New Patient Information for Dr. Merle Bari

Name_____ Social Security #_____
Address_____ Sex____ Age_____ Marital Status_____
City_____ State_____ Zip_____ Phone(home)_____ Cell_____
Email_____ Date of Birth_____
Occupation_____ Employer _____
Reason for Consulting A Dermatologist_____
Current Medications(including BCP, aspirin, Motrin)_____
Allergies_____

Name of Insurance Company_____ (please bring your card with you)
Name of Insured_____ Relation_____ DOB_____
Identification Number_____ Group number_____
Have you met your deductible?_____ Medicare number_____
Do you have a prescription plan?____ Family Physician_____ Address or fax_____
_____
Who Referred you? _____

Circle any Illnesses or conditions you have had:

| | | |
|---|---|---|
| Heart Disease | HIV/AIDS | Females: |
| Mitral Valve prolapse | Cancer | Last Menstrual period_____ |
| High Blood pressure | Diabetes | Regular cycles yes or no |
| Vein trouble | Thyroid Disease | Birth Control Method_____ |
| Lung Disease | Arthritis | |
| Asthma | Hay Fever | Skin: Eczema Psoriasis Skin Cancer |
| Glaucoma | Bleeding Disorders | Excess Scarring Recent Hair Loss |
| Hepatitis/liver disease | Blood transfusions | Abnormal moles |
| Kidney disease | Gastrointestinal disease | |
| Mental/nervous disorders | Glaucoma | Family history: Melanoma or Skin Cancer |
| Sexually Transmitted disease | Neurologic disease | Social history: tobacco alcohol drugs other |

For All Patients: Assignment of Insurance Benefits
I hereby authorize direct payment of surgical/medical benefits to Dr. Merle Bari for services rendered by her. I request that payment of authorized benefits be made on my behalf. I authorize the release of any medical information to the health care financing administration needed to determine those benefits.

Date_____ Signature_____

# PATIENT RESPONSIBILITY AGREEMENT

I understand and agree that I will be financially responsible for the patient services provided by the **OFFICE OF MERLE BARI, M.D.** (also called the "Office"), according to the policies stated in this Patient Responsibility Agreement.

**TREATMENT PLAN**. I acknowledge that I am financially responsible for all patient services, including services which may be itemized in the Treatment Plan which is attached as Exhibit A, as amended from time to time.

**PATIENT INFORMATION**. The patient information provided to the Office is true and correct. I will notify the Office about any significant future revisions to the patient information furnished.

**INSURANCE**. If I expect my insurer to cover some or all of the cost of the patient services, the Office will assist me, as a courtesy, in obtaining the appropriate benefits from the insurer by billing the insurer. I agree to cooperate and provide all information necessary to the Office. However, I have the primary relationship with my insurer and the Office is not responsible for guaranteeing that benefits will be received in the amounts and in the time-frame as requested. **I am responsible to resolve any problems with my insurer**. I may request that the Office obtain a pre-estimate of insurance benefits before patient services are performed.

**PAYMENT SCHEDULE**. Unless my treatment is scheduled over a period of time, and unless I specifically request, and the Office approves in advance, a payment schedule for the patient services, **all payments for services are due when a billing statement is presented after the services are performed**. The Office will not otherwise approve any deferred payment schedule.

**BILLING STATEMENT**. It is possible that portions of the bill for patient services, such as co-payments, deductibles and exclusions, may not be paid by the insurer. Those unpaid portions must be paid by me when a billing statement is presented after the patient services are performed. Payments may be made in cash, check or by credit card. If my insurer has not paid the benefits to the Office within 90 days after submitted, the Office may then require me to pay for the patient services in full, and any insurance benefits later received by the Office will be returned to me.

**REFERRAL FOR COLLECTION**. If my account is referred to an outside agency or attorney for collection after 90 days, I will also be responsible for actual collection costs incurred, including all attorney's fees and court costs. The Office may deny subsequent patient treatment if my account balance remains unpaid.

**ACCOUNT CHARGES**. If my account remains unpaid after 90 days, I can be assessed with additional account charges at the rate of 1 1/2% per month (18% annually).

**ACCOUNT ADJUSTMENT**. If I fail to make a co-payment by the date required by my insurer, if applicable, then my account can be adjusted and I would be responsible for the full amount due for the patient services rendered.

**FAMILY RESPONSIBILITY**. I am authorized to agree, for myself and on behalf of my spouse (if applicable), to remain financially responsible for all future services rendered to all of my family members, regardless of ages, unless I notify the Office in writing otherwise.

**COLLECTION FROM OTHERS**. If I am financially indigent and unable to pay for patient services rendered, the Office may seek to recover my account balance from certain of my adult relatives under applicable Pennsylvania law.

**CANCELED APPOINTMENTS**. If an office appointment is canceled with less than 24 hours notice, I can be assessed with a cancellation charge of $25.00.

**RETURNED CHECKS**. If my check is returned by the bank, I can be assessed with a processing charge of $20.00.

Dated: _____ _____

Patient or Responsible Party Signature

Merle Bari, MD
Dermatology& Dermatologic Surgery
610-649-5001

**Patient Consent Form**

The Department of Health and Human Services has established a “Privacy Rule” to help insure that personal healthcare information is protected for privacy. The Privacy rule was also created in order to provide a standard for certain healthcare providers to obtain their patients’ consent for uses and disclosures for health information about the patient to carry out treatment, payment, and healthcare operations.

As our patient we want you to know that we respect the privacy of your personal medical records and we do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information and information to only those we feel are in need of your healthcare information and information about treatment, payment, or healthcare operations, in order to provide healthcare that is in your best interest.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and other healthcare providers and not patients), and may have to disclose personal health information for purposes of treatment, payment, or healthcare operations. These entitles are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your personal health information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all of your PHI. You may not revoke actions that may already been taken with relied on this or a previously signed consent. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer.

You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy policy.

Signed this ____ day of _____, 20_____
Print Patient Name: _____
Relationship to Patient: _____
Signature: _____