BRYN MAWR
SKIN & CANCER
INSTITUTE

Medical Dermatology
CIRILLO INSTITUTE

Welcome Form

Patient Information

Last Name _____ First _____ Middle _____

Marital Status: Single___ Married___ LTP___ Divorced___ Widowed___ Separated___

DOB _____ /_____ /_____

Gender: Female___ Male___

ETHNICITY: Hispanic____ Non-Hispanic ____ (required by insurance company in compliance with health reform)

RACE: American Indian or Alaskan Native___ Asian___ Black___ Caucasian___ Pacific Islander___ Other___

Preferred Language_____

eMail*_____

Address _____

City _____ State _____ Zip _____

Home (_____) _____ Cell (_____) _____ Other (_____) _____

Best Contact Method (Please Circle): Home Cell Other Can we leave a detailed message? Yes___ No___

Emergency Contact _____Phone (_____) _____Relationship to Patient _____

Employer_____ Occupation _____

Primary Care Physician: _____ **Phone:** _____

Authorization to Disclose Protected Health Information (PHI)

Name _____ Relationship to Patient _____

Phone Number Cell (_____) _____ Home (_____) _____

Primary Insurance

Health Insurance Provider Name _____

Policy Holder Name_____ Relationship to Patient _____

Policy Holder DOB _____ /_____ /_____ Phone Number Cell (____) _____ Home (____) _____

Policy Holder eMail* _____

Policy Holder Address _____

Policy Holder City _____ State _____ Zip _____

Responsible Party employed by _____

Policy Holder Occupation: _____

*By providing my email address I give you permission to send me appointment reminders, patient information, newsletters and promotional emails about specials and events. I understand that I may unsubscribe at any time, and that you will never sell or share my email with any external entity.
Check here if you do not want to receive newsletters or promotional emails. [ ]

BRYN MAWR
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Financial Responsibility Form

Medical Dermatology
CIRILLO INSTITUTE

Thank you for choosing BRYN MAWR SKIN & CANCER INSTITUTE. We are committed to providing the highest quality dermatologic care. Please read and sign this form to acknowledge your understanding of our patient financial policies.

- It is **your responsibility** to verify that we are currently under contract with your insurance plan as an "in network" provider and, if required, that you have obtained a referral before your scheduled appointment. Please call our office for the necessary ID numbers needed. Failure to do so may result in your appointment being rescheduled.

"In Network" vs. "Out of Network" Insurance:

- Your insurance coverage and benefits are a contract between you and your insurance company. All disputes must be handled between you and your insurance company. If you come to the office knowing we are an "out of network" provider under your insurance plan then understand your insurance company may not cover the services leaving you responsible for payment.
- We will bill your insurance company, however you are ultimately responsible for the payment of the bill.
- While we make every effort to assist you with your insurance questions, you must understand that it is your responsibility to know your insurance plan and to understand the extent of that coverage.
- Insurance companies are obligated to you, the insured, not to our office. It is often difficult or impossible for us to get information regarding your insurance.
- If you have insurance coverage under a plan which we are not contracted with, you may be seen but considered a **self-pay** patient with payment due at the time of visit.
- If you have a **High Deductible Health Plan** and have not met your deductible, we will bill you directly.

Payment is Due at the Time Services are Rendered:

- Co-pays and all non-covered items and charges are the insured/patients financial responsibility and are due during the check-out process.
- **Self-Pay Patients** - We try to be very understanding for our cash paying patients. All fees will be due at the time services are rendered. Our staff will be able to give you an estimate of your appointment fees, but please keep in mind it is often impossible for us to quote what will be done at your appointment.
- **Please be advised that your visit to the dermatologist is for evaluation. There may be treatment at the time of your visit, such as a biopsy requiring special stains that may render additional charges that will be submitted to your insurance company.**

Payment Plans:

- Our office will work with those patients in need of a payment plan in order to pay any balance due to our practice.
- **Please mail payments to our office**:

BRYN MAWR SKIN & CANCER INSTITUTE
919 Conestoga Road
Building Two, Suite 106
Bryn Mawr, PA 19010

or by phone: 610.525.5028 ext. 802

Patient Consent:

By signing this document, I _____, have fully read, understand and consent to the financial policy of BRYN MAWR SKIN & CANCER INSTITUTE. I hereby consent to allow the BRYN MAWR SKIN & CANCER INSTITUTE to reach me if needed, concerning any billing questions or concerns. I will cooperate with the billing department to ensure payment for my services. In the event that the patient is a minor, I am the parent and/or legal guardian of said patient and agree that I am responsible for payment for all services rendered to the patient herein.

Print name of Patient/Guardian_____

Signature of Patient/Guardian_____ Date____/____/____

BRYN MAWR
SKIN & CANCER
INSTITUTE

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HIPAA Consent Form

Patient Name: _____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, except in certain limited instances, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of Protected Health Information about you for non-subsidized treatment, payment and health care operations, and for other purposes as permitted or required by law. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations, or for other purposes permitted or required by law. However, we will obtain from you a separate written authorization for "subsidized" disclosures, meaning disclosures involving product or service with respect to which the Practice receives remuneration from a third party.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions, except in certain limited instances.
- The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon the execution of this Consent.

This Consent was signed by: _____
Patient or Representative

Relationship to Patient (if other than patient):_____ Date: ___/___/___

In front of _____
Printed Name – Practice Representative