EAST PENN DERMATOLOGY, PC
Michael Stierstorfer, M.D.
Marvin Sasson, M.D.
1140 Welsh Road, Suite 130
North Wales, PA 19454
215-661-0300
Fax: 215-661-0302

POLICIES REGARDING CANCELLATIONS AND NO-SHOWS

EFFECTIVE JANUARY 1, 2018

We understand that there are times when you must miss an appointment due to emergencies or obligations for work or family. However, when you do not call to cancel an appointment, you may be preventing another patient from getting much needed treatment. Conversely, the situation may arise where another patient fails to cancel, and we are unable to schedule you for a visit.

Effective January 1, 2018, if an appointment is not cancelled at least 24 hours in advance and you do not arrive for your appointment, you will be charged a $50.00 fee. This fee will not be reimbursed by your insurance company, nor will it be credited toward a future appointment.

Since we certainly understand that illness or other problems can occur, and sometimes without any warning, we will not charge you for your *first* missed or cancelled appointment.

This policy is in effect for all appointments at all of our office locations. Please acknowledge that you have had the opportunity to review this policy by signing below.

Thank you for your understanding and cooperation.

_____

Patient Name

_____

Signature Patient/Guardian

_____

Relationship to Patient

_____

Date

EAST PENN DERMATOLOGY, P.C.
FINANCIAL POLICY

PATIENT NAME: _____ DATE OF BIRTH: _____

IF YOU HAVE INSURANCE:

YOU ARE RESPONSIBLE TO KNOW YOUR CURRENT INSURANCE BENEFITS AND TO ASCERTAIN IF EAST PENN DERMATOLOGY PROVIDERS ARE PARTICIPATING WITH YOUR INSURANCE NETWORK.

YOU ARE RESPONSIBLE TO PROVIDE OUR OFFICE WITH A CURRENT INSURANCE ID CARD AND TO OBTAIN A REFERRAL IF NECESSARY FOR EACH VISIT.

YOUR ESTIMATED PORTION, INCLUDING ANY COPAYS, DEDUCTIBLES, OR COINSURANCE WILL BE EXPECTED AT THE TIME OF THE VISIT.

PAYMENT FOR ANY NON-COVERED, COSMETIC SERVICE WILL BE EXPECTED AT THE TIME OF THE SERVICE.

IF YOU DO NOT HAVE INSURANCE OR CAN NOT PROVIDE A CURRENT INSURANCE OR REFERRAL AT THE TIME OF THE VISIT:

YOU WILL BE RESPONSIBLE FOR PAYMENT IN FULL AT THE TIME OF EACH VISIT.

EAST PENN DERMATOLOGY WILL:

RETRIEVE REFERRALS THAT ARE SENT TO US ELECTRONICALLY.

BILL YOUR INSURANCE COMPANY FOR SERVICES RENDERED THAT ARE DEEMED MEDICALLY NECESSARY (NON-COSMETIC).

MAIL YOU A BILL FOR ANY UNPAID CHARGES AFTER CONSIDERATION BY YOUR INSURANCE

SEND ANY OUTSTANDING ACCOUNTS TO A COLLECTION AGENCY AND ADD THE FEES INCURRED IN SETTLING THE ACCOUNT TO YOUR BALANCE.

FORWARD YOUR CURRENT INSURANCE INFORMATION TO ANY OUTSIDE FACILITY THAT MAY BE UTILIZED FOR BIOPSIES AND/OR CULTURES. THESE FACILITIES HANDLE THEIR OWN BILLING AND MAY BILL YOU SEPARATELY IF THERE IS A BALANCE DUE FOR THEIR SERVICES.

ACCEPT CASH, CHECK, VISA, MASTERCARD, OR AMERICAN EXPRESS FOR PAYMENT. YOU MAY ALSO REQUEST US TO KEEP YOUR CREDIT CARD INFORMATION ON FILE SO THAT WE CAN APPLY ANY BALANCE DUE ON YOUR ACCOUNT. RECEIPTS WILL BE AVAILABLE WHEN REQUESTED.

ADD ANY BANK FEES FOR RETURNED CHECKS TO YOUR BALANCE DUE.

REFUND ANY OVERPAYMENTS MADE BY YOU OR CREDIT YOUR ACCOUNT.

MY SIGNATURE BELOW INDICATES THAT I HAVE READ THE FINANCIAL POLICY AND I UNDERSTAND AND AGREE TO THIS POLICY.

PRINT NAME: _____
(PLEASE PRINT)

SIGNATURE: _____ _____
DATE

SIGNATURE IS (CIRCLE ONE): PATIENT PARENT GUARDIAN POA

Form 12/2015

Patient Consent for Use and Disclosure of Protected Health Information
And
Receipt of Notice of Privacy Practices Written Acknowledgement Form

East Penn Dermatology, P.C.
1140 Welsh Road, Suite 130
North Wales, PA 19454

Patient Name: _____ DOB: _____

I hereby give my consent for East Penn Dermatology, P.C. to use and disclose **protected health information** (**PHI**) about me to carry out **treatment, payment and healthcare operations** (**TPO**). East Penn Dermatology, P.C.'s Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. East Penn Dermatology, P.C. reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to East Penn Dermatology, P.C., and Attention Privacy Officer at 1140 Welsh Road, Suite 130, North Wales, PA 19454.

With this consent, East Penn Dermatology, P.C. may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results among others.

With this consent, East Penn Dermatology may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With this consent, East Penn Dermatology, P.C. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that East Penn Dermatology, P.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I hereby acknowledge receipt of East Penn Dermatology, P.C.'s Notice of Privacy Practices.

By signing this form, I am consenting to East Penn Dermatology, P.C.'s use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, East Penn Dermatology, P.C. may decline to provide treatment to me.

_____ PATIENT / PARENT / LEGAL GUARDIAN / POA

Signature of Patient or Legal Guardian Date RELATIONSHIP TO PATIENT (CIRCLE ONE)

_____

Print Name of Patient or Legal Guardian

Form Dated 8/21/2013

EAST PENN DERMATOLOGY, P.C.

Michael B. Stierstorfer, M.D. Marvin Sasson, M.D.

TODAY'S DATE: _____

PATIENT NAME: _____ **BIRTH DATE:** _____
Last **First** **Middle** ***Full Time Student*****:** Yes No

ADDRESS: _____

CITY: _____ **STATE:** _____ **ZIP:** _____ **Last 4 digits of SS#:** _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL:** _____

SEX**:** *M F* ***MARITAL STATUS*****:** *M W D S* **E-MAIL:** _____

REFERRED BY: _____ **PATIENT'S OCCUPATION:** _____

FAMILY DOCTOR: _____

Location (Group name, address or phone number): _____

PERSON RESPONSIBLE (if other than patient)/**EMERGENCY CONTACT:** _____

Relationship to patient: _____ Phone Number: _____

If patient lives in a residential facility provide name and phone number: _____

_____

WHAT IS THE NATURE OF YOUR PROBLEM? _____

WHAT MEDICATIONS ARE YOU TAKING? _____

_____

_____

ARE YOU ALLERGIC TO ANY MEDICATIONS? If so, what? _____

HAVE YOU HAD SURGERIES IN THE PAST? If so, what? _____

_____

DO YOU EVER BECOME LIGHTHEADED, SWEATY OR SICK TO YOUR STOMACH WHEN YOU HAVE BLOOD DRAWN? _____

PLEASE INDICATE IF ANY OF THE FOLLOWING APPLY TO THE PATIENT:

____**Problems healing after surgery**	____**Anemia**	_____**Scarring or keloids**	____**Tobacco use**
____**High blood pressure**	____**Diabetes**	_____**HIV**	____**Alcohol use**
____**Pacemaker**	____**Asthma or hay fever**	_____**Cancer**	____**Hepatitis**
____**Heart murmurs**	____**Eczema**	_____**Skin cancer**	____**Ulcer disease**
____**Unusual bleeding**	____**Hives**	_____**Family history of skin cancer**	
____**Irritable Bowel Syndrome**	____**Memory problems**		

* *Patient's Signature* (or parent if patient is child)**:** _____ **Date:** _____

Reviewed by: _____ **Date:** _____

(Doctor's Signature)

AUTHORIZATIONS AND ASSIGNMENT OF BENEFITS:

I authorize the release of any information including the records of any diagnosis, treatment or examination rendered to me or my child, to physicians and my insurance companies. I hereby assign all medical and/or surgical benefits to which I am entitled to East Penn Dermatology, P.C. I understand that I am financially responsible for all charges whether or not paid by insurance.

_____ **Date:** _____

* *Patient's Signature* (or parent if patient is child)

MEDIGAP (Patients covered by Medicare and a secondary insurance)

I request that payment of authorized Medigap benefits be made on my behalf to East Penn Dermatology, P.C for any services furnished me. I authorize the holder of medical information about me to release to my insurance carrier any information needed to determine these benefits payable for related services.

* *Patient's Signature*: _____ **Date:** _____

Form updated 1/20/16