NORTHSTAR
DERMATOLOGY

5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-3376 Fax: 817-427-3379

Patient Registration

Name: _____

Address: _____

City, State, Zip: _____

Date of birth: _____ Age: _____ ☐ Male ☐ Female

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Employer: _____

Primary Care Physician: _____ Phone # (of PCP): _____

City, State (of PCP): _____

Referring Physician: _____ Phone #: _____

City, State (of Referring Physician): _____

Emergency Contact: _____

Relationship to Patient: _____ Phone: _____

If Patient is a Minor: Information of Guardian or Legal Representative

Name (First and Last): _____

Street Address: _____

City: _____ State: _____ Zip: _____ Email: _____

Date of birth: _____ /_____ /_____ ☐ Male ☐ Female Home Phone: _____

Cell Phone: _____ Work Phone: _____

How did you hear about us?

□ Friend/Family Member □ Insurance Company □ ZocDoc □ Google □ Facebook

□ Physician Referral □ Walk-in □ Website □ Mail □ Other: _____

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General Consent Form

Updated 3/1/2018

Patient Name: _____ Date of Birth: _____ / _____ / _____

Consent for Treatment. I hereby consent to and authorize the physician(s) and employees at Northstar Dermatology to render care to me during my office visit(s). I authorize the release of my medical information to my primary care physician, referring physician, and/or consultants as necessary to carry out treatment and to process insurance claims and/or prescriptions. I understand that photography may be necessary for planning and evaluating treatment, and hereby authorize taking photographs at the direction of the physician and/or delegate, solely for documentation purposes and recognize they will be kept confidential unless otherwise disclosed.

Patient Initials: _____

Assignment of Benefits. In consideration of services rendered or to be rendered, I assign and transfer to Northstar Dermatology any benefits payable to me or on my behalf under any insurance coverage or Medicare. I authorize the release of any medical information for the purpose of processing insurance claims on my behalf. I understand it is my responsibility to provide current up-to-date insurance information prior to treatment. I understand that I am financially responsible for services provided which are to be paid on the date of service. This includes copayments, deductibles and/or coinsurance with any managed care contract. I also acknowledge that the filing of an insurance claim(s) is not a guarantee of payment, and that I am financially responsible for payment if such claim(s) are unpaid or denied by the insurance company.

Patient Initials: _____

May We Contact You by Phone and Leave a Message About Your Care or Regarding Lab/Pathology Results?
As our policy in delivering complete patient care, we make every attempt to notify you of all pathology and lab results, as well as other details pertaining to you care. This to acknowledge that you authorize us to:

☐ Leave a detailed message on voicemail/answering machine.

☐ Leave a message with authorized individual answering the phone.

☐ Please do not leave a detailed voicemail; leave message with call back number only.

Phone # for results: _____ ☐ Home ☐ Mobile ☐ Work

Authorized Person(s) to Receive Information: I authorize Northstar Dermatology to release medical, appointment, and/or financial information over the phone or in person to the following person(s) (i.e. spouse, family member, etc.):

Name	Relationship	Phone

☐ I DO NOT wish to add an additional contact to discuss my/the patient's needs.

Continued

Email Communication Consent. At Northstar Dermatology, we are always striving to improve communication and prioritize convenience for our patients and use email for some forms of communication. It is important to note that this type of communication is not always secure. Northstar Dermatology cannot promise security and confidentiality when emailing and will not be responsible if emails are incorrectly shared and someone other than Northstar Dermatology is at fault. E-mail should not be used for emergencies. Northstar Dermatology cannot use or share your health information without your permission except by ways listed in Northstar Dermatology Notice of Privacy Practices. These emails become a part of your medical record.

During an email transmission, it may be intercepted, read and/or forwarded by someone without your permission. Information that is particularly sensitive to you should not be sent by you via e-mail. This office is not responsible if you let someone else see your emails. This office is not responsible for loss, delay or misdirect of emails. If you do not receive a response to an email, you are responsible for calling this office to follow up.

☐ **I acknowledge that I have read the above and hereby give my consent to receive medical related correspondence and newsletters via email**.

☐ **I DO NOT wish to receive emails from Northstar Dermatology** **Patient Initials: _____**

Electronic Device Usage. In observance of the confidentiality rights of other patients and out of respect for the privacy of our employees and physicians, the use of cameras or other video-capable recording devices are strictly prohibited within the premises of Northstar Dermatology. Photo, video or audio recordings in the office are strictly prohibited. Patients are asked to please turn off cell phones or place them on silent while in the exam rooms. Patients that take calls while in the exam rooms with an employee/physician of Northstar Dermatology may need to reschedule their appointment for a later date.

Patient Initials: _____

Missed Appointment Policy. We require 24-hour advanced notice if you are unable to keep a scheduled appointment. It is our policy that a single missed appointment will require a $50 deposit to book any future appointments.
Our reasoning: Unfortunately, we can only accommodate so many patients in a day, and demand to see a physician on an urgent or timely basis is high. Appointments are time slots specifically reserved for you. A missed appointment takes time that may have been otherwise dedicated to another patient requiring urgent care.

Patient Initials: _____

Medication Compliance Policy. Under no circumstance will medications (antibiotics included) be refilled for missed or cancelled appointments. Missed office visits while on medications requiring monitoring may lead to discontinuation of the medication and dismissal from the practice. *Our reasoning: Medications, no matter how seemingly harmless, have the potential for serious side effects. As such, it is sound medical practice to monitor patients while on these medications.*

Patient Initials: _____

Notice of Office Financial Policy
I acknowledge receipt and agree to comply with the "Office Financial Policy." **Patient Initials: _____**

Notice of Privacy Practices
I acknowledge receipt of the HIPAA "Notice of Privacy Practices." **Patient Initials: _____**

I have read and understand the above, and agree to comply with the policies of Northstar Dermatology.

Name of Patient/Legal Representative: _____

Signature of Patient/Legal Representative: _____ Date: _____

Northstar Dermatology, PA
5320 N. Tarrant Parkway, Suite 200
Fort Worth, TX 76244
Phone: 817-427-3376 Fax: 817-427-3379

Office Financial Policies & Patient Responsibilities

Updated on: January 30, 2018

Thank you for choosing Northstar Dermatology for your skin care needs. It is our goal to provide you with a positive experience. Over the past few years, the practice of medicine has become more complicated for physicians and patients alike.

Because of the growing complexity of the insurance business, we feel that we can no longer assume that patients fully understand the relationship between the insurance company, the physician, and themselves. In an effort to clarify this relationship, we have established a set of guidelines regarding financial responsibility and office policies.

We will file your insurance for you if we are in your network.

- It is your responsibility to verify if a provider/physician is in your insurance network prior to your visit. If we have a contract with your plan, we will file a claim with your insurance company. If your insurance plan is not in network or not contracted with our practice, the total cost of your visit will be your responsibility.
- With some plans, you may be required to see a Primary Care Physician (PCP) in order to see a dermatologist or other specialist. If your plan requires authorization by a PCP, you must obtain a referral prior to your visit. If a referral is not obtained by the time or your visit, you may be responsible for the total cost of the visit.
- It is your responsibility to understand your insurance plan coverage. If you do not understand your policy, you may wish to contact the number on the back of your card to review and verify your benefits. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services or diagnosis codes which they will not cover. Our office never guarantees that your insurance will pay. We will make every attempt to file your claim as straightforward and simple as possible. However, if for any reason your claim is denied, you are responsible for the amount due on your account.

A valid Picture ID and your Insurance Card are required at the time of your office visit

- If we do not receive your insurance card before you see the doctor, that visit becomes fee for service and full payment will be due at the time of service.
- It is your responsibility to notify the staff of any changes in your address, phone number and/or insurance plan, and provide a current up-to-date insurance card at each visit. Failure to do so may cause your insurance claim to be rejected, thus making it your responsibility to pay for the total cost of the visit.

Copayments, Deductibles and Co-Insurance

- A copayment is a set dollar amount you owe for each office visit. All claims are subject to a deductible if a procedure is performed (i.e. biopsy, cryosurgery, excisions, etc.). A deductible is the amount you are obligated to pay before your insurance company starts paying for your healthcare costs. Some insurance plans may also have a coinsurance, in which you may be responsible for a percentage of healthcare costs in addition to your copay or deductible. It is your responsibility to understand your plan and any associated deductible or coinsurance. Payment will be due at time of service if your deductible has not been met or if your plan requires a coinsurance payment. You may be billed for this amount should your insurance company notify us that additional payment is due from you.

We are not providers for Medicaid

- We are not providers for Medicaid and will only accept Medicaid patients as self-pay. We will not file any claims to Medicaid as primary or secondary insurance.

Not Medically Necessary or Cosmetic Procedures

- Your insurance company may deem certain procedures as not medically necessary, or cosmetic. If you and your doctor decide to continue with a procedure that falls into this category, we require payment in full at the time of service. The following are some examples:
- Removal of benign lesions (i.e. skin tags, angiomas, sun spots or liver spots, cysts, milia, sebaceous hyperplasia, or seborrheic keratoses, etc.…)
- Botox, Fillers, Chemical Peels, Scar Revisions, Cosmetic Consults or Procedures
- The cost of any procedure will be a separate fee from an office visit or consultation fee.

Laboratory and Pathology Fees

- Many times, it may be necessary to obtain a tissue sample (biopsy) or perform lab tests to confirm a diagnosis or determine a course of treatment. If a biopsy or other lab work is done, there is a separate fee for processing and interpretation of the biopsy and/or lab work. **This means that you will receive a separate bill from another doctor or laboratory for these tests.** We will attempt to use a lab which files directly with your insurance carrier. Although the lab will file with your insurance, you are responsible for any bill you may receive from the laboratory or pathology services used. If you receive a bill from the lab, please contact the lab directly to resolve any billing concerns.

Medical Record Copies

- There is a $20 flat fee for medical record copies up to 100 pages. There is an additional $20 fee for each additional 100-page increment (any number of pages up to 100).

Missed Appointments, Late Cancellations, & Non-Compliance

- Please keep in mind that appointments are time-slots reserved specifically for you. We require a 24-hour advance notice if you are unable to keep your scheduled appointment. As a courtesy, we offer appointment reminder calls which will allow you to cancel or reschedule at that time. However, it is ultimately your responsibility to keep track of your appointments whether you receive a reminder call or not.
- If you miss an appointment without a 24-hour notice or cancel/reschedule on the same day of your appointment, a $50 deposit will be required to book your next appointment. This deposit applies towards the cost of your appointment, or may be refunded to you following your appointment if not applied.
- If you are more than 15 minutes late, your appointment may be cancelled and you will need to reschedule. We encourage new patients to show up 15 minutes early to complete their registration.
- Patients with repeat cancellations or missed appointments may be discharged from our practice.
- Please note that noncompliance with treatment plans (including medications and/or lab work) and abusive/inappropriate behavior towards staff and/or other patients will result in dismissal of your care from our practice.

Forms of Payment

- For your convenience, we accept cash, personal checks, MasterCard, Discover, and Visa.
- There is a $40 fee for all returned checks.

Secure Credit Card on File

- Northstar Dermatology requires all patients to provide a debit or credit card on file in order to make billing services more efficient and secure. See our “Secure Credit Card on File Policy” for more details.
- Once your insurance provider has processed your claim, an Explanation of Benefits (EOB) is sent to our office stating how much you owe based on your benefits. We will then send you a statement for this balance.
- If payment is not received within 30 days of the statement, we will charge your authorized credit card for the balance owed. This policy in no way compromises your ability to dispute a charge or question your insurance company’s determination of payment. Patients with a balance over $100 may call our office to setup a payment plan if needed.

Collection Efforts

- Should you have any unpaid balances, you will receive a statement regarding the balance in accordance with our Secure Credit Card on File policy. If the balance is not paid within 30 days of the statement, and we are unable to charge an authorized card on file, the balance will be turned over to a collection agency. The collection agency will add up to 35% to any balance turned over to them.

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Secure Credit Card on File Policy

Updated 1/10/2018

Northstar Dermatology requires all patients to provide a debit or credit card in order to make billing services more efficient and secure. Your authorized credit card information will be stored using a "Wallet" feature with our payment processor that is Payment Card Industry (PCI) and HIPAA compliant and completely secure as required by law. All data is encrypted and safeguarded against fraud and other data breaches. The credit card information is **NOT** kept on file here in our office or on any of our computers.

How It Works: Once your insurance provider has processed your claim, an Explanation of Benefits (EOB) is sent to our office stating how much you owe based on your benefits. We will then send you a statement for this balance. If payment is not received within 30 days of the statement, we will charge your authorized credit card for the balance owed. This policy in no way compromises your ability to dispute a charge or question your insurance company's determination of payment. Patients with a balance over $100 may call our office to setup a payment plan if needed.

Should your credit card expire or become invalid, we expect you to promptly provide an updated, valid card for us to charge with the same authorization as the original card. If we are unable to charge your card for the balance owed, we will forward the account to our collections agency. If there is a problem with your bill or claim and it is brought to our attention after your credit card payment processes, we can apply a refund directly to your card if we have made a billing error.

Credit Card on File Authorization

I agree to place the following credit card on file. I authorize Northstar Dermatology and their staff to automatically charge my credit card only for the purposes stated above. This agreement will expire after 1 year.

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Last Four Digits of Credit Card Number: _____ Expires: _____ / _____

Credit Card Holder's Name (as printed on card): _____

Patient Name: _____ **DOB: _____**

Card Holder Signature: _____ **Date**: _____

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Secure Credit Card on File Policy FAQs

Do I have to leave a credit card on file?

Yes, all patients of Northstar Dermatology will need to have a credit or debit card on file. This is our office policy and it is a growing trend in the healthcare industry. This system will improve efficiency in our billing and collections process by reducing the time and costs spent on mailing out multiple statements. Additionally, maintaining a credit card on file is more secure for our patients than asking them to send a check or credit card information through the mail.

How do I know that my credit card information is safe?

We place a high priority on keeping your personal and financial information secure. Your card information is protected by our payment processor, TSYS, which is legally required to comply with very strict PCI (Payment Card Industry) data security standards to safeguard your credit card information. When you check-in for your appointment, our office staff will enter your authorized credit card information into our secure merchant portal. This portal stores the card information for future transactions in the same way a hotel or other retailer like iTunes or your electric company would. We cannot see the full card number, so there is no way to use the card outside of our billing system.

How do I know how much you will charge?

After your insurance has processed your claim they will send you an Explanation of Benefits (EOB). We will receive the same EOB which shows how much your insurance has paid and what the patient responsibility amount is based on your benefits. We then apply any insurance payments and adjustments, as well as patient payments made in the office for that date of service. If there is a remaining patient responsibility balance, we will send you a statement showing your account balance. This is the amount we will charge to your card if payment is not received in the allotted amount of time.

What if I need to dispute my bill?

You may call our office if you ever have a concern about your bill. If a mistake has been made we would be happy to work with you to get it resolved, and we will refund your card if we have made a billing error. Remember, we will only charge the amount assigned as “patient responsibility” as shown on your EOB.

What if I can’t afford the whole balance?

If your balance is over $100, you may call our office to set up a payment plan. Our system will then automatically charge your authorized card based upon your payment plan. Cosmetic services must be paid in full at the time of service.

What if you overdraft my account?

If you are concerned about the possibility of insufficient funds, we recommend that you use a credit card for the Credit Card on File program rather than a debit or check card.

I have two insurance plans. Do I still need to give you a credit card?

Yes. Even with multiple insurances, there can be times a patient still owes a responsibility. Please keep in mind, we will not charge your card if you do not owe anything.

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Patient Name: _____ **Date of Birth**: _____

Pharmacy (including address or intersection): _____

_____

Reason for today's visit:

_____

Do we have the pleasure of seeing any family members? _____

Past Medical History: (please answer all questions)

	No	Yes
Eczema		
Skin Cancer		
Other Cancer		
Artificial Joints		
Artificial Heart Valves		
Mitral Valve Prolapse		
Pacemaker/Defibrillator		
Heart Disease		
High Blood Pressure		
Bleeding Tendency		
Keloids or Excessive Scarring		
Diabetes		
Thyroid Disorder		
Asthma		

	No	Yes
Tuberculosis		
Arthritis		
Lupus Erythematosus		
Chronic Pain		
Nervous or Mental Problems		
Seizures		
Liver Disorder(s)		
Hepatitis B		
Hepatitis C		
Kidney Disorder(s)		
Lung Problem(s)		
Organ Transplant		
HIV (AIDS)		
Other		

History of Skin Cancer:

	No	Yes	Location
Basal Cell Carcinoma			
Squamous Cell Carcinoma			
Malignant Melanoma			
Other			

Family History:

	No	Yes	Family Member
Eczema			
Psoriasis			
Melanoma			
Unknown – Adopted			

Social History:

	No	Yes	How Often/How Much? (Socially, Daily, etc.)
Do you consume alcohol?			
Do you smoke?			
Do you chew tobacco?			
Ever smoke in the past?			When?
Do you use any sun protection?			

Allergies: (if none, please write "none")

Allergy	What kind of Reaction?	Notes

Patient Current Medications: (if none, please write "none")

Drug	Dosage	How Often?

Review of Systems:

	No	**Yes**	**Describe:**
Unintentional Weight Loss			
Night Sweats			
Rash/Itching			
Sun Sensitivity			
Joint Pain			
Headache			
Abdominal Pain			
Depression			
Stress/Anxiety			
Bruising			
Swollen Lymph Nodes			

Women:	**No**	**Yes**
Are you pregnant?		
Trying to get pregnant?		
Are you nursing?		