

PATIENT \_\_\_\_\_ SSN \_\_\_\_\_  
LAST FIRST MI (REQUIRED)

(If Patient is Minor, Name of Parent or Guardian: \_\_\_\_\_)

MARITAL STATUS: Single Married Widowed Divorced (Circle One)  Male  Female DATE OF BIRTH \_\_\_\_/\_\_\_\_/\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_

HOME PHONE (\_\_\_\_) \_\_\_\_\_ WORK PHONE- (\_\_\_\_) \_\_\_\_\_ CELL PHONE (\_\_\_\_) \_\_\_\_\_  
 Permission to leave a message  Permission to leave a message  Permission to leave a message

BILLING / RESPONSIBLE PARTY: \_\_\_\_\_ Relation to patient \_\_\_\_\_

ADDRESS \_\_\_\_\_ CITY/STATE \_\_\_\_\_ ZIP \_\_\_\_\_ Phone:(\_\_\_\_)

Primary Care Physician: \_\_\_\_\_ Office phone # \_\_\_\_\_

Were you referred to this office? \_\_\_\_ If yes, please specify: Referring Physician \_\_\_\_\_ Phone #: \_\_\_\_\_

Other Referral Source - (if not referred by a physician) \_\_\_\_\_

**EMERGENCY CONTACT**

Name \_\_\_\_\_ Address \_\_\_\_\_

City/State \_\_\_\_\_ ZIP \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Commercial Insurance Information:** Please Give Insurance Card(s) to Receptionist to Make Copies

Insurance Company Name: \_\_\_\_\_ Insured's Name \_\_\_\_\_

Relation to Patient \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ INSURED'S SOCIAL SECURITY# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is insurance through your Employer?  Yes  No Employer's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Insurance Company Name: \_\_\_\_\_ Insured's Name \_\_\_\_\_

Relation to Patient \_\_\_\_\_ D.O.B. \_\_\_\_/\_\_\_\_/\_\_\_\_ INSURED'S SOCIAL SECURITY# \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is insurance through your Employer?  Yes  No Employer's Name \_\_\_\_\_ Phone # \_\_\_\_\_

**MEDICARE PATIENTS - Please complete this section**

Medicare # \_\_\_\_\_

YES NO

- Have you recently joined a Medicare HMO or Medicare Advantage(PFFS)? If yes, identify \_\_\_\_\_
- Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at that job?
- Are you covered by a HMO/PPO which makes Medicare secondary?
- Are you receiving Medicaid?

*I request that payment of authorized Medicare benefits and, if applicable, Medigap benefits, be made either to me or on my behalf to Advanced Dermatology and Mohs Surgery for any services furnished to me by that provider. To the extent permitted by law, I authorize any holder of medical or other information about me to release to the Centers for Medicare and Medicaid Services, my Medigap insurer, and their agents any information needed to determine these benefits or benefits for related services.*

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

PATIENT  
SIGNATURE \_\_\_\_\_  
DATE \_\_\_\_\_

PARENT/GUARDIAN  
SIGNATURE \_\_\_\_\_  
DATE \_\_\_\_\_

# ADVANCED DERMATOLOGY AND MOHS SURGERY

## CONSENT FOR TREATMENT

I acknowledge and understand that, in presenting myself for treatment and continuing medical care at ADVANCED DERMATOLOGY AND MOHS SURGERY, that I authorize and consent to such procedures and care and to such medical, surgical or other services under the general and specific instructions of SHARON L. HORTON, M.D. and her assistants or her designee as is necessary in her judgment. I also acknowledge that the practice of medicine is not an exact science and that no guarantees will be made to me as the result of treatments or examinations by Sharon L. Horton, M.D.

MINORS must be accompanied by a parent/legal guardian for medical care. The parent/legal guardian may sign a release giving permission to Dr. Sharon L. Horton or her designee to treat the minor in the absence of the parent/legal guardian.

## ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

### TO BE SIGNED AT TIME OF VISIT:

I have received and have been presented with the opportunity to review the ADVANCED DERMATOLOGY AND MOHS SURGERY Privacy Notice during this visit/prior visit. I understand that I may obtain a copy of any future revised Notices.

\_\_\_\_\_  
Patient / Parent / Spouse / Legal Guardian

\_\_\_\_\_  
Date

Reason that Notice was not accepted or patient / representative did not acknowledge receipt:

\_\_\_ Patient indicates received on prior visit      \_\_\_ Patient declined to sign      \_\_\_ Other \_\_\_\_\_

\_\_\_\_\_ Patient / Representative initials declined      \_\_\_\_\_ Employee initials (if patient / representative did not accept notice)

## ASSIGNMENT OF BENEFITS

In consideration of these medical services I hereby assign, transfer and set over to Advanced Dermatology and Mohs Surgery, all my rights, title, and interest to medical reimbursement benefits under my insurance policy(s) as indicated below.

## AUTHORIZATION TO RELEASE INFORMATION

I authorize Sharon L. Horton, M.D. DBA Advanced Dermatology and Mohs Surgery to furnish any consulting physician or insurance company and its representative, any information or copies of all hospital, medical records, consultation and prescriptions relating to illness or injury. A copy of this authorization shall be effective and valid. This authorization may be revoked at any time.

## AUTHORIZATION TO LEAVE MESSAGE

I authorize Sharon L. Horton, M.D. DBA Advanced Dermatology and Mohs Surgery, or her office staff to leave necessary messages at my home or place of employment.

## PAYMENT AGREEMENT

I hereby assume full responsibility for and agree to pay all costs, charges, and expenses incurred by the patient to Advanced Dermatology and Mohs Surgery. I understand and agree that this understanding constitutes a direct primary and personal undertaking by me and is not conditioned or contingent upon payment of any such costs, charges or expenses by any third party. An assignment of benefits of any insurance policy or medical reimbursement plan shall not be deemed waiver of the Provider's right to require payment directly from the undersigned. The Provider expressly reserves its right to require such payment. In the event that this obligation remains unpaid and requires referral for collection, the undersigned agrees to pay all costs of collection, including, but not limited to reasonable attorney's fees. If the undersigned is more than one person, every obligation hereunder shall be joint and several.

All deductibles and co-pays are due at the time of service. We accept cash, checks or Visa/Master cards. Our charges are usual and customary for our area. You are responsible for payment regardless of any insurance company's determination of usual and customary rates, unless we have a participating agreement with that company. Necessary forms will be completed to expedite claims.

I understand and agree to the above statements. A copy of this consent/s shall be considered as valid as the original.

\_\_\_\_\_  
Signature of Patient / Parent / Guardian

\_\_\_\_\_  
Date

# Advanced Dermatology and Mohs Surgery

1049 East Wilson Street, Ste. 190; Batavia, IL 60510  
630-482-3700

## STATEMENT OF FINANCIAL POLICY

**Thank you** for choosing us as your health care provider! We are committed to the success of your treatment and care. Please understand that payment of your bill is part of this treatment and care. The following is our Statement of Financial Policy, which we require all of our patients to read, understand, and sign prior to any non-emergent treatment or care.

In order for us to successfully bill your insurance company, we need complete information and require a copy of your insurance card at **each** visit. Please cooperate with our Reception Staff in providing this information.

### **When is Payment Due:**

Payment is due at the time services are rendered in the office. To see how this affects your specific insurance situation, please discuss with the registration staff or your insurance company. ***We accept Cash, Checks, Visa and Master Card.***

### **About Your Insurance Coverage:**

- **Commercial / Indemnity Insurance** - Your policy is a contract between you and your insurance company. Since we are not a part to the contract, your account balance is your responsibility whether your insurance pays or not. As a courtesy, we will file a claim on your behalf. However, if your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow up with your insurance directly.
- **Managed Care Plan** (HMO, POS, PPO) - You are responsible for paying any **co-payments, deductibles, and non-covered services** at the time services are rendered. It is the patient's responsibility to verify a physician's participation in their health plan prior to making an appointment. If your plan requires a referral for **ANY** service beyond your Primary Care Physician's office, you must contact our office staff. This will allow you to obtain the necessary information and authorization for your visit. Please understand that if you fail to do so, your insurance carrier may **NOT** authorize the visit. We must comply with your insurance company's rules and will **NOT** issue a retroactive referral for services already provided by another provider.
- **Medicare** - As required, we will file claims with Medicare. (We are a participating provider in the Medicare program). You are responsible to pay all Medicare co-payments and for services not covered under the Medicare program (such as cosmetic services). If Medicare does not forward claim information to your secondary insurance carrier, our office will do so and attach the primary explanation of benefits.
- **Self-Pay or Self-Filing** - Patients who do not have insurance coverage, who are unable to provide us with valid insurance information, or who wish to file their own insurance claims are responsible to pay 100% of charges at the time services are rendered.

**We offer you the opportunity to provide us with your credit card information so that we can automatically charge your account for any remaining balance AFTER INSURANCE PAYMENTS.**

### **About our Staff:**

Our staff has been trained to understand many insurance company policies, but they **DO NOT** have all the answers about your specific benefits. Please contact your employer for a copy of your *Benefits Guidebook*, or call your customer service number located on the back of your insurance I.D. card to obtain detailed information about your plan coverage.

### **Past Due Account Balances:**

If your account balance becomes past due, appropriate action will be taken to collect the amount due. If you have issues that prevent you from paying the full balance due, please contact our office so we can help find a solution. If your account is in Collections, you may be dismissed from the practice and no longer eligible for services until your balance is paid in full.

### **Returned Checks:**

The fee for each check returned for insufficient funds is \$25. This fee will be automatically charged to your account when your check is returned from the bank.

**Thank you for reading and understanding our Statement of Financial Policy. Please let our Practice or Office Staff know if you have any questions or concerns.**

**I HAVE READ THE STATEMENT OF FINANCIAL POLICY  
I UNDERSTAND AND AGREE TO THE POLICY**

\_\_\_\_\_  
Patient's Name (Please Print)

\_\_\_\_\_  
Signature of Patient or Guarantor

\_\_\_\_\_  
Date

# Advanced Dermatology and Mohs Surgery

## Credit Card Authorization

To Our Patients:

As you know if you have ever checked into a hotel or rented a car, the first thing you are asked for is a credit card, which is imprinted and later used to pay your bill. This is an advantage for both you and the hotel or rental company, since it makes checkout easier, faster, and more efficient.

We have implemented a similar policy. You will be asked for a credit card number at the time you check in and the information will be held securely until your insurance(s) have paid their portion and notified us of the amount of your share. At that time, any remaining balance owed by you will be charged to your credit card, and a copy of the charge will be mailed to you.

**This will be an advantage to you, since you will no longer have to write out and mail us checks. It will be an advantage to us, as well, since it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down. The American Medical Association estimates it costs \$7 to \$12 to collect \$20 dollars.**

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

Co-Pays due at the time of the visit will, of course, still be due at the time of the visit.

If you have any questions about this payment method, please do not hesitate to ask.

Sincerely,

Sharon L. Horton, M.D.

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***I authorize Advanced Dermatology and Mohs Surgery to charge outstanding balances on my account to the following card:***

Visa

MasterCard

Account Number \_\_\_\_\_ Expiration Date \_\_\_\_\_

3-Digit Signature Code (located on the back of the card) \_\_\_\_\_

Name on Card (Please print) \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Advanced Dermatology and Mohs Surgery

RELEASE OF CONFIDENTIAL MEDICAL RECORDS

(Patient Sticker)

I hereby give my consent for ADVANCED DERMATOLOGY AND MOHS SURGERY to disclose protected health information (PIH) to person(s) as designated below:

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
NAME RELATIONSHIP PHONE NUMBER

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
NAME RELATIONSHIP PHONE NUMBER

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
NAME RELATIONSHIP PHONE NUMBER

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
NAME RELATIONSHIP PHONE NUMBER

\_\_\_\_\_  
Patient Signature / Authorization

\_\_\_\_\_  
Date

ADVANCED DERMATOLOGY AND MOHS SURGERY

Patient Name \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth \_\_\_\_\_

Referred By: (Please circle appropriate referral source)

- Physician - Please provide NAME & ADDRESS: \_\_\_\_\_
Friend - Please provide Name: \_\_\_\_\_
Insurance Telephone Book Newspaper Website Physician Referral Line

Preferred Pharmacy and Phone # \_\_\_\_\_

Please list any medication ALLERGIES (include nut allergies)
Please list or attach a list of all MEDICATIONS and DOSAGES you are taking by mouth (Include Aspirin, Ibuprofen, Vitamin E and Herbal Supplements):

Please list any medications or products you are currently using on your skin: \_\_\_\_\_

Table with 3 columns: Chief Complaint, Problem #1, Problem #2. Rows include: What is the reason for your visit?, Where is the location of your problem?, How long has it been present?, Does it itch, hurt, bleed or other?, Have you used any treatment for it?

ROS - REVIEW OF SYMPTOMS (Please circle if you are presently experiencing any trouble with the following)

Fever Swollen Lymph Nodes Problems with your - Eyes Ears Nose Mouth Heart Lungs
Stomach/bowels Urinary Tract Joints Blood Nerves Mood

FOR WOMEN: Are you or could you be pregnant now? YES NO
Are you breast feeding? YES NO

PMH - PAST MEDICAL HISTORY

(Please circle any conditions you have or have had)

SKIN CANCER: Basal Cell Squamous Cell Melanoma

Skin cancer location(s): \_\_\_\_\_

Table with 5 columns: Keloids, Artificial Valve, Artificial Joint, Liver/Hepatitis, OTHER DISEASES; Eczema, Pacemaker, Organ Transplant, Blood/Anemia; Psoriasis, Defibrillator, Diabetes, Lung Disorder; Cold Sores, Heart Problems, AIDS, Kidney Disorder; High Blood Pressure, Lupus, Neurologic, Psychiatric

Other Cancers: \_\_\_\_\_

History of Radiation: \_\_\_\_\_

PSH - PAST SURGICAL HISTORY: Please list any other prior surgeries, including cosmetic surgery:

FH - FAMILY HISTORY: (Please circle any conditions anyone in your family has had)

Skin Cancer Abnormal Moles Hay Fever Eczema Asthma Psoriasis

What family member has / had the condition? \_\_\_\_\_

SH - SOCIAL HISTORY: Please list your occupation: \_\_\_\_\_

Do you smoke? YES NO Do you drink alcohol? YES NO SOCIALLY



## **YOUR RIGHT AS OUR PATIENT**

**At Advanced Dermatology and Mohs Surgery we are committed to delivering quality health care consistent with our patients' needs. With this as our goal, we honor and attest to the following rights as our patient.**

### **ACCESS:**

- Receive appropriate medical care
- Contact and speak with the doctor
- Communicate and receive a timely response to your complaints
- Change your physician at any time (A list of local dermatologists is available upon request)

### **RESPECT AND DIGNITY:**

- Be treated as an individual
- Receive care free of unnecessary restraints
- Ensure confidentiality of your medical information
- Have your personal privacy respected
- Make informed choices about your care and treatment including the decision to refuse treatment
- Refuse to participate in experimental research

### **INFORMATION, EDUCATION AND COMMUNICATION:**

- Know the identity of your physician, nurse and/or your caregiver
- Be given complete and current information about your illness, treatments and outcomes of care, including unanticipated outcomes, in a manner that you can understand
- Participate in decisions about your treatment
- Know the potential risks and benefits of procedures and treatments
- Receive an itemized bill and an explanation of charges at your request

### **PHYSICAL COMFORT:**

- Be cared for in an environment that is healing, clean and safe

### **AS A PARTNER OF OUR HEALTH CARE TEAM, WE ASK THAT YOU:**

- Provide complete and accurate information about your current and past state of health, including past illnesses, and the medications you are taking
- Inform us if you perceive there may be a problem with your care
- Ask questions when you do not understand what we are saying or asking you to do
- Follow the treatment plan
- Be respectful to all the Health Care Providers and Staff, as well as other patients.

### **IF YOU HAVE A CONCERN:**

We encourage you to let us know how we can serve you better. Most of your concerns can be handled by talking to your physician or caregivers.

If you would like additional assistance or wish to express a grievance, please call our Office Manager at 630-482-3700. If a grievance concerning patient safety or quality of care cannot be resolved in our office, you may report these concerns to AAAHC 1-847-853-6060.

Advanced Dermatology and Mohs Surgery

PERMISSION TO TREAT A MINOR CHILD

Patient Name \_\_\_\_\_

Patient Date of Birth \_\_\_\_\_

I, \_\_\_\_\_ , hereby give  
(Print Parent/Guardian Name)

Dr. Sharon L. Horton and/or Purvi Patel, PAC, permission to treat my  
son/daughter \_\_\_\_\_ as a minor in my  
(Print patient Name)  
absence.

\_\_\_\_\_  
Parent / Guardian Signature

\_\_\_\_\_  
Date