WINDSOR DERMATOLOGY
HEALTHY SKIN

HIPAA

Our office complies with the Health Insurance Portability & Accountability Act to ensure that all of our patients' information is kept properly confidential. Unless you notify us otherwise, we may use and disclose your medical records ONLY for the purposes of treatment (as regards coordination of your care with other providers and services), payment (as regards obtaining reimbursement for services, confirming coverage and billing your insurance company) and health care operations. We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services. Unless otherwise notified by you, we may at times leave a message at your home phone answering machine, with a family member, or mail information to your home address regarding your medical information.

Please list any other parties who can have access to your health information (this includes step parents, grandparents, and any caretakers who can have access to this patient's records)

Name_____ Relationship _____

Name_____ Relationship _____

The undersigned acknowledges you have reviewed the posted currently effective notice of privacy practices for Windsor Dermatology, PC and The Psoriasis Treatment Center Of Central New Jersey. I understand that my personal information will only be used and/or disclosed as above, and that I have the right to request restrictions concerning the use of my personal information. A copy of this signed, dated document shall be as effective as the original. My signature will also serve as a PHI document release should I request treatment/medical records be sent to other attending doctors/facilities in the future.

You may refuse to sign this acknowledgement and authorization. In refusing, we may not be allowed to process your insurance claims.

Patient printed name	Patient signature	Date
Legal representative/parent name	Legal representative/parent signature	

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Windsor Dermatology, PC and The Psoriasis Treatment Center Of Central New Jersey to view my external prescription history via the Rx hub service of SureScripts. I understand that prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient printed name	Patient signature	Date
Legal representative/parent name	Legal representative/parent signature	

WINDSOR DERMATOLOGY, PC

Jerry Bagel, MD, David S. Nieves, MD, Brian R. Keegan, MD, PhD, Matthew Halpern, MD, Wendy Myers, MD, Jessica Simon, MD,

WELCOME TO OUR OFFICE * THIS INFORMATION MAY SAVE YOU UNNECESSARY EXPENSE!

Please take some time to read our policy on medical insurance plans. Your signature below indicates your understanding and acceptance of our medical insurance policy. Please feel free to discuss any questions with our office staff.

- ***Primary*** insurance is coverage through **YOUR** employer or your spouse if you are not employed
- ***Secondary*** insurance is additional coverage through a **SPOUSE**
- ***Children*** with coverage through both parents will be considered to be primary under whichever parent's birthday falls first in the calendar year

If our office participates with either your primary or secondary insurance, we will submit the claim as appropriate and it is your responsibility at the time of service to provide our office with the following:

- All information that applies to the primary insured including date of birth and social security number
- The insurance claim submission address for both insurance companies
- The co-payment as required by your insurance company

***For plans requiring referrals you must have a valid referral*, which must be presented prior to service to qualify for your insurance benefit. If you do not have a valid referral as required by your insurance plan:**

- You may reschedule your appointment
- If you choose to be seen without a valid referral, you must understand that any charges incurred resulting from this visit will be your responsibility. *As per your contract with your insurance carrier, you have agreed to bring a referral coordinated by your Primary Care Physician to be treated by a Specialist.* We will submit to your insurance carrier and then bill you if necessary.

For plans requiring referrals for maximum or optimal benefits (POS or Point of Service Plans)

We do not require a referral for these plans, however, it is the responsibility of the insured to be aware of their insurance benefits.

- If you choose to be seen without a referral *you will be responsible for all deductibles or charges as per your contract with your insurance company.* We will submit charges with a referral when properly provided to us.
- We will submit to your insurance carrier and then bill you if necessary.

Following claim submission

- You will be billed for any deductibles or co-payments as determined by your insurance company.
- Payment is expected upon receipt of statement from our office.
- Occasionally, insurance companies will request information from you regarding medical claims. You must respond to these inquiries within 14 days, or you may be held responsible for the entire charge of the medical visit.

Medicaid Notice: The Physicians of Windsor Dermatology, PC do not participate with any Medicaid plans. This includes Medicaid plans offered by private insurance companies. If your primary or secondary insurance is a Medicaid plan and you accept services by a Windsor Dermatology, PC physician, you will be billed for services rendered. By signing, you understand that if you have a Medicaid plan you will be billed and responsible for any charges for services rendered.

Please note *cosmetic procedures are not covered by insurance plans and you will be responsible for these charges at the time of service. Your physician will notify you if a procedure is cosmetic and the cost of the procedure before service is rendered. If on the same date of service as a cosmetic procedure you also incur charges that will be accepted by your insurance company, these will be submitted to your insurance carrier on a completely separate basis.*

I am aware of, have read the above, and accept the insurance policy of this office as indicated by my signature below.

Signature of Patient/Responsible Party Date

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions, as well as the release of information to all my insurance companies allowing my physician to submit claims and receive payment for benefits covering services rendered for myself or dependents. I permit a copy of this authorization to be used in place of the original and understand that I am financially responsible for all charges as per my agreement with my insurance company and this office.

Name (Please Print) Date Signature