Date:

Your Appointment Date and Time: _____ at ____:_____ AM/ PM

Dear Patient:

Thank you for being a valued patient of our dermatology practice! Wegman Dermatology, PLLC is part of your Patient-Centered Medical Home Neighborhood. We look forward to providing you quality dermatologic care in a warm and friendly environment. Your healthcare is our primary concern, and we partner with your Primary Care Physician to efficiently co-manage your healthcare over time. As your Dermatology provider, we will be sharing limited or long-term management (depending on the nature and impact) of your condition and will provide you with advice, guidance, and periodic follow up for as long as you need. Our philosophy is to provide comprehensive care while treating every patient with dignity and respect. **Examining the skin can be an involved process and delays may occur as Dr. Wegman provides thorough dermatologic care to his patients**. Please see the information under each of the headings listed below. We understand that coming in for a medical appointment can, often, cause apprehension and concern and we want you to feel comfortable when you arrive for your appointment Wegman Dermatology. This information can answer many questions about how Wegman Dermatology operates.

WHAT TO EXPECT AT YOUR APPOINTMENT

When you arrive at your appointment, you will be asked for your insurance cards, driver's license, and a list of medications. On the day of your appointment at check in, you will be asked to pay your copay, deductible (if not met), and coinsurance (if applicable). This payment policy does NOT apply to those patients with government issued Medicare and all Medicaid patients. In addition to the enclosed forms, you will also be asked to fill out a questionnaire related to your visit with Wegman Dermatology on the day of your appointment.
Enclosed are the intake forms that ***you need to fill out completely*** before your appointment with Wegman Dermatology. ***Regarding forms requiring a witness for patient signatures, please sign these forms when completing the packet BEFORE your appointment. The signatures will be witnessed by our staff at the time of your appointment.*** Please return these completed forms to the office on or before your appointment with Wegman Dermatology. All forms will be reviewed with you on an annual basis. **According to practice and various governmental/insurance regulations, you will be asked to fill these forms out at regular intervals. Please keep in mind that if the forms are NOT completely filled out, you may experience greater wait times once you are in the office for your appointment.**

As stated above, Dr. Wegman aims to provide **quality medical care to each one of his patients** and this involves ***taking a detailed history from each patient and completing a comprehensive physical examination on each patient***. The process to take a detailed history and provide a comprehensive physical examination is lengthy and, therefore, **patient appointments with Dr. Wegman usually take approximately 2 hours**.

OFFICE HOURS, SCHEDULING, & CONFIRMATION OF APPOINTMENTS

Patients are scheduled Monday through Thursday. Our telephones are answered from 10 AM until 5 PM on Mondays and Wednesdays except during the lunch hour (11:30 AM-1:30 PM). ***We are usually closed on Fridays***. You may leave a message on our voicemail and your call will be returned on the next business day.

We will attempt to confirm your appointment using multiple modes of communication (email, phone, and text messaging). The process to confirm an appointment begins a few days to a week before your scheduled appointment. Please acknowledge your appointment during one of our confirmation contacts. We will continue calling to confirm your appointment until we hear from you. We also send "just in time" text reminders the day of your appointment. Patients who are unresponsive or no-show their appointment may be charged a missed appointment fee.

PLEASE TURN OVER – MORE INFORMATION ON BACK

INSURANCE & PAYMENT INFORMATION

We will try to verify your insurance coverage, including your deductible and copays prior to your appointment. **Please call the office if your insurance has changed since your last appointment**. For payments, the practice accepts credit cards (VISA, MASTERCARD, AMERCIAN EXPRESS, and DISCOVER), cash, money orders, and personal checks (written to Wegman Dermatology, PLLC). We also offer a credit card option through CareCredit, which offers a no interest plan if paid within the time frame selected.

Patients with HMO insurance are required to obtain authorization from their Primary Care Physician so they can be seen by Wegman Dermatology. It is the patient's responsibility to obtain this authorization from their Primary Care Physician and patients who arrive to their appointment without a proper HMO authorization will be asked to pay out of pocket for the visit or will be asked to reschedule their appointment.

COORDINATION OF CARE & PATIENT PORTAL

You may notice that we will be communicating with your Primary Care Physician and may be providing them with timely written reports on our consultations with you, including all diagnostic testing results and medications that we order for you. In addition, we may notify your Primary Care Physician of cancellations, missed appointments, and other actions that may place your care in jeopardy. If your care requires a referral to another physician, we will inform your Primary Care Physician of any additional referral(s) that Dr. Wegman recommend(s).

Wegman Dermatology provides each patient with access to their electronic health record via our patient portal. This is a unique feature that allows patients the ability to request change of information, request medication refills, request appointments, send messages to the office, and review documents in their electronic medical record such as diagnostic testing results and visit notes. If you would like to use your patient portal, please provide your email address on the enclosed forms and our intake questionnaire. Our staff will be happy to help you establish your patient portal.

AFTER HOURS/EXTENDED ACCESS POLICY

Wegman Dermatology, PLLC offers its patients after-hours medical care if they are having a medical concern after our business hours (8 AM- 5 PM, Monday-Thursday). Patients are directed to call our office's after-hours phone numbers: 989-725-2702 OR 989-277-5240 (Monday-Thursday from 5:00 PM to 8 AM and on Fridays, Saturdays, and Sundays) if they feel that they need to contact Dr. Wegman after hours for a medical question or concern. If Dr. Wegman is out of the area and/or unavailable to come into the office, patients may be directed to an area urgent care facility. As always, if a patient feels that they are experiencing a medical emergency, they should call 911 or go directly to their nearest Emergency Department.

PATIENT RESPONSIBILITIES

We trust you, our patient to:

- Keep your appointments as scheduled or call to let us know when you cannot keep an appointment.
- Learn about your insurance so you know what it covers.
- Follow the care plan that is agreed upon or let us know why you cannot so that we can try to help or change the plan.
- Tell us what medications you are taking and ask for refills at your next scheduled appointment.
- Tell us about emergency care or hospitalization(s) you receive.

If you have any questions for the office staff, please do not hesitate to call the office before your appointment. We look forward to seeing you at your next appointment with Wegman Dermatology, PLLC!

Sincerely,

Wegman Dermatology Staff

WEGMAN DERMATOLOGY, PLLC
DATE:_____

PATIENT CONTACT INFORMATION

Name: _____Middle Initial_____ Age: _____ Birth Date: _____

Preferred Name:_____ Primary Phone #: (_____) _____

Secondary Phone#:(_____) _____*May we leave message for you at listed phone number(s)? YES NO*

Address: _____ Email address: _____

City, State, Zip: _____ Gender: _____

Social Security Number: _____ Relationship Status: S M W D

Primary Doctor/ NP/PA: _____Pharmacy (City): _____

Do you winter/summer out of the state? YES NO If yes, what months are you out of the state _____

I have an: Durable Medical Power of Attorney___ Advanced Directives __ (Please Provide Copy at Appointment if possible)

Patient's Occupation & City: _____ Hours of Work: _____

Work Phone: _____You may leave a message for me at work: Yes No

Significant Other Name: _____Significant Other Phone #:_____

Significant Other Work Phone: _____You may leave a message for my significant other at work: Yes No

<u>If Minor</u>, Parent Name:_____ <u>If Minor</u>, Parent Phone #:_____

Parent's Employer:_____ Parent's Work Phone: _____

Legal Guardian:_____ Guardian's Best Contact Number:_____

If patient is under the age of 18 OR has legal guardian, the patient's parent and/or legal guardian must be present at all appointments.

DESIGNATED REPRESENTATIVE(S) INFORMATION

Our office staff may discuss your test results or other medical information regarding your care with the person(s) listed below:

****Please note that we will not leave any medical information on an answering machine****

(<u>Your information may not be discussed with your spouse, parent, or any other person unless listed in this section of the form</u>.)

- Name: _____ Phone #_____ Relationship: _____
- Name: _____ Phone #_____ Relationship: _____
- Name: _____ Phone #_____ Relationship: _____
- *****No –** I **do not** want my medical or any other information discussed with my spouse or any other person _____***

EMERGENCY CONTACT INFORMATION

Please provide the name(s) of person(s) **NOT living in your home. This person would ONLY be contacted if we were UNABLE to reach you at your phone number(s) and/or address provided. We will NOT provide medical information to these people.**

Name _____ Phone _____ Relationship_____

Name _____ Phone _____ Relationship_____

NAME:_____WEGMAN DERMATOLOGY, PLLC DATE:_____
DOCTOR:_____ PHARMACY
(CITY):_____

MEDICATION & ALLERGY INVENTOY

(WE WILL COPY YOUR PRE-MADE MED LIST IF YOU HAVE ONE)
(PLEASE INCLUDE ALL OTC MEDICATIONS, VITAMINS AND SUPPLEMENTS)

ALLERGIES:

ADVERSE DRUG REACTIONS:

MEDICATION NAME	STRENGTH/DOSAGE	FREQUENCY	REASON FOR TAKING

_____

PATIENT NAME DOB

REVIEWED BY:
DATE:

WEGMAN DERMATOLOGY, PLLC

PATIENT:_____

DOB:_____TODAY'S DATE:_____

SKIN CONDIITONS	No	Yes	Onset/Type
Have you had skin cancer?			
Melanoma?			
Basal Cell Carcinoma?			
Squamous Cell Carcinoma?			
Have you had an abnormal moles?			
Have you had pre-skin cancer lesions?			
List any other skin conditions: (Examples: Eczema, Psoriasis, Acne, Rosacea, etc…) _____			
Do you use sunscreen? SPF #____			
Have you used tanning beds in the past?			
Do you currently use tanning beds?			
Have you had blistering sunburns?			
Do you heal with thick (Keloid) scars?			
Do you need antibiotics for the Dentist?			
Do you work outdoors?			
Have you had Staph infections/MRSA?			
PAST SURGICAL HISTORY	**NO**	**YES**	**YEAR/TYPE**
Pacemaker/Defibrillator			
Orthopedic/Joint Replacement-Site:_____			
Heart Bypass/Stents			
Heart Valve Replacement			
Organ Transplant-Type:_____			
Appendix/Tonsil/Gall Bladder			
Cancer			
Other			
FAMILY MEDICAL HISTORY	**NO**	**YES**	**ONSET/TYPE**
Skin Cancer?			
Abnormal Moles			
Eczema			
Asthma			
Seasonal Allergies			
Psoriasis			
Autoimmune Diseases (Lupus, Rheumatoid Arthritis, MS, Crohn's Colitis, Thyroid, etc…)			

PERSONAL MEDICAL HISTORY	No	Yes	Onset/Type
Alzheimer's Disease/Dementia			
Arthritis			
Asthma			
Back Problems			
Blood Disorder/Anemia			
Cancer (indicate type)			
Depression/Anxiety			
Diabetes			
Digestive/Bowel Disorder			
Emphysema / COPD			
Glaucoma/ Cataract			
Hay Fever			
Headaches___ Migraines_ __			
Hearing Loss			
Heart Disease (Heart Attack, Atrial Fibrillation, etc…)			
Hepatitis – A, B, or C?			
High Blood Pressure			
High Cholesterol			
HIV / AIDS			
Kidney Disease			
Liver Disesase / Gall Bladder			
Lung Disease			
Lupus			
Mitral Valve Prolapse			
Other Auto-Immune Disorders			
Neurological Disorder			
Parkinson's Disease			
Psychological Disorder			
Seizure / Epilepsy			
Stroke			
Thyroid Disorder			

SOCIAL HISTORY	RESPONSE
Occupation (If Retired please indicate former occupation)	
Alcohol History	Oz per Week____ # Years Since Quit_____ NEVER
Smoking History	# per Day____ # years ____ # Years Since Quit_____ NEVER
Illicit Drug History- LIST	
List any Pets in your household	
Who Referred you to Dr. Wegman?	

WEGMAN DERMATOLOGY, PLLC

Patient's Name _____ Birth Date _____

YOUR FINANCIAL RESPONSIBILITIES

GENERAL INSURANCE BILLING INFO & SPECIAL CIRCUMSTANCES: I understand that, as a courtesy to me, Wegman Dermatology, PLLC may bill my medical claim to my insurance company according to the rules and/or policies of my insurance company. I authorize my insurance company to send their determination and/or payment of my insurance claim directly to Wegman Dermatology, PLLC. I understand that Wegman Dermatology, PLLC participates with most Medicare, Medicaid, Blue Cross Blue Shield, several HMO's, and many other commercial insurance companies. ***If I have an insurance with which Wegman Dermatology, PLLC does not contract, if I am uninsured (have no medical insurance coverage), and/or if I am requesting procedures or medical services that are not medically necessary, my signature on this form indicates my acceptance of my full financial responsibility for the charges associated for my visit.***

HMO AUTHS/REC RELEASE: If my insurance company requires a referral from my primary physician to process my claim, ***I understand that it is my responsibility to obtain the referral***. **If I do not obtain a referral, I agree to be responsible for payment of the claim.** I authorize Wegman Dermatology, PLLC to release any personal, medical, and/or financial information (including alcohol, drug abuse, mental health, HIV, AIDS & AIDS related complex treatment) related to my care, to my insurance carrier(s) or persons/agency responsible for the processing of my medical claim.

DESCRIPTION OF CHARGES ASSOCIATED WITH MY VISIT: I understand that for my best medical care Dr. Wegman prefers to do a complete skin evaluation. During my evaluations, Dr. Wegman may diagnose and treat skin conditions that he considers to be medically necessary. The treatment of these conditions will be billed separately from the office call to my insurance company according to general coding guidelines. Your insurance company may call some of the procedures performed at the visit a "surgery" on your explanation of benefits. Some conditions require more than one treatment and each treatment will be billed to your insurance company. **Any medically necessary procedures that are performed at my appointment(s) will be billed to my insurance in accordance with coding guidelines**.

BILLING/STATEMENTS AND PAYMENT METHODS: I understand that I will receive a statement from Wegman Dermatology, PLLC if a balance remains after my insurance company processes my claim and determines that I am responsible for a co-pay, co-insurance, deductible or any other amount that my insurance company approves, but does not pay to Wegman Dermatology, PLLC. ***This unpaid balance will remain my responsibility until it is paid.*** **I agree to be responsible for any balance my insurance company determines I am responsible for and does not pay to Wegman Dermatology, PLLC.** Wegman Dermatology, PLLC offers several methods of payment: cash, check, moneyorder, credit card payment, Care Credit, and online credit card payments (with option to do recurrent payment). You may mail the payment, call for payment, or complete a payment online on our website: wegmandermatology.com.

NSF CHEK POLICY: If the check I use to make payment from my bank account has insufficient funds, I will be charged any bank fees that Dr. Wegman incurs as a result of the transaction plus the original balance.

PAYMENTS: When possible, my deductible and copay will be determined prior to my visit. The office may call me to ask that I bring my office call copay and/or approximately $150 of my deductible to my appointment. These payments will be applied to any charges processed but not paid by my insurance company. If I am experiencing a financial hardship, I may set up a payment plan. If I have any questions regarding my charges or remaining balance I may ask to speak to the Billing Specialist.

NO SHOW POLICY/FEE: I understand that Wegman Dermatology, PLLC charges a no-show fee for missed appointments. If I no show an appointment, I may be charged: $ 75-$ 150 (based on appointment type).

ACCEPTANC OF FINANCIAL RESPONSIBILITY: I have been made fully aware and agree to be financially responsible for all charges incurred as a result of my visit(s) with Wegman Dermatology, PLLC and the insurance information stated above. I permit a copy of this authorization to be used in place of the original. This authorization is valid until I provide Wegman Dermatology, PLLC with written revocation.

SIGNED_____ **DATE**_____

MEDICARE AUTHORIZATION:

I request that payment of authorized Medicare benefits be made on my behalf to Wegman Dermatology, PLLC for any services furnished to me by him or his office staff at his direction. I authorize any holder of my personal medical records to release to the Health Care Financing Administration, or its agents, any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original. This authorization is valid until I provide Wegman Dermatology, PLLC with written revocation.

SIGNED_____ **DATE**_____

WEGMAN DERMATOLOGY, PLLC

Name _____Date of Birth_____ Today's Date ___ _____

GENERAL CONSENT FORM AND PRIVACY PRACTICES

The protection of your identity and the privacy of your personal medical information is very important to our office. To comply with new government rulings we are required to verify your identity at each appointment by asking you for a photo ID and your insurance card. In addition, your identity must be confirmed when you call with questions regarding your condition, prescription refills, requesting or cancelling an appointment, and account demographic changes.

The following information will assist us in your care and in our communications with you, while protecting your confidentiality.

1. **RECORDS:** Your signature below indicates that you authorize Dr. Wegman to retrieve any data, films, records, slides, medical records, and laboratory or pathology reports from other providers/labs to assist in your treatment.
2. **RISK:** Your signature below indicates that in the event that Dr. Wegman or any of his employees is exposed to your blood or body fluids, you have been informed that an HIV antibody test may be performed on you. (Public Act 488).
3. **CONTACT:** Your signature below indicates that you authorize Dr. Wegman to contact, leave a message on your home answering machine, and/or mail to you, your spouse, or a minor's parent, at your home address information regarding your medical condition, your account statement, appointment information, or insurance items.
4. **PHOTOGRAPHS:** Your condition may need to be photographed by Dr Wegman for educational/scientific/medical record purposes. Your signature also indicates you have been informed that any pictures taken will remain the property of Dr. Wegman. If your pictures are used for education or research, you will **NOT** be identified by name.
   [Example: a picture of your mole, cancer site, or unusual skin condition**]**
5. **MEDICATION HISTORY:** My signature below gives my permission for Dr. Wegman or his representative to obtain a list of all of my current and previous medications from my pharmacy or from a website that stores all medications my insurance company has processed.
   My local pharmacy is _____ I have a prescription insurance card **Yes No**

   My mail order pharmacy is (if applicable) _____
6. **PATIENT PORTAL, DIRECT MESSAGING, & REGISTRY REPORTING:** Your signature below indicates that you understand that the Affordable Care Act has required that physician's offices share information with you, your other physicians, and regulatory registries electronically. Please be assured that this is **always** done in a secure or encrypted method. Some reports to regulatory registries may require statistical information from your encounter but your name will not be included.
7. **HIPAA:** My signature below indicates that I have received and/or reviewed or have declined to receive and/or review a copy of Dr. Wegman's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices). My signature allows Dr. Wegman to keep this information in my medical chart. A separate Privacy Practices Acknowledgement Form may be reviewed and signed at my request.

Because of the importance of each of these notifications, if I do not sign this form, Dr. Wegman may need to decline to provide my dermatologic care. This form is valid indefinitely or until I provide written revocation.

****
IT IS OKAY TO SIGN DOCUMENT- IT WILL BE WITNESSED BY STAFF ON THE APPT DATE

_____
Signature of Patient/Parent/Guardian **Date**

_____
Signature of Employee Witness **Date**

WEGMAN DERMATOLOGY, PLLC

CONSENT FOR MINOR DERMATOLOGIC DIAGNOSTIC OR SURGICAL PROCEDURES

I understand that for my best medical care Dr. Wegman prefers to do a complete skin evaluation. During this evaluation, Dr. Wegman may diagnose skin conditions that he considers to be medically necessary or advisable to treat today. The treatment of these conditions will be billed separately from the office call to my insurance company according to general coding guidelines. Diagnosis of some conditions may require a KOH, which is a scraping of the skin that Dr. Wegman will examine under the microscope. Certain wounds require treatment with special surgical dressings and/or debridement that will also be billed separately to my insurance company. Any procedure provided to treat a medically necessary condition will be billed to my insurance.

Conditions that are not medically necessary to treat, such as Seborrheic Keratoses, Milia, Skin Tags, etc., may be noted by Dr. Wegman during your exam. Depending on the amount of time available in your appointment he may treat these areas at your request and at his discretion. Procedures provided to treat a condition that is not medically necessary will not be charged to your insurance and will be your personal responsibility when the appointment is scheduled specifically for the treatment of that condition and you have been provided with an estimate of your out of pocket charges.

Cryotherapy, is the application of Liquid Nitrogen, which is an extremely cold substance used to freeze/burn lesions or growths on the skin. Your insurance company may call this procedure a "surgery" on your explanation of benefits. If an area treated today does not resolve your insurance will be charged for whatever treatment is necessary when you return. Most Warts require more than one treatment and the appointment will be scheduled today. When you return for treatment of your Warts your insurance company will be billed again. These are correct billing procedures according to coding guidelines.

By signing below, I indicate that Dr. Wegman or his representative has discussed the above treatment or procedure with me and has explained the information that is briefly summarized below:

1. The nature, purpose, and intended outcome of the recommended treatment or procedure.
2. The risks and possible complications of the recommended procedure. I am aware that in addition to the specific risks of the treatment or procedure explained to me, as in any procedure, there are other risks such as infection, scar tissue, poor healing process, minimal blood loss.
3. The prognosis (medical prediction) if the treatment or procedure is refused.

I understand that the practice of medicine and surgery is not an exact science, and that no guarantees have been made concerning the results of any procedure. I feel I have had sufficient opportunity to discuss my condition with Dr. Wegman and/or his staff and all of my questions have been answered to my satisfaction.

- **I believe that I have adequate knowledge and understanding upon which to base an informed consent to the treatment or procedure.**
- **I understand and authorize that my insurance will be charged for an office call and for any medically necessary diagnostic or treatment procedures performed today.**
- **I also understand that I may be responsible for any charges that are approved but not paid by my insurance such as my deductible, copay, and co-insurance.**
- **My signature is valid for one year from the date signed unless I provide written revocation.**

If you have questions regarding the fees for treatment please ask to speak to our biller.

_____ _____

Signature of Patient, Parent, or Guardian Date Print Name of Patient Date of Birth/Age

_____, Signature of Witnessing Employee _____, Date

*****IT IS OKAY TO SIGN DOCUMENT - IT WILL BE WITNESSED BY STAFF ON THE APPT DATE*****