FINANCIAL POLICY

Thank you for choosing us as your healthcare provider. We are committed to quality care. Please read and sign this Financial Policy before treatment. You may be asked to sign again if updated. Let us know if you have questions. Frontier Dermatology will submit claims to your insurance if current information is provided, but some services may be denied (e.g., non-allowable diagnoses). Patients are responsible for these charges and any cosmetic procedures not covered by insurance.

YOUR RESPONSIBILITY:

- I authorize Frontier Dermatology to bill my insurance carrier. I acknowledge that I am responsible for all charges for services provided, including any amount not paid by my healthcare plan(s). I understand that it is my responsibility to verify with my insurance company if the provider is "in-network" to receive full insurance benefits. I certify that the information I provided related to my insurance coverage or other payment source(s) is correct.
- I understand that it is my responsibility to provide Frontier Dermatology with accurate and updated insurance information and provide copies of all insurance cards, as well as updated address information to ensure receipt of statements.
- I will remit payment for all balances in a timely manner.
- I will pay my copay/balance at the time of service. I understand that Frontier Dermatology accepts all major credit cards, cash, and checks and that all returned, and NSF checks will result in a $25.00 fee.

REFERRALS/AUTHORIZATIONS:

- Referrals and/or Authorizations are not a guarantee of payment. I am responsible for any balances classified as 'Patient Responsibility' by my insurance company. Any dispute with claim processing is between me and my insurance company. I am, ultimately, responsible for ensuring my Primary Care Provider (PCP) has provided Frontier Dermatology with a referral or prior authorization prior to my appointment.

PAYMENT ARRANGEMENTS:

- I understand that Frontier Dermatology may store my credit card on file for future payments, although I can choose to opt out.
- If my card on file expires or payment cannot be processed for any reason, I will promptly call Frontier Dermatology's office to reinstate my payment plan before defaulting on a payment.
- Past Due balances must be settled prior to making an appointment or being seen for subsequent appointments.

GENERAL INFORMATION:

- Per the Office of the Inspector General, providers cannot change coding to obtain payment; this is illegal and falls under the "False Claims Act" and is considered Fraud and Abuse.
- If you are present for a Cosmetic Appointment and have medical questions or concerns that result in what the AMA defines as an office visit or another medical procedure, the visit and subsequent procedure(s) will be submitted to your insurance. You will be billed according to your individual insurance plan benefits.
- Pursuant to current AMA and CPT guidelines, all procedures (such as biopsies, pathology, liquid nitrogen/freezing, benign removals, skin tags, etc.) are billed separately and are not included in the office visit.
- Additional skin specimen pathology stains, tests, or consultations may be required through an in-house and/or outside laboratory. These services will be billed separately and will not be included in bill estimates. There is no way to determine these fees until a dermatopathologist processes your specimen in the lab.
- When outside labs, x-rays, or other tests are ordered by Frontier Dermatology, you are responsible for checking with your insurance regarding where you are authorized to have these studies done. An outside laboratory is used for these services; billing for these services is separate and you are responsible for any related balance. Any balance due outside of Frontier Dermatology is between you and that agency. Frontier Dermatology is not affiliated.
- No show appointments/cancellations less than 24 hours in advance will be charged $75.00 for a standard appointment and $150.00 for a missed surgery or cosmetic appointment.
- Some surgical procedures have a set number of days that are included in the package. This is called a 'Global Period". Suture removals may fall within the global period and no extra payment will be due. However, if the provider discusses or performs anything besides the suture removal, the visit is no longer considered global and will be billed to your insurance. The appropriate patient balance will be due.
- Ambulatory Surgery Center patients may be charged a facility fee. Insurers consider procedures in an ambulatory surgical center outpatient surgery, and you may have a higher out-of-pocket responsibility.

COLLECTION POLICY:

- If we have been unable to obtain payment in full or maintain scheduled payment arrangements from you after 3 months of repeated attempts, the account will be turned over to an outside collection agency and you will be required to pay the remaining balance prior to scheduling a future appointment.

This is a legal document and by signing, you agree that you understand and accept the terms on this form.

_______________________________	_______________________
Patient Name	**Patient Date of Birth**
_______________________________	_______________________
Patient Signature (or Legal Guardian)	**Date**

PATIENT ACKNOWLEDGMENT

I acknowledge that I have received, read, and understood the information provided in Frontier Dermatology's intake forms, including the Notice of Privacy Practices (HIPAA) and the Non-Discrimination Notice to Patients.

I confirm that the information I have provided is accurate and complete to the best of my knowledge. I understand that this information is essential for my healthcare provider to deliver appropriate and effective care.

I recognize that the information I provide will remain confidential and will only be shared with relevant healthcare professionals as needed for my treatment and in accordance with applicable laws and regulations.

I also understand my rights and responsibilities as a patient, including my right to privacy, the right to receive information about treatment options, and my responsibility to provide accurate information and follow the prescribed treatment plan.

I authorize benefit claim payments to be assigned to my physician at Frontier Dermatology and permit the release of any medical or other information necessary to process claims. If I have not provided medical insurance, I confirm that I do not have coverage to be billed and understand that payment is due at the time of service.

By signing below, I consent to the use and sharing of my health information as outlined and agree to the terms stated in the healthcare intake forms.

______________________________	______________________________
Patient Name	**Patient Date of Birth**
______________________________	______________________________
Patient Signature (or Legal Guardian)	**Date**

PATIENT DEMOGRAPHICS		
Today's Date:	Patient Date of Birth:	Patient Age:
Patient Legal Last Name:	Patient Legal First Name:	
Name:		
Sex Assigned at Birth:	Legal Sex (gender on ID card):	
Gender Identity:	Pronouns:	
Language:	Ethnic Group:	Race:
Preferred Contact Method: ☐ Patient Portal ☐ Phone ☐ Email ☐ Unspecified		
Home Phone:	Work Phone:	Mobile Phone:
Preferred Phone: ☐ Home ☐ Work ☐ Mobile		
Email Address:		
Would you like to opt into email notifications? ☐ Yes ☐ No		
Street Address:		
City, State, and ZIP Code:		

GUARANTOR (REQUIRED IF PATIENT IS UNDER 18 YEARS OF AGE)		
Patient's Relationship to Guarantor: ☐ Self ☐ Spouse ☐ Child ☐ Other:		
Guarantor Last Name:	Guarantor First Name:	
Guarantor Date of Birth:		
Contact Information Same as Patient's? ☐ Yes ☐ No (complete information below)		
Street Address:		
City, State, and ZIP Code:		
Home Phone:	Work Phone:	Mobile Phone:
Email Address:		

PRIMARY CARE PROVIDER AND REFERRING PROVIDER
Who is your primary care provider?
Were you referred to our office? ☐ Yes ☐ No If yes, who is the referring provider?

PRIMARY INSURANCE	
Do you have health insurance? ☐ Yes ☐ No	
Insurance Name:	
Are you the policy holder? ☐ Yes ☐ No	
If no, patient's relationship to policy holder: ☐ Spouse ☐ Child ☐ Other:	
Policy Holder First Name:	Policy Holder Last Name:
Policy holder Date of Birth:	Policy holder Birth Sex:
Is the billing address the same as the patient's? ☐ Yes ☐ No (complete the information below)	
Street Address:	

See back side →

City, State, and ZIP Code:		
Home Phone:	Work Phone:	Mobile Phone:
Preferred Phone: ☐ Home ☐ Work ☐ Mobile		

SECONDARY INSURANCE	
Do you have a secondary health insurance plan? ☐ Yes ☐ No	
Insurance Name:	
Are you the policy holder? ☐ Yes ☐ No	
If no, patient’s relationship to policy holder: ☐ Spouse ☐ Child ☐ Other:	
Policy Holder First Name:	Policy Holder Last Name:
Policy holder Date of Birth:	Policy holder Birth Sex:
Is the billing address the same as the patient’s? ☐ Yes ☐ No (complete the information below)	
Street Address:	
City, State, and ZIP Code:	

Home Phone:	Work Phone:	Mobile Phone:
Preferred Phone: ☐ Home ☐ Work ☐ Mobile		

See back side →

MEDICAL HISTORY – PATIENT INFORMATION	
Today's Date:	
Patient Name:	**Patient DOB:**

MEDICAL HISTORY (PLEASE CIRCLE ALL THAT APPLY):		
Arthritis	End Stage Renal Disease (kidney disease)	Leukemia
Asthma	Hepatitis (A / B / C)	Lymphoma
Atrial fibrillation	High Blood pressure	Radiation Treatment
Breast Cancer	HIV/AIDS	Seizures
Coronary Artery Disease (heart disease)	High Cholesterol	Stroke
Diabetes	Hypothyroid or Hyperthyroid	NONE

OTHER (CIRCLE ALL THAT APPLY OR LIST BELOW):				
Autoimmune Disorders	Bleeding Disorders	Cold Sores on Lips	Keloid Formation	Scleroderma

PAST SURGICAL HISTORY:

SKIN DISEASE HISTORY (PLEASE CIRCLE ALL THAT APPLY):		
Basal Cell Skin Cancer	Melanoma	Squamous Cell Skin Cancer
Blistering Sunburns	Precancerous Moles	Actinic Keratosis
NONE		

Do you wear sunscreen? Yes No

Do you tan in a tanning salon? Yes No Previous

Do you have ~~an immediate family~~ any blood relatives with a history of melanoma? Yes No

Do you have ~~a family history~~ any blood relatives with a history of skin cancer (basal cell, squamous cell, melanoma)? Yes No

If yes, which relative(s)?

MEDICATIONS (PLEASE ENTER ALL MEDICATIONS, INCLUDING DOSE AND FREQUENCY OR ATTACH LIST):

ALLERGIES (PLEASE ENTER ALL ALLERGIES):

Height:	**Weight:**

SOCIAL HISTORY (PLEASE CIRCLE ALL THAT APPLY):
Cigarette smoking: now previously never
Alcohol use: none # of drinks per day:

See back side →

For patients 65 and older: Have you received a pneumonia vaccination? Yes No

FAMILY HISTORY OF ANY MEDICAL CONDITIONS (ONLY FIRST-DEGREE RELATIVES; PARENTS AND SIBLINGS):

REVIEW OF SYSTEMS: ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING? (PLEASE CHECK YES OR NO)					
Symptom	**Yes**	**No**	**Symptom**	**Yes**	**No**
Weight loss			Shortness of breath		
Depression			Chest pain		
Muscle aches			Easy bruising		
Joint pain			Blood clots		
Fever			Swollen lymph nodes		

OTHER SYMPTOMS:

ALERTS (PLEASE CIRCLE ALL THAT APPLY):	
Allergy to Adhesive or latex	MRSA
Allergy to local anesthetics	Pacemaker
Allergy to topical antibiotics	Require antibiotics prior to a dental or surgical procedure
Artificial heart valve	Rapid heartbeat with epinephrine
Artificial joint replacement	Are you pregnant or currently trying to get pregnant?
Blood thinners	Are you currently breastfeeding?
Defibrillator	

PHARMACY INFORMATION:
Preferred pharmacy:
Phone:
City or Zip Code: