Housel Dermatology, P.C.

Joseph P. Housel, MD
Mohs and Reconstructive Surgery
235 Greenfield Parkway
Liverpool, NY 13088
Phone (315) 452-3376
Fax (315) 452-3377

Patient Information Date _____

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F
Referred By: _____ Phone: _____
Address: _____ City: _____
Zip: _____ Email: _____
Home Phone: _____ Cell: _____ May we leave a message? ☐ Y ☐ N
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Employer: _____ Work Number: _____

Ethnic Group
- ☐ Hispanic or Latino
- ☐ Not Hispanic or Latino
- ☐ Decline

Race
- ☐ White
- ☐ African American
- ☐ American Indian or Alaska Native
- ☐ Hispanic
- ☐ Other race

Emergency Contact: _____ Relationship: _____
Emergency Phone: _____

Insurance Information
Insurance Company: _____ Policy Holder: _____
Policy Number: _____ Relationship to patient: _____
Group Number: _____ Policy Holder DOB: _____
Effective Date: _____ Policy Holder SS#: _____

Secondary Insurance
Insurance Company: _____ Policy Holder: _____
Policy Number: _____ Relationship to patient: _____
Group Number: _____ Policy Holder DOB: _____
Effective Date: _____ Policy Holder SS#: _____

I certify that the information given by me in applying for payment under my insurance carrier is correct. I authorize any holder if medical/insurance information about me to release to my physician/insurance any information required to process my claims. I understand that to knowingly withhold insurance reimbursement payments for medical services rendered services to rendered would be committing a wrongful act. I request that reimbursement from my insurance be made payable to the physician's office that rendered services to me. I attest that the information I have given on these forms is true and correct to the best of my knowledge.

Signature: _____ Date: _____

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Acknowledgment of
Privacy Practices

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA),
I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used for:

- **Treatment:** Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- **Payment:** Obtain payment from third-party payers.
- **Operations:** Conduct normal healthcare operations such as quality assessments and physician certification.

I acknowledge that should I request a copy of Housel Dermatology, P.C.'s privacy practices containing a more complete description of the uses and disclosures of health information, one will be provided. I understand that this organization has the right to chance its Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy.

I authorize Dr. Housel and/or his staff to discuss my medical condition, including laboratory findings with the following individuals:

_____

_____

_____

_____

Signature: _____ Date: _____

Patient Printed Name: _____ Relationship to Patient: _____

Medical practice use only

If patient refuses to sign, a good faith effort was made to obtain the patient's or authorized representative's written acknowledgement of Privacy Practices. The reason the patient or authorized representative acknowledgment was not obtained is as follows:

_____

_____

_____

_____

Documented by: _____ Date: _____

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Patient Name: _____ **Primary Care Physician:** _____
Date: _____ **Referring Physician:** _____
Date of Birth: _____ **Email:** _____

1. Select any of the following medical conditions that you are *currently* having:

- ☐ None
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation (Irregular heartbeat)
- ☐ Bone Marrow Transplantation
- ☐ BPH
- ☐ Breast Cancer
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Depression
- ☐ Diabetes
- ☐ End Stage Renal Disease
- ☐ GERD
- ☐ Hearing Loss
- ☐ Hepatitis
- ☐ Hypertension
- ☐ HIV/AIDS
- ☐ Hypercholesterolemia
- ☐ Hyperthyroidism
- ☐ Leukemia
- ☐ Lung Cancer
- ☐ Lymphoma
- ☐ Prostate Cancer
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Stoke
- ☐ Other

2. Please list any surgeries or hospitalizations and the dates:

Date	Procedure

3. Have you had any of the following skin conditions?

- ☐ None
- ☐ Acne
- ☐ Actinic Keratosis
- ☐ Asthma
- ☐ Blistering Sunburns
- ☐ Eczema (Dry Skin)
- ☐ Flaking or Itchy Scalp
- ☐ Hay Fever/Allergies
- ☐ Melanoma
- ☐ Poison Ivy
- ☐ Squamous Cell Carcinoma
- ☐ Other

Do you wear sunscreen? ☐ Y ☐ N
If yes, what SPF? _____
Do you tan in a tanning salon? _____
Do you have a family history of melanoma? ☐ Y ☐ N
If yes, which relatives? _____

4. Do you drink alcohol?

- ☐ None
- ☐ Less than 1 Drink per week
- ☐ One Drink Per Week
- ☐ 2-3 drinks per week
- ☐ 3 or More drinks per week

Do you Smoke?

- ☐ Never smoked
- ☐ Former Smoker
- ☐ Current Smoker
- ☐ Smokeless tobacco
- ☐ Cigar

5. Please list any medications you are currently taking, including over-the-counter:

Medication	*Dosage*	*Frequency*

6. Do you have any allergies to medications, latex, adhesives, or other sensitivities?

_____

7. Are you experiencing difficulty *today* with any of the following?

- ☐ None
- ☐ Problems with bleeding
- ☐ Immunosuppression
- ☐ Fever or Chills
- ☐ Shortness of breath
- ☐ Chest Pain
- ☐ Unintentional weight loss
- ☐ Night Sweet
- ☐ Blurry Vision
- ☐ Abdominal pain
- ☐ Muscle weakness
- ☐ Headaches
- ☐ Anxiety
- ☐ Depression
- ☐ Bloody stool
- ☐ Thyroid problems
- ☐ Other _____

8. Family health history (1st degree relative): (Ex Heart disease, Cancer, Asthma, Diabetes, Allergies)

_____

_____

9. Please describe the reason for your visit to the dermatologist today, include how long the problem has been present and all treatments.

_____

_____

10. What is your occupation? _____

Emergency Contact: _____

Relationship to patient: _____

Phone number: _____

11. Which pharmacy do you use? (PLEASE BE SPECIFIC)

Name _____ Phone Number _____

Address _____ City/State _____

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Housel Dermatology, P.C. Financial Policy

Thank you for allowing Dr. Housel and the medical providers at Housel Dermatology, P.C. to provide care for your dermatological healthcare needs. The providers at Housel Dermatology, P.C are committed to the success of your medical treatment and care. Our practice will work with you to help fulfill your payment responsibility. Our billing office will file your primary and secondary medical claims for you. It is imperative that you provide us with accurate insurance information at EVERY visit. If you fail to provide the appropriate insurance information you will be considered SELF PAY, and we will make payment arrangements at the time of visit. It is important that you realize that we as a medical provider and you as the insured both have a contract with the insurance company. You may need to assist us if necessary with the reimbursement process. **As the insured you are responsible for any unpaid balance not contractually covered by your insurance.**

HOUSEL DERMATOLOGY, P.C IS NOT A MEDICAID PROVIDER: We are unable to bill any claims to Medicaid even as a secondary insurance.

Medicare: This office participates as a Medicare provider, accepting assignment for Medicare Part B (Physician Services) claims. The patient is responsible for their Medicare coinsurance, deductibles, and any other service rendered that is not covered by Medicare.

Managed Care Plans: In order to see a specialist, some insurance companies require that you obtain a referral from your primary care provider or a precertification before being seen at a specialist's office. It is the patient's responsibility to ensure that we have the necessary paperwork on file prior to your visit or the patient will be responsible for payment**. ALL COPAYS ARE DUE AT THE TIME OF SERVICE.**

Commercial Plans: Housel Dermatology, P.C. has established fees that are usual and customary for this healthcare service area. Every insurance carrier has their own usual and customary fee schedule; however, the patient is responsible for the fee regardless of the insurance carrier's arbitrary determination of rates.

Non-Covered Services: Some services we provide may not be deemed medically necessary by your insurance carrier or not a covered service benefit by your specific policy, therefore, not paid by your insurance policy. Many cosmetic procedures are not covered by your insurance company i.e. SKIN TAG REMOVAL. We cannot bill your insurance for any cosmetic procedures. The patient is responsible for the payment of any cosmetic charge at the time of the visit for ALL services not covered by insurance.

Laboratory Services: Some services such as biopsies and other specimens will be sent to an outside lab for further evaluation and processing. The patient WILL receive a separate bill for these types of services. The laboratory that we send most of specimens to is Mass General Dermatopathology Services. The phone number to call with any billing questions for pathology specimens at Mass General is 1-855-644-3376. The patient is responsible for any laboratory service that is not covered by insurance.

Self Pay: Patients who do not have insurance coverage are considered self pay. Self pay patients need to make payment arrangements prior to being treated at this office.

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Payment Arrangements: Housel Dermatology, P.C. may consider payment arrangements for those patients that are in need of assistance in meeting their account obligation. Housel Dermatology, P.C. reserves the right to set the terms, conditions, and charge interest for any payment arrangement. The arrangement needs to be made prior to being treated as a patient.

Returned Check Policy: Housel Dermatology, P.C will charge a $25.00 fee for each check that is returned by our bank for insufficient funds.

Collections: There will be a 40% fee added to any account balance that is sent to collections.

Authorization for Assignment of Benefits: In consideration of medical services provided, with your signature below, Housel Dermatology, P.C. (and/or Mass General Dermatopathology Associates in the case of laboratory services) is given the rights/title/interest to the medical reimbursement in accordance with the terms and benefits of the patient's insurance policy or other health benefits including Medicare Part B. **THE PATIENT WILL BE FULLY RESPONSIBLE FOR ANY AND ALL CHARGES NOT COVERED BY INSURANCE.**

Cancellation: Appointments must be canceled more than 24 hours in advance. If the patient does not show up for an appointment without 24 hours notice there will be a $25.00 fee for office visits and a $250.00 fee for surgical procedures. IF WE ARE UNABLE TO COMMUNICATE WITH YOU DUE TO THE FACT THAT THE PHONE NUMBER THAT YOU PROVIDED US DOES NOT ACCEPT ROBO CALLS YOU WILL STILL BE CHARGED A NO SHOW FEE. We make every attempt to leave a reminder and all reminder calls are recorded for verification.

I have read this financial policy and authorization. I understand that there is no guarantee or assurance as to the results that may be obtained for any treatment. I understand the terms and conditions outlined herein as confirmed by my signature below.

Signature/Date

Printed Patient Name/ Relationship to Patient
