NAME: _____ EMERGENCY CONTACT: _____

NICKNAME: _____ EMERGENCY PHONE #: _____

ADDRESS: _____ DRIVER LICENSE #: _____

(City/State/Zipcode)_____ **REFERRING DOCTOR:** _____

PHONE #: H ( )_____ **ADDRESS:** _____

W( )_____ **FAMILY DOCTOR:** _____

Cell ( ) _____ **ADDRESS:** _____

SOCIAL SECURITY #_____ PERSON RESPONSIBLE FOR PAYMENT

MARITAL STATUS: M W D S G NAME: _____

BIRTHDATE: _____ SEX: M F ADDRESS: _____

RACE: _____ RELIGION: _____ (City/State/Zipcode): _____

EMPLOYER NAME: _____ **LIST PHARMACY, ADDRESS AND PHONE NUMBER:**

E-MAIL ADDRESS:_____ _____

ALLERGIES: _____ _____

_____ _____

Do you have a Living Will (Advanced Directive)?: YES_____ NO_____

If so, do you wish to provide us with a copy?: YES_____ NO_____ If yes, please provide.

* * * * * * * * * * * * * * * *

Do we have your permission to leave a message on an answering machine and/or with a family member?

____yes ____no ***Please sign** _____

INSURANCE INFORMATION

PRIMARY COVERAGE: _____ **SECONDARY COVERAGE:** _____

SUBSCRIBER'S NAME: _____ **SUBSCRIBER'S NAME:** _____

SUBSCRIBER'S SS#: _____ **SUBSCRIBER'S SS#:**_____

SUBSCRIBER'S DOB: _____

RELATIONSHIP TO SUBSCRIBER: **RELATIONSHIP TO SUBSCRIBER:**

SELF __ SPOUSE __ CHILD __ OTHER__ **SELF ___ SPOUSE ___ CHILD ___ OTHER___**

POLICY EFFECTIVE DATE: _____ **POLICY EFFECTIVE DATE:** _____

POLICY ID#: _____ **POLICY ID#:** _____

GROUP #: _____ TYPE: _____ **GROUP #:** _____ **TYPE:** _____

ASSIGNMENT OF BENEFITS/PERMISSION FOR DIAGNOSTIC STUDIES

I REQUEST THAT PAYMENT UNDER THE MEDICAL INSURANCE PROGRAM BE MADE DIRECTLY TO:

BENEDETTO DERMATOLOGY, P.C., ON ANY UNPAID BILL FOR SERVICES RENDERED BY

DRS. ANTHONY V. BENEDETTO; ERNEST A. BENEDETTO; PAUL X. BENEDETTO;

SIGNATURE: _____ DATE: _____

If signing for patient, please list your name and relationship on the line below:

Name: _____ Relationship: _____

DERMATOLOGIC SURGICENTER LASER SURGERY

Anthony V. Benedetto, D.O., FACP
Ernest A. Benedetto, M.D.
Paul X. Benedetto, M.D.
Mohs Micrographic Surgery for Skin Cancer
Dermatologic Surgery

2221 Garrett Road, Drexel Hill, PA 19026 Tel: 610-623-5885 Fax: 610-623-7276
1200 Locust Street, Philadelphia, PA 19107 Tel: 215-546-3666 Fax: 215-546-6060

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: _____ Date of Birth: _____

Benedetto Dermatology, PC, appreciates the confidence you have shown in choosing us for your health care needs and will offer the best quality medical care to all of our patients. As a courtesy to our patients we will verify your current insurance coverage and bill your insurance carrier on your behalf. However, due to the rising costs of medical coverage many insurance companies now have additional stipulations that may affect your coverage and it is ultimately the patient's responsibility to know their individual coverage and benefits. Furthermore, if your insurance carrier denies any part of your claim, or if you elect to continue services past your coverage and policy period, you will be responsible for the remaining balance on your account. Thank you for your cooperation and understanding in this matter.

I have read the above policy regarding my financial responsibility to Benedetto Dermatology, LLC, for providing medical services to me or the above named patient. I certify that the information provided by me is to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Benedetto Dermatology, PC - the full and entire amount of the bill incurred by me or the above named patient with the agreement that any amount remaining after such payment becomes the patient's responsibility. It is my understanding that Drs. Anthony, Ernest, and Paul Benedetto are the owners and administrators of Benedetto Dermatology, LLC and the Dermatologic SurgiCenter.

_____ _____

Signature of Patient/Parent or Guardian/Surrogate Date

_____

Name (please print)

DERMATOLOGIC SURGICENTER
LASER, SURGICAL & COSMETIC DERMATOLOGY

Anthony V. Benedetto, D.O., FACP
Ernest A. Benedetto, M.D.
Paul X. Benedetto, M.D.

March 16, 2018

In the last few years, insurance companies have changed their reimbursement policies. Even if your physician is reimbursed. The insurance companies are shifting responsibility for payment to the patient. Your individual contract with your insurance company determines the amount that you, as the patient, have a responsibility to pay for each treatment or procedure.

As a result of this change, we will be collecting your credit card information before you are seen. All information will be stored securely via Integrated Payments by Retriever Med Software. You will be charged your patient responsibility balance only after we received your EOB (Explanation of Benefits) from your insurance carrier.

If that balance is below $200, the card on file will be charged automatically.

If the balance is between $200-$500, arrangements can be made through our billing office.

If the balance is above $500, payments can be made in installments through our office or CareCredit® can be used. Our office is able to offer interest-free installments for up to 6 months.

To verify your responsibility of payment, please refer to your personal EOB, which should be sent to you by your insurance carrier.

I certify that I have read and understand the terms and conditions as detailed above.

_____ _____

Patient Signature Date

_____ _____

Patient's Representative or Guarantor Date

DERMATOLOGIC SURGICENTER LASER SURGERY

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2221 Garrett Road, Drexel Hill, PA 19106 Tel: 610-623-5885 Fax: 610-623-7276

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE AND CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

Read before signing the Acknowledgement and Consent

This acknowledgement of notice and consent authorizes the Dermatologic SurgiCenter to use and disclose health information about you for treatment, payment and health care operation purposes.

Notice of Privacy Practices. The Dermatologic SurgiCenter has a Notice of Privacy Practices, which describes how we may use and disclose your protected health information and how you can access your protected health information and exercise other rights concerning your protected health information. You may review our current notice prior to signing this acknowledgment and consent.

Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of the change. You may obtain a revised notice by submitting a written request to our Privacy Officer.

Anti-Fraud Mandate by the Government requires a digital photograph to be taken.

How to contact our Privacy Officer:

Mail: Dermatologic SurgiCenter
1200 Locust Street
Philadelphia, PA 19107
ATTN: Ernest A. Benedetto M.D.
215-546-3666
215-546-6060 (fax)

Dermatologic SurgiCenter
2221 Garrett Road
Drexel Hill, PA 19026
ATTN: Ernest A. Benedetto M.D.
610-623-5885
610-623-7276 (fax)

Acknowledgment and Consent

I have received the Notice of Privacy Practices for the Dermatologic SurgiCenter. The Dermatologic SurgiCenter is authorized to use and disclose health information about _____ (patient name) for treatment, payment, and healthcare operation purposes consistent with its Notice of Privacy Practices.

_____ _____

Signature of Patient
(or patient's personal representative)

Date

Personal Representative Information (if applicable):

_____ _____

Name of Personal Representative

Relationship to Patient (or other authority)

DERMATOLOGIC SURGI CENTER LASER SURGERY

Dermatologic Cosmetic Surgery
1200 Locust Street, Philadelphia, PA 19107

Anthony V. Benedetto, D.O., FACP
Ernest A. Benedetto, M.D.
Paul X. Benedetto, M.D.
Mohs Micrographic Surgery for Skin Cancer

Tel: 215-546-3666 Fax: 215-546-6060

Authorization for Release of Information:

Patient's Name: _____ **Date of Birth:** _____ **Social Security #:** _____

HIPAA PRIVACY AUTHORIZATION FORM

Authorization for Disclosure of Protected Health Information

Name: Benedetto Dermatology LLC

I, _____, authorize Address: _____
Individual Giving Authorization **Person Providing Information**
to disclose the following protected health information:

A. ____My complete medical record for services provided on or after the following date _____.
Unless this authorization is expressly limited by filling in Part B below, this authorization grants the Health Care Provider the right to release all personal medical information for the purposes described, including medical information about any diagnosis or treatment for any mental health, drug, alcohol or substance abuse condition, sexually transmitted diseases (such as HIV), cancer and the manifestation of and effects of a condition that happens to be genetic. It does not authorize the disclosure of any other genetic information or psychotherapy notes.

B. ____Release only the following medical information from my medical record: (Specifically describe the information to be released, including, but not limited to, meaningful descriptors such as date of service, type of service performed, level of detail to be released, origin of information etc.)

_____

This information may be released to _____.
Recipient

This information shall be provided for the purpose of _____.
Purpose of Disclosure

This authorization shall be in force and effective **[until** _____**/for** _____ **days/months/years].**

I understand that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notification to the person authorized to make the disclosure, identified above.
- My revocation will not be effective to the extent that the authorized person has relied on the authorization before receiving the revocation, but will be effective from that date forward.
- Failure to furnish this authorization will not affect my medical treatment/eligibility or enrollment for health coverage or the payment of health benefits.
- Once disclosed, the protected health information may no longer be protected by federal or state law and could be disclosed again by the recipient.

_____ _____
Signature of Individual or Personal Representative **Date**

If a personal representative is signing the form on behalf of the individual whose medical information is to be disclosed, please print the personal representative's name and describe his or her authority to act on behalf of the individual.

_____ _____
Name of Personal Representative **Authority of Personal Representative**

A fax or photocopy of this form shall be as effective as the original. A copy of this form shall be provided to the authorizing individual.

DERMATOLOGIC SURGICENTER LASER SURGERY

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1200 Locust Street, Philadelphia, PA 19107 Tel: 215-546-3666 Fax: 215-546-6060

Date _____

Patient Name _____

I give permission to the Dermatologic SurgiCenter to release my medical information to the following persons, whether by telephone, email, print or in person

_____ Relation _____

_____ Relation _____

_____ Relation _____

_____ Relation _____

This includes reports of medical tests, treatment options, diagnosis, prognosis and other pertinent facts that may impact on my health or well being. I have been informed about HIPAA and consent to this disclosure to the above individuals.

A copy of the Patient Bill of Rights and Responsibilities has been provided.

_____ or _____

Signature (Patient) Legal Guardian/Surrogate

There is a post-graduate Surgical Fellow in training at this practice. He is a board eligible/certified Dermatologist. I accept the participation of the Fellow in my care.

_____ _____

Signature of Patient Date

Date: _____ Chart # : _____

GENERAL MEDICAL HISTORY

NAME: _____ AGE: _____ DOB: _____

BIRTHPLACE: _____ ETHNIC BACKGROUND: _____

OCCUPATION: _____ GENERAL HEALTH: Good Fair Poor

Hair Color: _____ Complexion: _____ Sun Exposure: Minimal Average Excessive

CHECK IF YOU HAVE BEEN OR ARE BEING TREATED FOR CONDITIONS/DISEASES BELOW:

____ Heart	____ Eyes	____ High Bld Pressure	____ Blood Clots
____ Lung	____ Ears	____ Diabetes	____ Heart Attack
____ Stomach	____ Nose	____ Anemia	____ Tuberculosis
____ Bowels	____ Throat	____ Asthma	____ Hepatitis
____ Blood Vessels	____ Kidney	____ Emphysema	____ HIV/AIDS
____ Neurologic	____ Bladder	____ Stroke	____ Rashes
____ Thyroid	____ Transfusions	____ Cancer	____ Skin Cancer

LIST ALLERGIES TO MEDICATIONS: _____

OTHER ALLERGIES: _____

LIST OF MEDICATIONS: _____

_____

_____

HABITS: Coffee _____ cups/day Tobacco: _____ pk/day _____ # of years Alcohol _____ oz/day

Do you have a Living Will (Advanced Directive)?: YES _____ NO _____

Prior X-Ray Treatments or Radiation: _____

For What Disorder: _____ At What Age: _____

CHEMICAL EXPOSURES: At Work _____ At Home _____

HAVE YOU BEEN EXPOSED TO THE FOLLOWING? IF YES, WHERE AND WHEN:

Well Water _____ Arsenic _____

Fruit Sprays _____ Insecticides _____

Agent Orange _____ Other Toxins _____

FAMILY HISTORY OF CANCERS:

	TYPE OF CANCER	ALIVE	DECEASED
Grandparents			
Father			
Mother			
Sisters			
Brothers			
Children			

DERMATOLOGIC SURGICENTER
PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

1. You have the right to respectful care given by competent personnel with standards that are continually maintained and reviewed.

2. You have the right, upon request, to be given the name of his attending practitioner, the names of all other practitioners directly participating in his care and the names and functions of other health care persons having direct contact with you. You are informed of your right to change your provider if other qualified providers are requested and available.

3. You have the right to know that we credential our physicians in accordance with state accreditation association for ambulatory healthcare regulations.

4. You have the right to consideration of privacy concerning your own medical care program. Case discussion, consultation, examination and treatment are considered confidential and shall be conducted discreetly.

5. You have the right to have records pertaining to your medical care treated as confidential except as otherwise provided by law or third party contractual arrangements.

6. You have the right to know what DSC rules and regulations apply to your conduct as a patient. The patient is expected to treat the staff with dignity and respect and carry themselves in a courteous fashion.

7. You have the right to expect emergency procedures to be implemented without unnecessary delay.

8. You have the right to full information in layman's terms, concerning diagnosis, treatment and prognosis, including information about alternative treatments and possible complications. When it is not medically advisable to give the information to the patient, the information shall be given on his behalf to the responsible person/surrogate.

9. Except for emergencies, the DSC physician shall obtain the necessary informed consent prior to the start of a procedure.

10. You or, a responsible person/surrogate, have the right to be advised when a DSC physician is considering the patient as a part of a medical care research program/clinical study, and the patient, or responsible person/surrogate, shall give informed consent prior to actual participation to the program. A patient, or responsible person/surrogate, may refuse to continue in a program to which he has previously given informed consent.

11. A patient has the right to refuse drugs or procedures, to the extent permitted by statute and a DSC physician shall inform the patient of the medical consequences of the patient's refusal of drugs or procedures.

12. You have the right to medical and nursing services without discrimination based upon age, race, color, religion, sex, national origin, handicap, disability or source of payment.

13. The patient who does not speak English shall have access, where possible, to an interpreter.

14. Prior to receiving care, patients are informed of their responsibilities.
a. You must provide complete and accurate information to the best of your ability about health, medications, allergies, over the counter products.
b. You have the responsibility to adhere to the prescribed medical advice/treatment plan.
c. You must provide a responsible adult to transport you from the facility and remain with you for 24 hours if required by the provider.
d. You must inform the provider about any living will, medical power of attorney, or other directive that could affect your care. If you do not have an Advanced Directive and would be interested in completing one, we are happy to supply you with information.
e. You are responsible for making known whether or not you clearly understand the medical treatment plan.

15. The DSC shall provide the patient or patient designee/surrogate, upon request, access to the information contained in his medical record, unless access is specifically restricted by the DSC physician for medical reasons.

16. When an emergency occurs and a patient is transferred to another facility, the responsible person shall be notified. The institution to which the patient is to be transferred shall be notified prior to the patient's transfer.

17. You have the right to examine and receive a detailed explanation of your bill. The patient must accept personal financial responsibility for any charges not covered by insurance.

18. You have the right to expect that the DSC will provide information for continuing health care requirements following discharge and the means of meeting them.

19. Patients are informed about procedures for expressing suggestions to the DSC and policies regarding grievance procedures and external appeals. You have the right to submit a grievance either verbally or in writing to: Administrators of the Surgical Center, Drs. Anthony and Ernest Benedetto, 2221 Garrett Road, Drexel Hill, PA 19026. Telephone: 610-623-5885. You will receive a written notice of decision within 21 calendar days describing the steps taken to investigate, the results, and the completion date.

20. For complaints, concerns, and grievances:
Pennsylvania Department of Health: Division of Acute Ambulatory Care (DAAC)
Central Office: 625 Forster Street
H&W Building, Room 532
Harrisburg, PA 17120-0701
Phone Number: 1-800-254-5164

Website for the Office of the Medicare Beneficiary Ombudsman:
http://www.cms.hhs.gov/ombudsman/resources.asp

21. Financial Interest/Ownership: Drs. Anthony, Ernest, and Paul Benedetto are the sole owners and medical directors of the Dermatologic SurgiCenter.