SPRINGHOUSE
DERMATOLOGY

904 Sumneytown Pike, Suite 100 | Spring House, PA 19477 | 215.542.0655

PATIENT INFORMATION

Name _____ Sex_____ DOB_____/_____/_____
Last First M.I M / F MO DAY YR

Address _____ Tel_____(Home)
Street Address

_____ Tel_____(Cell)
City State Zip

Please provide Springhouse Dermatology a means of confirming your appointment.

Email:_____ Text :_____

Social Security Number_____Driver's License #_____

How did you find out about our practice? _____

Primary Care Physician_____
Name Address Phone

INSURANCE INFORMATION

Primary Insurance Carrier _____

Subscriber (if different) _____ SS#_____DOB_____/_____/_____

Secondary Insurance Carrier _____

Subscriber (if different) _____ SS#_____DOB_____/_____/_____

IN CASE OF EMERGENCY, CONTACT

Name_____

Relationship_____ Tel_____

REQUEST FOR CONFIDENTIAL COMMUNICATIONS

I request that all medical result communications to me by Margo Weishar M.D. and/or her staff be by telephone (unless otherwise requested).

The best number to contact me would be:_____H C W (circle one)

May we leave a message? Yes_____ No_____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependant) have insurance coverage as specified above. I assign directly to Dr. Weishar all insurance benefits, if any, otherwise payable to me for the services rendered. I understand that I am financially responsible for all charges whether or not paid by the insurance. I hereby authorize Dr. Weishar to release all information necessary to secure payment of benefits.

I will be responsible for a missed appointment fee.

Responsible Party Signature _____ Date_____/_____/_____

HIPAA PRIVACY PRACTICES NOTIFICATION

I, the undersigned, have been issued (if requested) the HIPAA Notice of Privacy Practices and this office's "Patient Rights and Responsibilities". I fully understand that Springhouse Dermatology, P.C is required by law to maintain the privacy of my medical and health information. I acknowledge that the Practice will use and disclose any health information for the purposes of treating me, obtaining payment for services referred to me and conducting health care operations.

Signature of Patient _____ Date_____/_____/_____

CONSENT FOR THE GENERAL MINOR PROCEDURES NECESSARY TO THE PRACTICE OF DERMATOLOGY AUTHORIZATION FOR MEDICAL TREATMENT, ADMINISTRATION OF LOCAL ANESTHESIA AND THE PERFORMANCE OF MINOR SURGERY AND/OR PROCEDURES.

1) I do hereby authorize the use of and the administration of such drugs, anesthetics, and other treatments, including the performance of a skin biopsy, the use of cryosurgery with liquid nitrogen, and the injection of intralesional kenalog (cortisone), should any of these be deemed advisable, desirable, or necessary for diagnostic, therapeutic, or investigational purposes by Margo Weishar, MD, or by any physician, physician assistant or appropriately trained and/or licensed heath care personnel on the staff of Springhouse Dermatology, for or upon me or my minor.
I understand that any of the above procedures may have some unwanted effects, which include, but are not limited to permanent scarring, permanent discoloration of the skin at the the site of treatment, atrophy (thinning or depression of the skin), infection, bleeding, nerve damage resulting in temporary or permanent numbness ore temporary or permanent loss of function of certain muscles (paralysis).
2) I further consent to the examination for diagnostic, investigational purposes, and disposal by authorities of the above named medical facility or its designates herein, of any tissue or parts which may be removed.
3) I recognize the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees or assurances have been made to me concerning the results of such procedures.

I CERTIFY THAT I HAVE READ, FULLY UNDERSTOOD AND RECEIVED A COPY OF THE ABOVE CONSENT AND THAT I HAVE RECEIVED CLEAR EXPLANATIONS REGARDING THE PROVIDED INFORMATION.

Signature of Patient _____ Date_____/_____/_____

If patient is under age 18 or unable to authorize consent: Signature of Parent or Legal

Guardian _____ Date_____/_____/_____

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FINANCIAL POLICY

You are responsible for any charges incurred as a patient of Springhouse Dermatology whether or not your insurer will cover them. Please provide valid and up to date information regarding your insurance if you wish us to bill them for you. This includes addresses, Social Security # of the insured, new cards, or any change in your insurance coverage. We require you to properly identify primary insurance. Coordination of Benefit denials will result in a patient bill. Springhouse Dermatology will only send out one bill to your insurer. If it is rejected due to incorrect information we will bill you for your entire visit and it will become your responsibility to send your claim in for reimbursement.

All cosmetic and laser services must be paid at the time of service.

Statement Balances – Patients will be assessed a $25.00 fee for any balance that is not paid in thirty days from the statement date. Patients who fail to pay overdue balances after two statements will be referred to our collection agency.

CANCELLATION POLICY

Medical Patients-please be advised that we require at least 24 hr notice to cancel an appointment. A $25 fee will be assessed to your account with a cancellation of less than 24 hrs notice and will be billed to your account.

Cosmetic Patients-please be advised we require at least 72 hr notice to cancel a cosmetic appointment. Should you cancel less than 3 business days, a non-refundable fee of $50 per 15 minutes of appointment time will be assessed to your account.

Springhouse Dermatology will attempt to remind you of your appointment.
All patients will be able to opt in to either text via smartphone or email confirmation reminders. It is the patient's responsibility to sign up for these reminders. If a patient misses an appointment without 24 hour notice for a medical appointment or 72 hours for a cosmetic appointment they are subject to a minimum $25 cancellation fee. * We do not share emails with any outside parties.

-I certify that I have read and accepted the terms of the Springhouse Dermatology Financial Policy.
-I authorize payment of medical benefits to the named provider for professional services rendered.
-I authorize the release of any medical information necessary to process this claim.

Patient Signature _____ Date_____/_____/_____

Signature of Parent _____ Date_____/_____/_____
(for patients under 18)

CREDIT CARD ON FILE POLICY

We request that all patients keep a CREDIT/DEBIT/HSA/FSA card on file. This policy will be effective and required beginning July 1, 2018. No exceptions will be made, as this will be used for any unpaid balance by your insurance company. Due to the high number of deductible plans, and higher patient coinsurance benefits, this has become necessary for our practice. Springhouse Dermatology, Inc. will not charge your card on file if you do not have an owed balance on your account. You will have 30 days to pay your bill with another payment form if preferred, after the Explanation of Benefits (EOB) has explained your responsibility and the bill has been sent to you. As a courtesy, our practice will call prior to charging the card on file for any balance that is over $250.

Once your credit card information is entered in our system, it is encrypted and cannot be viewed or accessed by our organization. The iTransact Group LLC is registered with Visa, MasterCard, American Express, Discover and independently certified. We will not retain your credit card information in this office.

Charges will be made ONLY after the claim has been adjudicated by your insurance and you will have received an EOB from your insurance detailing the amount billed. Circumstances when your card would be charged include but are not limited to the following: missed appointments, co-payments, deductibles and co-insurance, and non-covered services and/or denial of services.

I HAVE READ AND UNDERSTAND THE FINANCIAL, CREDIT CARD ON FILE, AND OFFICE POLICIES OF SPRINGHOUSE DERMATOLOGY INC.

Patient Signature _____ Date____/____/____

Signature of Parent _____ Date____/____/____
(for patients under 18)