SHETH DERMATOLOGY
& MOHS SURGERY CENTER

9131 West 151st Street
Orland Park, IL, 60462
Phone: (708) 323-3376
Fax: (708) 390-0842
www.shethdermatology.com

Welcome to Our Practice!

If you are a new patient to our practice, we recommend completing your new patient information online. You can access the patient portal at https://shethderm.ema.md. Please call our office so that we can give you your personal access information. We hope you will find this an easy way to provide us with your important health information. If you do not have internet access, you may mail or fax your completed forms to the address/fax number listed above.

Your First Visit

You will need to bring a photo ID, current insurance card, credit or debit card and an up-to-date list of current medications.

New Patient Intake Form

Legal Name: _____
(First) (Middle Initial) (Last)

SSN#: _____ Date of Birth: _____ Age: _____ Gender (circle): M F

Marital Status: _____ Occupation: _____ Email Address: _____

Mailing Address: _____
(Street) (City) (State) (Zip Code)

Home Phone: _____Cell Phone: _____Work Phone: _____

Preferred Phone: Home / Work / Cell May we leave a detailed message? Yes / No

Emergency Contact: _____Relationship: _____Phone#: _____

Primary Care Physician: _____ Referring Physician: _____

Pharmacy Name: _____ City/State _____

Illinois State/Federal Government REQUIRES we ask the following questions:

Primary Language: _____English _____Spanish _____Somali _____Chinese _____Other _____

Race: _____Caucasian _____Asian _____African American _____ Other_____

Ethnicity: _____Hispanic _____Latino _____Not Hispanic or Latino _____

How did you hear about our practice? (Circle)

*Internet/ZocDoc/Facebook/Drove by Office/Friend/Physician/Insurance Plan/Church Bulletin/Other*_____

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Consent for Treatment and Fee Responsibility

This is to certify that I (or my authorized agent) consent to the performing of any surgical or medical procedure or examination as required. I (or my authorized agent) assume financial responsibility for any services rendered.

Photo Consent

I consent to photographing for medical, scientific, or educational purposes, provided my identity is not revealed by these pictures or descriptive text. In addition, I permit that these photographs may be used for educational and explanatory purposes to the general public. I also permit these photographs to be used as before/after illustrations.

HIPPA Consent

I consent to Sheth Dermatology's uses and disclosures of my protected health information. I agree that Sheth Dermatology may release my information, including information related to substance abuse, communicable disease, psychiatric treatment, HIV/AIDS, and/or genetic testing to other physicians for the coordination of care. I understand that this consent will remain in effect until I revoke it, in writing by sending my request to the company's Privacy Officer. Such a revocation shall not affect any disclosures Sheth Dermatology had made with my prior consent. I have been offered/received a Notice of Privacy Practices dated March 8th, 2016 and that there are additional copies available upon my request.

Patient/Guardian Signature Date

Release of Medical Information

I authorize Sheth Dermatology & Mohs Surgery Center to release any medical information requested by my insurance company, Medicare, and/or supplemental insurance, as well as the names listed below.

Sheth Dermatology & Mohs Surgery Center has my permission to release information to the following people:

Name: _____ Relationship: _____ Phone #: _____

Name: _____ Relationship: _____ Phone #: _____

Responsible Party *(if different from patient)*

Name:_____D.O.B:_____Relationship to Patient:_____
(First) (Middle) (Last)

Address:_____City:_____State:_____Zip Code:_____

Home Phone: _____Work Phone:_____

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Financial / Payment Policy

Insurance

Please remember that your health insurance is a contract between you and your insurance company. It is YOUR responsibility to know your health plan benefits, including co-payment amounts, deductibles, co-insurance, and lab contracts. As a service to you, we will submit a claim to your insurance company for all visit charges, but we do not share in the contract between you and your insurance company. *You are responsible for any charges not covered by your insurance plan.*

Please contact your insurance company with any questions you may have regarding your benefits and coverage.

Co-Payments, Deductibles & Credit Card on File

If your insurance plan includes a co-pay, it must be paid upon check-in on the day of service. Failure to collect a required co-payment can constitute insurance fraud. If you cannot pay your co-pay on your day of service, we will ask that you reschedule your appointment.

Sheth Dermatology requires patients to keep a credit card on file to pay any balance due after insurance has made payment to us (including both primary and secondary insurance companies). This card will be used only to charge the balance due on the patient's account (co-payments, co-insurance amounts, and deductibles). We will send you one invoice and await payment. If no payment is received within 30 days after the date of the invoice/statement, we will charge your card for the balance due. If the balance due is more than $100.00, we will give you a courtesy call prior to charging your card.

Itemized receipts will be mailed to you for any charges made on your card.

By signing this form, I authorize Sheth Dermatology to charge co-pays and outstanding deductibles on my account to the Credit card or check kept on file.

Patient/Guardian Date

Referrals

Some insurance plans require a prior authorization or a referral from a patient's Primary Care Physician to see a Specialist. You can determine whether you need prior authorization or a referral by checking your insurance card or by calling your insurance company, using the telephone number on the back of your insurance card. Contact your Primary Care Provider if a prior authorization or a referral is needed for your visit. If either a prior authorization or referral is required, it must be received by us prior to your visit.

Payment

We accept cash, Visa, Master Card, Discover, American Express and Care Credit. We are sorry, we do **NOT** accept checks.

Cosmetic and elective procedures require a full payment on the day of service.

Some diagnoses might be considered cosmetic or may not be covered by your insurance company. Payment in full for these cosmetic services will be required at the time of service. Services provided which your insurance company determines are not

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covered under your plan, are your responsibility and will be billed to you. If you have any questions regarding benefits and coverage, please contact your insurance company.

Financial Responsibility

Sheth Dermatology uses an outside laboratory for interpretation of specimens collected during your visit. This will result in a separate bill from the pathology laboratory. This charge may or may not be included in your insurance plan deductible. You are ultimately responsible for this charge.

Cancellation Policy

Sheth Dermatology is dedicated to providing the highest quality of care for our patients in a timely and efficient manner. No-Shows prevent access for other people who may be waiting for an appointment. We have implemented a policy regarding no-show appointments and cancellations without 24 hour prior notice as follows:

No-Shows:

- A patient who fails to show for their scheduled appointment without prior notice will be considered a "no-Show". Patients who no-show will be charged a $100.00 fee.
- A patient having two no-show appointments will be considered for dismissal from the practice.

Cancellations:

- Our office requires at least 24 hour prior notice for cancelled appointments to allow the appointment slot to be available to another patient.
- Cancellations within 24 hours of the appointment time will be considered a "no-show" appointment, and Charged a $100.00 fee.
- Patients cancelling two times without at least 24 hour prior notice will be considered for dismissal from the Practice.

Collections

I understand that if my balance becomes delinquent, it will be turned over to a third party collector. An additional fee will be added to your account of $30.00 if sent to the third party collector.

I acknowledge that I have read and agree to the financial policy of Sheth Dermatology & Mohs Surgery Center.

I hereby assign medical benefits otherwise payable to me to the Provider for services rendered.

I hereby authorize release of my medical information to the insurance companies to process claims, to my referring physician and to any physician involved in my care.

Patient/Guardian Signature Date

Patient/Guardian Printed Name Relationship to Patient Patient Date of Birth