit.

If you have any questions, please do not hesitate to ask.

**********

**Please note, any charges over $150 will receive a courtesy call to advise that we will be charging this to your credit card on file.**

I authorize Skin Cancer & Mohs Surgery, LLC to charge outstanding balances on my account to the following credit card. If the billing address for this credit card differs from your home address, please advise us of the billing address. Thank you.

Visa___ MC___ AmEx___ Discover___

CC Number_____

Exp Date____ /_____ Security Code_____

Name on Card [Print]_____ Primary Phone # _____

Patient Name _____ Patient DOB _____

Signature _____ Date _____

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**BIOPSY CONSENT**

Name: _____

Date of Birth: _____

Photo of the site will be taken for medical purposes.

Procedure: Shave or Punch or Elliptical Excision Biopsy

Anesthetic: 1% Xylocaine with/without Epinephrine

The skin will be cleansed with alcohol, iodine, or antibacterial soap. A local anesthetic will be applied and/or injected into the skin. An area of skin will be removed and may be sent for testing. The incision/site may be sewn, and antibacterial ointment and a bandage will be applied.

A scar will result. Far less common are other potential risks of complications, which include but may not be limited to:

-Bleeding

-Infection

-Irritant or allergic reaction (rash, discoloration) to ointment of dressing

-Wound separation

-Thick scar or Keloid

- Nerve damage, temporary or permanent loss of sensation or muscle function

-Adverse reaction to anesthetic (hives, difficulty breathing, very rarely death)

I *certify that I have read or had read to me the contents of this form. My doctor explained to me the procedure, anticipated results, alternative forms of treatment including non-treatment, and the possible risks of complications of the proposed procedure. I understand the potential risks and complications and alternatives to this procedure. I have had the opportunity to ask questions about this procedure and all my questions have been answered to my satisfaction. I authorize my physician, his associate or assistants or other qualified medical personnel to perform such treatment or procedures. By signing this consent, I authorized the physician or a representative of this practice to call me with the results and leave a message on my answering machine/voicemail.*

_____ _____

Witness Signature Date Patient/Agent/Guardian Signature Date

# Skin Cancer & Mohs Surgery, LLC

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PHOTO CONSENT AND RELEASE FORM

Patient Name: _____

I consent for photographs and/or video images to be taken of me by Skin Cancer & Mohs Surgery, LLC. or a representative. I understand the images will be a part of my medical record and may be used for purposes of medical teaching or training or for marketing purposes (website, print, digital or social media).

By consenting to photographs and/or video images I understand I will not be compensated from any party. Although photographs and/or video images will be used without identifying information such as name, I understand it is possible someone may recognize me.

I further acknowledge that my participation is voluntary and agree that use of any photographs and/or video images confers no rights of ownership or royalties whatsoever.

I authorize the use of photographs and/or video images: (please initial indicating YES or NO below)

_____ YES _____ NO For educational purposes
(medical teaching or training and/or patient education),

_____ YES _____ NO Website, print, digital, or social media

_____ YES _____ NO Dermatologic Journals, AAD Journal, etc.

I hereby release Skin Cancer & Mohs Surgery, LLC., its employees, and any third parties involved in the creation of or publication of educational or marketing materials, from liability for any claims by me or any third party in connection with my participation.

By signing this form, I confirm understanding of this consent. If I wish to withdraw my consent in the future, I may do so via written request submitted to Skin Cancer & Mohs Surgery, LLC. or by completion of a new form.

Patient Signature: _____ Date: _____