Patient Name: _____

Jane Yoo, MD, PLLC
Board Certified Cosmetic Dermatologist & Mohs Surgeon
162 West 56th Street, Suite 304-305
New York, NY 10065
646.844.0424

Welcome to our practice!

(PLEASE READ CAREFULLY)

Attached is our Patient Registration Package. Please complete these so we can maintain accurate contact and medical records. If you printed these forms from our website, you may fax them to us at (646) 344-1053 prior to your appointment. Please bring the completed original forms with you to your appointment along with the other items listed at the bottom of this letter.

We realize that you have a choice of where to be treated and realize that you place a great deal of trust in your dermatologist to provide you with the most up to date information and treatment options regarding your skin care health. We do appreciate and value the trust you have placed in us.

Dr. Yoo specializes in cosmetic dermatology and dermatologic surgery. She seeks to provide her patients with comprehensive dermatologic care—whether the visit is for a mole check or a cosmetic laser procedure. Our team is highly committed to providing excellent patient care with an emphasis on individual attention for each patient. Providing the best service in a comfortable, private atmosphere is extremely important to us.

We place a high value on our relationship with our patients. We especially value patient feedback. Therefore, we will ask you to communicate to us your experiences with us. Be assured your feedback matters. It helps us continue to serve you and our other patients with the highest level of care possible. If you have any questions or concerns, please do not hesitate to ask any member of our team.

REMINDERS OF REQUIRED ITEMS FOR YOUR VISIT

- **Insurance Card**
  If you have health insurance, we can't see you without making a copy of your insurance card.
- **Written Referral** from your Primary Care Physician **if required** by your insurance plan or verify that it has already been faxed to us by your primary care physician. Please be aware that we are not obligated to inform you if you need a referral or not. It is the responsibility of the patient to know.
- **Co-pay** or **Deductible** is collected at check in
- **Cosmetic procedure fees** are due at time of visit
- **Completed Patient Registration Package**
- **Parent or Legal Guardian must accompany patients who are minors**

Phone: (646) 844-0424 ❖ **Fax**: (646) 344-1053 ❖ **Web**: www.janeyoomd.com

Patients MUST sign and date below before medical care can be rendered.

PATIENTS WHO ARE MINORS: Parents or legal guardians must sign for patients who are younger than eighteen. A parent or legal guardian must be present at all visits for any patient younger than sixteen.

Privacy Practices (HIPAA)

We use the contact information that you provide for appointment reminders and to contact you regarding your appointments and care. By signing below, I acknowledge that I have read and understand the privacy practices of this office. Notice of Privacy Practices are available at the check-in desk.

Release of Medical Information

By signing below, I authorize the release of medical information to my primary care and/or referring physician, to medical consultants if needed, and as necessary to process insurance claims, insurance applications, and prescriptions.

Financial Policy (Please see attached document)

Patient Name: _____

Patient Signature: _____ Date:_____/_____/_____

Guardian Name (**if patient is younger than 18**): _____

Guardian Signature:_____Date:_____/_____/_____

Referred by: Whom may we thank for referring you to our practice?
❑ Family/Friend - Name:_____
❑ Insurance Provider List
❑ Internet Search
❑ Newspaper Ad
❑ Physician - Name:_____
❑ Yellow Pages
❑ Other_____

PATIENT INFORMATION

Last Name: _____ PCP/Family Doctor: _____

First Name: _____ MI: _____ Patient Date of Birth: _____ ❑ Male ❑ Female

Preferred Name: _____
("John", "Mr. Jones", etc.)

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Legally Separated ❑ Partner

Mailing Address:_____
(if PO Box, complete Street Address below)

Patient Social Security Number: _____

City:_____State:_____Zip:_____

SEND PATIENT STATEMENTS TO:
❑Patient ❑Primary ins Policy Holder ❑Secondary Ins Policy Holder
❑Other:
Name_____Relation _____

Street Address:_____
(complete only if Mailing Address provided above is a PO Box)

Address:_____
(if different from patient's)

City:_____State:_____Zip:_____

City:_____State:_____Zip:_____

Email _____

Preferred Phone: (_____)_____❑Cell ❑Home ❑Work

Alternate Phone: (_____)_____❑Cell ❑Home ❑Work

INSURANCE INFORMATION ❑ Self Pay *(no insurance)*

Primary
Insurance:_____ID#:_____

Policy Holder:
❑ Patient (if not patient, complete information below)
❑ Name:_____DOB:_____

SS#_____Relation _____

Address:_____
(if different from patient's)

City:_____State:_____Zip:_____

Secondary
Insurance:_____ID#:_____

Policy Holder:
❑ Patient (if not patient, complete information below)
❑ Name:_____DOB:_____

SS#_____Relation _____

Address:_____
(if different from patient's)

City:_____State:_____Zip:_____

Does your insurance plan require you to have a referral to see a specialist? ❑ No ❑ Yes ❑ I don't know
NOTE: It is the patient's responsibility to get any required referrals. Failure to do so may result in denied claims and the patient will be responsible for all services rendered.

IMPORTANT – WE ARE NOT CONTRACTED WITH ANY WORKERS COMP OR MEDICAID PLANS.

CMS QUALITY REPORTING INFORMATION: My preferred language is: ❑ English ❑ Spanish ❑ Other
Race (optional): ❑ White ❑ Black/African American ❑ Asian ❑ Hispanic ❑ American Indian/Alaska Native ❑ Native Hawaiian ❑ Other

PHARMACY INFORMATION (WHERE YOU MOST OFTEN GET PRESCRIPTIONS FILLED):

_____ _____ Phone: (_____)_____

_____ _____ Phone: (_____)_____

Mail Order: _____ Location: _____ Phone: (_____)_____

Reason for Visit: What brings you to the office today?

_____
_____
_____

Please describe any previous skin problems you have had.

_____
_____
_____

Current Medications:

Are you taking any blood thinners?

- ❑ Yes
- ❑ No

What medications are you currently taking?

_____
Name Dosage Frequency

_____
Name Dosage Frequency

_____
Name Dosage Frequency

Allergies:

Are you allergic to any of the following?

- ❑ Adhesive Tape
- ❑ Antibiotics
- ❑ Latex
- ❑ Barbiturates (Sleeping pills)
- ❑ Codeine
- ❑ Aspirin
- ❑ Sulfa
- ❑ Iodine
- ❑ Local Anesthetics

Skin:

Do you have any of the following?

- ❑ Abnormal moles
- ❑ Cold Sores
- ❑ Psoriasis
- ❑ Acne
- ❑ Dry/Sensitive Skin
- ❑ Rash
- ❑ Boils
- ❑ Eczema
- ❑ Rosacea
- ❑ Bleed Easily
- ❑ Hives
- ❑ Scars
- ❑ Changes in Moles
- ❑ Itching
- ❑ Sores That Won't Heal
- ❑ Chills

When you are exposed to the sun do you:

- ❑ Tan only
- ❑ Burn Only
- ❑ Tan and Burn

Have you visited tanning salons or do you sunbathe?

- ❑ Yes
- ❑ No

Do you regularly apply sunblock to exposed areas?

- ❑ Yes
- ❑ No

Have you ever had skin cancer?

- ❑ Yes
- ❑ No

If yes, what type?

When? _____ Where? _____

Have you ever had a biopsy for a suspicious growth?

- ❑ Yes
- ❑ No

Past Medical History:

Have you ever had any of the following?

- ❑ Alcoholism
- ❑ Allergies
- ❑ Anemia
- ❑ Anxiety Disorder
- ❑ Arthritis
- ❑ Asthma
- ❑ AID/HIV
- ❑ Bleeding Disorder
- ❑ Blood Disease
- ❑ Blood Transfusion
- ❑ Bowel Disorder
- ❑ Cancer
- ❑ Diabetes
- ❑ Depression
- ❑ Eating Disorder
- ❑ Epilepsy
- ❑ Hay Fever
- ❑ Heart Fever
- ❑ Heart Disease
- ❑ Heart Problems
- ❑ Hepatitis -A, B, or C
- ❑ High Blood Pressure
- ❑ High Cholesterol
- ❑ Joint Disorder
- ❑ Kidney Disorder
- ❑ Liver Disorder
- ❑ Lung Disease
- ❑ Lupus
- ❑ Measles
- ❑ Migraines
- ❑ Osteoporosis
- ❑ Pacemaker
- ❑ Rheumatic Fever
- ❑ Sinus Problems
- ❑ Skin Disorder
- ❑ Stroke
- ❑ Thyroid Disorder
- ❑ Tuberculosis
- ❑ Venereal Disease

Hospitalizations & Surgeries:

_____ _____
Reason Date

_____ _____
Reason Date

Women Only:

Are you pregnant? □Yes □No

Are you breastfeeding? □Yes □No

Family History:

Has anyone in your family ever had any of the following conditions?

- ❑ Abnormal Moles
- ❑ Acne
- ❑ Allergies
- ❑ Arthritis
- ❑ Asthma
- ❑ Basal Cell Carcinoma
- ❑ Cancer
- ❑ Diabetes
- ❑ Eczema
- ❑ Melanoma
- ❑ Psoriasis
- ❑ Skin Cancer
- ❑ Squamous Cell Carcinoma

Lifestyle Factors:

Have you ever smoked? □Yes □No
# of years _____
# of packs/day_____

Do you smoke now? □Yes □No
# of years_____
# of packs/day_____

Do you use recreational drugs? □Yes □No
Types_____
# of times/week_____

How much alcohol do you drink per week? _____ /week
How much caffeine do you drink per day? _____/day

Emergency Contact Information:

Name_____Phone_____ Relationship_____

Signature (patient **or** guardian) _____ Date_____

To Our Patients: (**This information is never kept in paper in our office, your registration forms are uploaded to our EMR system and then SHREDDED.**)

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 (as are your medical records) 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 may be charged to your credit card and it will be presented on your credit card statement.

This will be an advantage to you because it will save writing and mailing another 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. **If you have a credit card that is designated for health care expenses, such as an HSA, FSA, or flex spend card, then this is the card you should put on file for any medical expense balances.**

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

Sincerely yours,

I authorize the practice to charge outstanding patient portion balances for me to the following credit card:

Card Type: ❑ Visa ❑ Mastercard ❑ Discover ❑ American Express

Category: ❑ Debit ❑ Credit ❑ Healthcare Credit/Debit Card (HSA, FSA, health flex spends, etc.)

Credit Card Number _____

Expiration Date _____

Security code (4 digits for Amex)
_____

Zip Code: _____

Signature _____ Date _____

Full name on card (please print) _____

Jane Yoo, MD, PLLC

Financial Policies

Thank you for choosing us for your dermatological services! We are committed to compassionate, personalized care in a professional and confidential environment. We ask that you review and accept our financial policies prior to provision of services. *Not agreeing to leave a card on file for future outstanding balances will result in your visit being cancelled.* We appreciate the trust our patients have in us and we understand there are many other options for our patients to choose from when it comes to medical care. Please read carefully.

Instructions: Please review each part of our financial policies, initial each one, and sign at the bottom of the form. Complete the form and bring it with you at the time of your visit.

Payment Required at Time of Service: We require payment at the time of service. If you have health insurance and we are a participating network provider, we will ask for your **co-insurance**, **co-payment** and any unmet deductible, if applicable. If we are not a participating network provider for your insurance plan or if you do not have insurance, we require full payment at the time of service. We accept VISA, MasterCard, Discover, and American Express. We **do not** accept personal checks or cash.

(Initials) _____

Credit Card on File: We require that you provide our office with a valid credit card number and authorization so that we can keep the information on file. We may charge this card for one of three reasons: (1) if there is an unpaid balance remaining on your account 61 days after service that neither you nor your insurance company has paid; (2) to schedule all cosmetic procedures; and (3) if you fail to comply with our cancellation policy as explained below.

(Initials) _____

Policy for Filing Insurance: We participate with most major insurance plans. If we are a participating network provider for your plan, we will be happy to file a claim on your behalf. Please remember that your health benefit plan is an arrangement between you and your insurance company. Your individual plan determines what benefits it covers, coverage limits, and the need for prior authorizations and referrals. We will be happy to help, but we strongly encourage you to contact a representative of your insurance company for answers to questions regarding your insurance benefits.

Each time you come to our office, please bring with you a current insurance ID card and a valid government issued photo identification card (e.g. driver's license, passport). We will seek to verify eligibility and, if valid, we will file a claim on your behalf. Even when your insurance plan verifies your eligibility and benefits, it does not guarantee the accuracy of the confirmation of coverage of benefits. In some cases, your insurance plan may not cover the services we provide or may determine that some of the services are not medically necessary. Your insurance company's rejection of all or part of your medical insurance claim does not relieve you of your financial obligation.

If we cannot verify your insurance or you are not eligible for insurance, we will consider you to be self-pay and financially responsible for the cost of your care at the time of the visit. By signing our Insurance Coverage Waiver Form, you will agree to accept full financial responsibility for the care that we provide.

(Initials) _____

Pathology Studies and Laboratory Tests: Our bills for **service may not** include pathology studies or laboratory tests. If you receive any of these services, you may receive a separate bill from the facility where the services were performed.

(Initials) _____

Referrals: Some insurance plans require a referral from the patient's primary care physician in order to be seen by a specialist. It is the patient's responsibility to: (1) know if his/her plan requires a referral; and (2) to obtain a referral, if needed, prior to the visit to our office. If you are uncertain about your plan's requirements, please contact your insurance plan prior to your visit. Patients without a valid referral that meets insurance plan requirements will have to to pay out-of-pocket for the visit on the day of service or reschedule the appointment until the office receives the referral (see late cancellation policy below). Please note that any claims that are denied because of a missing referral, will be the patient's responsibility.

(Initials) _____

Insurance, Co-Payments and Co-Insurance Co-Payments: (a fixed dollar amount that is assigned to the patient) and co-insurance (a percentage of total charges that is the patient's responsibility) are due at the time of visit. Our contracts with insurance companies obligate us to collect these fees; we cannot waive them or bill them. It is the patient's responsibility to know their insurance plan.

(Initials) _____

Self-Pay Patients: Payment is due in full at the time of service for self-pay patients. **Self-pay appointments start at $400.** We offer discounts for many of our medically necessary services for people who pay out-of-pocket. We will discuss the cost of any recommended procedures or services in excess of the basic office visit fee prior to the provision of service. We do not and WILL NOT bill insurance after a patient has paid a medical visit out of pocket. If your insurance is not active at the time of visit, we advise you to reschedule your appointment to a more convenient time (when insurance is active).

(Initials) _____

Credits and Refunds: We will return any refunds owed to your insurance plan. If there are credits or refunds owed to a patient, we will first apply them to any outstanding balance. Remaining patient credits and refunds can be left on the account to be used towards future charges or can be returned to the patient (or to the responsible party who made payment). Please allow 30-45 days for processing.

(Initials) _____

Outstanding Balances: Athena Health mails billing statements to patients. Payment for any outstanding balance is due upon receipt. Outstanding balances may result from remaining patient balances after we have billed your insurance company. For example, we will bill insured patients for unmet deductibles, additional, co-payments, non-covered services or any other charge that the insurance carrier assigns to the patient. We will also bill patient's penalty fees associated with our policy for cancellations, rescheduling, and no-shows. In those instances when a patient has a follow-up visit before receiving a statement for prior amounts owed, we will inform the patient of the outstanding balance and request payment at the time of that follow-up visit.

(Initials) _____

Cosmetic Procedures and Services: If your appointment is cosmetic we require payment in full at the time of service for cosmetic/non-medically necessary procedures and services provided by staff. There is a **cosmetic consultation fee of $375.** As explained above, in order to schedule cosmetic procedures, we must have a valid credit card and authorization on file as we require a deposit to hold any aesthetic appointments. **There are no refunds for cosmetic procedures or any products bought in the office.**

(Initials) _____

Cancellations, Lateness, Rescheduled Appointments, and No-Shows: We understand that plans change and emergencies arise. Please notify us as soon as possible if you need to cancel or reschedule your appointment. We have a strict 24-hour cancellation policy. If you fail to notify us of a cancellation or rescheduled appointment within 1 business day prior to your scheduled appointment or you miss an

appointment, **we charge a penalty fee of $75 for office visits, $150 for medical procedures, and one in a series of 50% of the cost of the procedure (minimum $200) for cosmetic procedures. If you are more than 15 minutes late for your scheduled appointment, it is up the discretion of the practice to decide whether or not you will be seen. Please keep in mind that patients will be seen in a timely manner and you might have to wait.** The penalties apply regardless of whether or not you receive a courtesy reminder from our office. They also apply to appointments made just one day in advance.

(Initials) _____

Responsible Party: When a patient is less than 18 years of age, the parent or guardian who signs the patient registration form is responsible for all fees incurred by the minor. When a patient turns 18 or older, he/she becomes responsible for his/her account and financial obligations. If a parent prefers to assume complete financial responsibility for an adult offspring, _____ **we must receive notification in writing.**

(Initials) _____

Method of Payment: The practice accepts all major credit cards. Payments may be made in person, by email, or by phone. We DO NOT accept checks.

(Initials) _____

Collections: If you have an outstanding balance that requires special arrangements, please call our Practice Manager at (646) 844-0424 for assistance. It is our sincere desire to help you meet your financial obligations without being sent to collections. Outstanding balances that are not paid within 90 days will be sent to a collection's agency. Once a patient's account is sent to collections he/she is responsible for the outstanding balance on the account in addition to a Collections Fee of 35% of the outstanding balance plus any interest, service fees and/or legal fees that accrue while the account is in collections.

(Initials) _____

Surgical Procedures: We ask our patients to please arrive 15-30 minutes earlier when scheduled for surgical procedures. This will allow extra time to prepare before starting any procedures and to review consent forms. **If you are more than 15 minutes late for your scheduled surgery/procedure, it is up the discretion of the practice to decide whether or not you will be seen. Please keep in mind that patients will be seen in a timely manner and you might have to wait or re-schedule.**

(Initials) _____

Patient Authorization: My initials above and my signature below signify that I understand and agree to the policies above.

_____ _____

Patient/Guardian Signature **Date**

_____

Patient/Guardian Printed Name

**For a copy of our Notice of Privacy Practices, or our Financial Policies, please ask the front desk, thank you!*

Written Acknowledgement of Receipt of Notice of Privacy Practices

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak to our Practice Manager in person or by phone (646-844- 0424).

I, _____
have received a copy of JANE YOO, MD, MPP, DERMATOLOGIC SURGEON Notice of Privacy Practices.

Patient Signature_____ Date_____

*****IF YOU WOULD LIKE A COPY TO TAKE HOME OF THESE FORMS PLEASE ASK THE FRONT DESK TO PROVIDE YOU WITH ONE.**

Assignment of Benefits Form

I assign and authorize insurance benefits to be paid directly to Jane Yoo MD, MPP. I also understand that I am financially responsible for any balance due. I authorized release of medical information to my insurance company are due at time of the service. All cosmetic procedures are to be paid at the time of service. It is the responsibility of the patient to understand their individual policy. Appointments must be cancelled 1 business days in advance. All non-cancelled appointments may be subject to charge.

Signature: _____ Date: _____/_____/_____

Do you give our office permission to discuss your medical information with family members?

YES NO: If yes, please provide their name and phone number.

Name: _____ Relationship: _____

Phone number (_____) _____-_____

May we leave personal medical information on your answering machine (home and/or cell)

- YES
- NO

May we e-mail personal medical information to you

- YES
- NO

Signature: _____ Date _____/_____/_____

FOR MEDICARE PATIENTS

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payer if they require it for the proper consideration of a claim. Please read and sign the following statement.

I authorize any holder of medical or other information about me to release to the Social Security Administration and Center for Medicare and Medicaid Services, or its intermediaries or carrier, any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

_____ _____/_____/_____

Signature as it appears on Medicare Card Date

If you have a supplemental policy and it is a MEDIGAP policy to which your Medicare Carrier automatically "crosses over", we are required to keep a separate signature on file:

I request authorized MEDIGAP benefits be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine these benefits of the benefits payable for related services.

_____ _____/_____/_____

Signature as it appears on Medigap Card Date

Fee and OTHER important information

Failure to cancel Appointment within 1 (24hrs) business day:
Office visit: $75
Non-cosmetic office procedure: $150
Cosmetic procedures: 50% cost of procedure (minimum $200 for cosmetic procedures)

Please be aware that we don't do prior-Authorizations for medications/ prescriptions. If your insurance requires a prior-Auth, your medication will be sent to a Cedra Pharmacy. This is a specialty pharmacy that specializes in completing prior-Authorizations and they also apply coupons if medication is too expensive. After a prescription is sent to Cedra, they will contact you by phone once the medication is ready, and they will deliver it to your home at the time of your convenience.

***I have been informed about the fee information at JANE YOO, MD, MPP.**

Signature: _____

Print Name: _____