Elmhurst Dermatology

103 N. Haven Rd, Ste7 Elmhurst, IL 60126 T: 630-832-2111 F: 630-832-5199

Dear New Patient,

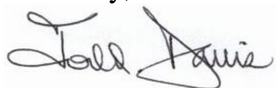
Welcome! Thank you for choosing Elmhurst Dermatology. We provide expert skin care with the utmost attention, respect and effort in a caring and professional environment. We value our patients and will strive to ensure you receive the highest quality of medical services. The following information is provided to help you with planning your office visits. Please feel free to call for any questions or for additional information.

Clinic Office Hours are	Monday	12pm-8pm	Dr. Davis
	Tuesday	8am-4pm	Dr. Eng
	Wednesday	8am-4pm	Dr. Davis
	Friday	7am-3pm	Dr. Davis
	Saturday	8am-12pm	Dr. Davis

- You will receive a reminder call 2-3 days prior to your appointment. We request a 24 hour notice to cancel or reschedule your appointment.
- Bring your completed Patient Packet, picture ID, insurance card, and either your social security number or credit card for billing purposes to your appointment. If you have access to a fax machine, please fax them to 630-832-5199.
- If your insurance requires a referral, please present it at the time of your appointment.
- If you have an urgent issue and need to contact the doctor immediately call the office for his/her phone number at any time.
- Parking, including handicap parking is available in the parking lots in front and on the side of the building.
- There is an elevator at the main entrance. It is small, but it can accommodate a wheelchair.
- We accept cash, checks and Visa, MasterCard and Discover.
- Co-pays and any balance on your account are due and payable at the time of the appointment.
- As a courtesy we bill your insurance; however, the balance due is your responsibility. Bills are payable within 30 days of receipt.

For more information about Elmhurst Dermatology visit our website at www.elmhurstdermatology.com. Thank you for choosing Elmhurst Dermatology. We appreciate the opportunity to serve your healthcare needs and wish you continuing good health.

Sincerely,



Todd T. Davis, M.D.

Elmhurst Dermatology

103 N. Haven Rd, Ste7 Elmhurst, IL 60126 T: 630-832-2111 F: 630-832-5199

Patient Demographics

Patient Name:				
Referred By:	☐ **Physician:**		☐ **Patient:**	
	☐ **Insurance Website**	☐ **Yellow Pages**	☐ **Newspaper**	☐ **Other:**

Mailing Address:	**Apt:**	**City:**	**Zip:**
Home Phone:	**Cell Phone:**		
Select Primary Phone: ☐ **Home** ☐ **Cell**	**Email Address:**		
Social Security Number:	**Date of Birth:**	**Marital Status:**	

Primary Insurance:		
Address:		
Insured Name:	**Date of Birth:**	**Relationship to Pt:**
Subscriber Id:	**Group Number:**	**SSN:**

Secondary Insurance:		
Address:		
Insured Name:	**Date of Birth:**	**Relationship to Pt:**
Subscriber Id:	**Group Number:**	**SSN:**

Employer Name:	**Work Phone:**
Address:	

Emergency Contact Name:	**Relationship:**
Home Phone:	**Work Phone:**

Pharmacy Name:	**Phone:**
Address:	

Benefit Assignment

I hereby authorize the assignment of benefits (payments) directly to Elmhurst Dermatology for all insurance claims related to services received. I agree to pay any and all charges that exceed, or are not covered by my insurance. I understand that co-pays, deductibles and non-covered services are due at the time of services.

Signature of Patient or Guardian: ______________________________ Date: ________________

Records Release

I authorize the release of any medical information necessary for the purpose of processing claims with my insurance company. I permit a copy of this authorization to be used in place of the original.

Signature of Patient or Guardian: ______________________________ Date: ________________

Medical History Questionnaire

Patient Name:				**Date:**
Reason for today's visit:				**Referring Doctor:**

Medications: Names only. Include prescriptions, over-the-counter drugs, vitamins, herbals, supplements, oral contraceptives, etc.

1.	2.	3.
4.	5.	6.
7.	8.	9.

Are you taking more medications than the space provided? (If yes, bring a list to your appointment.)

Past Medical History: ☐ None (I have no significant medical problems)

☐ High Blood Pressure	☐ Diabetes	☐High Cholesterol/Lipids	☐Asthma

List Others:

Past Dermatologic History: ☐ None (I have no history of significant skin diseases) If yes, mark below

☐ Melanoma	☐ Squamous Cell Carcinoma		☐ Basal Cell Carcinoma	☐ Skin Cancer (unknown type)
☐ Actinic Keratosis	☐ Atypical/Dysplastic Moles	☐ Psoriasis	☐ Keloid/Scars	☐ Eczema/Atopic Dermatitis

List Others:

Allergies: Are you allergic to any medication? ☐ No If yes, please describe below
(if more than space allows bring a list to your appointment)

Name of Medication:	Reaction:
Name of Medication:	Reaction:
Name of Medication:	Reaction:

Past Surgical History: ☐ None (I have had no significant surgeries) If yes, list with dates below

Family History: If known, identify conditions that have occurred in your blood relatives

☐ None (no significant history of disease in the family or history unknown)

☐ Melanoma	☐ Squamous Cell Carcinoma	☐ Basal Cell Carcinoma	☐ Skin Cancer (unknown type)
☐ Psoriasis	☐ Eczema	☐ Hay Fever	☐ Asthma
☐ High Blood Pressure	☐ High Cholesterol/Lipids	☐ Diabetes	☐ Other Cancer (list below)

List Others:

Medical History Questionnaire

Social History:	Occupation:	Hobbies:
Do you Drink Alcohol? ☐ No ☐ Yes	Do you smoke? ☐ No ☐ Yes	Do you use drugs (including marijuana)? ☐ No ☐ Yes
Regular Use of Sunscreen? ☐ No ☐ Yes	Use tanning beds? ☐ No ☐ Yes	History of blistering sunburns? ☐ No ☐ Yes
Significant sun exposure at work? ☐ No ☐ Yes		Travel outside the USA in past 6 months? ☐ No ☐ Yes
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed		Children: ☐ None ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

General Health: ☐ None (I am not experiencing any of these symptoms)

☐ Unexplained weight gain or loss	☐ Fever or Chills	☐ Loss of appetite	☐ Weakness	☐ Night Sweats	☐ Breast Feeding (if applicable)

Common Dermatologic Problems: ☐ None (I am not experiencing any of these problems)

☐ Rash	☐ Dry/Sensitive Skin	☐ Itching	☐ Suspicious Lesions	☐ Suspicious Moles
☐ Acne	☐ Hives		☐ Excessive Sweating	☐ Excessive Hair

About the main reason for today's visit: (answer these as best you can if they are relevant to your visit)

General description of problem:

How long has the problem been present? ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Unknown Duration

☐ Days	☐ Weeks	☐ Months	☐ Years

Location of the problem/spread:

Onset of the problem:	☐ Gradual	☐ Intermittent	☐ Insidious	☐Sudden	
Current Severity:	☐ Mild	☐ Mild to Moderate	☐ Moderate	☐ Moderate to Severe	☐ Severe
Nature/Symptoms of problem:	☐ Itchy	☐ Tender	☐ Painful	☐ Asymptomatic	
Things that aggravate/worsen the condition:	☐ Nothing	☐ Sun	☐ Heat	☐ Exercise	

Other:

Treatments that improved the condition:	☐ Over the counter treatments	☐ Prescriptions	☐ Nothing

Other:

Any associated symptoms (things that seem related to the problem)? ☐ No, none

Other:

*BRING ANY ADDITIONAL INFORMATION THAT YOU FEEL IS RELAVENT FOR THE DOCTOR. Thank you.

Financial Policy

Thank you for selecting Elmhurst Dermatology, P.C. for you dermatologic care. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or any laboratory fees, the following information is provided:

HMO/PPO/Other Insurance Coverage: If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a driver's license. **All co-payments are due prior to seeing the physician. All co-insurance and deductibles are due at the time of service.** If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provider all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services by your insurance carrier as not medically necessary and/or not covered.

Medicare: Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory: Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients (Will Pay): For patients with no insurance, payment is full is due at the time of service.

Cosmetic Patients: Deposits are required prior to the date of the procedure. The balance of the charge is required prior to the procedure being performed.

Payments: Payments can be made by cash, check, VISA, MasterCard, Discover or American Express.

Appointment Cancellation Fee: If you are unable to keep your appointment, please call at least 24 hours in advance and speak with a front desk representative or leave a message. If you do not give sufficient notice you may be subject to a $35 fee.

Financial Policy:
Financial Information: Either your social security number or credit card on file is required. Subsequent to your visit a claim will be processed thru your insurance. Any remaining balance (resulting from deductible, co-insurance, etc.) is then billed to you or charge to your credit card if less than $250. Obtaining your security number or credit card helps avoid any financial issues.

Returned Checks and Collections: A charge of $20 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay the 50% fee for collections cost and/or any reasonable attorney fees. My signature below indicates my understanding and full responsibility for the balance on my account for any professional services.

__________________________ __________________________ ____________

Signature Last Name, First Name (Print) Date

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact the Privacy Official for
Elmhurst Dermatology, P.C.
(630) 832-2111

Introduction

This Notice of Privacy Practices is provided to you as a requirement of the Health Insurance Portability and Accountability Act (HIPAA).

At Elmhurst Dermatology, P.C., we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Privacy Practices describes the personal health information we collect, and how and when we use or disclose that information. This notice also describes your rights as they relate to your Protected Health Information. This Notice is effective April 14, 2003, and applies to all protected health information as defined by federal regulations.

Acknowledgment of Receipt of this Notice

You will be asked to provide a signed acknowledgment of receipt of this notice. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide you treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

Understanding Your Health Record/Information

Each time you visit Elmhurst Dermatology, P.C., a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, and serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Elmhurst Dermatology, P.C., the information belongs to you. You have the right to:

- Obtain a paper copy of this Notice of Privacy Practices upon request,
- Inspect and obtain a copy your health record as provided for in 45 CFR 164.524,
- Request to amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and,
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Privacy Notice

Our Responsibilities

Elmhurst Dermatology, P.C. is required to:

1. Maintain the privacy of your health information,
2. Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
3. Abide by the terms of this notice,
4. Notify you if we are unable to agree to a requested restriction,
5. Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative location, and
6. Obtain your written authorization to use or disclose your health information for reasons other than those listed above and permitted under law.

Elmhurst Dermatology, P.C., reserves the right to change our Privacy Information practices and to make the new provisions effective for all protected health information we maintain. Revised notices will be available to you at this office during business hours, or by mail if requested. We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

Examples of How Elmhurst Dermatology, P.C., May Use or Disclose Your Health Information

For Treatment: Elmhurst Dermatology, P.C., may use your health information to provide you with medical treatment or services. For example, information obtained by a health care provider, such as a physician, nurse, or other person providing health services to you, will record information in your record that is related to your treatment. This information is necessary for health care providers to determine what treatment you should receive. Health care providers will also record actions taken by them in the course of your treatment and note how you respond to those actions.

For Payment: Elmhurst Dermatology, P.C., may use and disclose your health information to others for purposes of receiving payment for treatment and services that you receive. For example, a bill may be sent to you or a third-party payor, such as an insurance company or health plan. The information on the bill may contain information that identifies you, your diagnosis, and treatment or supplies used in the course of treatment.

For health care operations: For example, Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Appointments: Elmhurst Dermatology, P.C., may use your information to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to the individual.

Business associates: Some services provided in our organization are provided through Business Associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, or a copy service we may use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we may use your name, if you have been transported to a hospital or other facility, and give your general condition, and religious affiliation for directory purposes. This information may be provided to family members or members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification or Communication with Family Members: Health professionals, using their best judgment, may use, or disclose information to notify or assist in notifying family relatives, personal representatives, close personal friends, or other people you identify; information relevant to that persons' involvement in your care or payment information related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Privacy Notice

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant

Marketing: We may contact you to provide appointment reminders, information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers Compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public Health: Your health information may be used or disclosed for public health activities such as assisting public health authorities or other legal authorities to prevent or control disease, injury, or disability, or for other health oversight activities.

Required by Law: Elmhurst Dermatology, P.C., may use and disclose information about you as required by law. For example, Elmhurst Dermatology, P.C., may disclose information for the following purposes:

For judicial and administrative proceedings pursuant to legal authority;
To report information related to victims of abuse, neglect or domestic violence; and
To assist law enforcement officials in their law enforcement duties.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Health and Safety: Your health information may be disclosed to avert a serious threat to the health or safety of you or any other person pursuant to applicable law.

Government Functions: Specialized government functions such as protection of public officials or reporting to various branches of the armed services that may require use or disclosure of your health information.

For More Information or to Report a Problem, or if you have questions and would like additional information, you may contact our practice's Privacy Official, [Practice: Privacy Official].

Elmhurst Dermatology, P.C.
103 N. Haven Rd, Ste 7
Elmhurst, IL 60126
Phone: (630) 832-2111
Fax: (630) 832-5199

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights - U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
866-OCR-PRIV (866-627-7748) or 886-788-4989 TTY

Privacy Notice

Acknowledgment of Receipt/Review of this Notice

Elmhurst Dermatology, P.C. is concerned about the privacy of our patients' health care information. Our intent is to make you aware of the possible uses and disclosures of your protected health information and your privacy rights. The delivery of your health care service will in no way be conditioned upon your signed acknowledgment. If you decline to provide a signed acknowledgment, we will continue to provide your treatment, and will use and disclose your protected health information for treatment, payment, and health care operations when necessary.

I acknowledge that I was offered the opportunity to review the Notice of Privacy Practices for:
Elmhurst Dermatology, P.C.

Name of Patient (PRINT) ____

____ ____________________
Signature of Patient or Authorized Representative Date

DISCLOSURE OF INFORMATION

In the event that Elmhurst Dermatology is unable to contact me, I give full permission to Elmhurst Dermatology to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not be limited to information regarding pathology reports, laboratory tests, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Elmhurst Dermatology for the disclosure of information to the individual(s) designated below.

Name	Date of Birth	Phone Number
____________________	____________	______________
____________________	____________	______________
____________________	____________	______________

____ ____________________
Signature of Patient or Authorized Representative Date

I do not agree to allow Elmhurst Dermatology to disclose any medical information regarding myself to any individual other than myself.

____ ____________________
Signature of Patient or Authorized Representative Date

Credit Card on File FAQs

Frequently Asked Questions about our Credit Card Policy:

Why is Elmhurst Dermatology requiring a credit card agreement from patients?
This practice will improve efficiency for everyone, and lower total costs of providing service to our patients. It will also allow us to focus our energies on providing dermatologic care, rather than patient billing.

When will my credit card be charged?
As a courtesy to our patients, we submit claims to their insurance within a few days of providing the patient service. Claims are typically settled by insurance companies within 2 – 8 weeks after service was provided. Once a claim is adjudicated, your card will be charged for your portion.

How will I know how much the charge will be?
Insurance typically sends an Explanation of Benefits (EOB) to both the patient and the provider after claims have been settled that explains the contracted fees agreed between our office and the insurance. The EOB also shows whether any of the agreed upon fee must be paid by patient in the form of co-pay, co-insurance, or deductible. At that time, any patient balance is due in full.

What if I do not agree with the patient portion as specified by my insurance?
As the customer of the insurance company, patients can exercise procedures with their insurance for handling disputes as to whether insurance or patient is responsible for a particular fee. These procedures are typically regulated by state governments.
Our office's position is that the patient is ultimately responsible for the cost of the service provided, up to the amount allowed by an insurance plan that our office accepts. We are not a party to disputes involving what portion of payment is the patient's versus the insurance's. Nonetheless, we will provide our expertise to our patients as a resource to help facilitate understanding of what their insurance company communicates to them about their contract.

What if I still do not agree with the charge applied to my card?
Our office's billing staff will review each patient's situation before applying a charge. In the event of any question or issue, please do not hesitate to contact our billing staff or office manager and we will work to resolve it as quickly as possible.
As a last resort, our patients should rest assured that credit card issuers typically have procedures for a cardholder to dispute a charge applied by any merchant. Credit card companies can typically suspend or reverse charges if they determine it was not appropriate.

What if I don't have a credit card, or do not want to participate? Is this mandatory?
Either your social security number or credit card on file is required. Subsequent to your visit a claim will be processed thru your insurance. Any remaining balance (resulting from deductible, co-insurance, etc.) is then billed to you. Obtaining your security number or credit card helps avoid any financial issues.

Elmhurst Dermatology

Credit Card on File

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time you check in. That information will be held securely until your insurances have paid their portion and notified both you and us how much, if any, is your portion. At that time, any remaining balance owed by you will be charged to your credit card and it will be presented on your statement.

This will be an advantage to you, because you will no longer have to write out and mail us a check. It will be an advantage to us as well, because 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.

You can think of this as much like when you check into a hotel or rent a car; you are asked for a credit card which is imprinted and later used to pay your bill.

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

If your balance is more than $250 we will call you for approval.

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

Sincerely yours,

Elmhurst Dermatology

I authorize Elmhurst Dermatology to charge outstanding patient portion balances for me and my dependents to the following credit card:

☐ Visa ☐ MasterCard ☐ Discover (please select one)

Account number __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __

Expiration Date __ __ / __ __ Signature Code: __ __ __ Billing Zip Code: __ __ __ __ __

Signature ____ Date ____________________

Full name on card (please print) ____

Patient name (if other than cardholder) ____