ASSOCIATES
IN DERMATOLOGY

Accessing your Patient Portal

1) **Visit https://assocderm.ema.md/ema/PatientLogin.action and select "Forgot Password**

2) **Your username is the email address you used when registering for your appointment**

3) **Enter your date of birth and last name, check the "I'm not a robot" box and then click Request Email.**

4) **The system will send a password reset link to your email.**

5) **Once you access your portal, please complete all data fields listed under the My Health tab prior to your appointment. This will expedite the check in process and ensure**

Please contact our office at 502-583-1749 if you need further assistance accessing your portal.

PATIENT FINANCIAL AGREEMENT AND MEDICAL CONSENT

- **Insurance Changes -** It is the responsibility of the patient/guardian to provide correct information and notify the practice of any changes to your insurance coverage, so that we can correctly file claims and accurately determine out of pocket costs. The patient is responsible for providing a current referral when/if required.
- **Co-Payments -** Co-payments are due at the time of service. If you are unable to remit your co-payment amount, the practice reserves the right to reschedule your appointment for another day/time that is convenient for you.
- **High Deductible Health Plans -** Due to the recent increase in high deductible health plans, patients with a remaining in-network balance, will be responsible for a deposit, due at the time of service.
  - Charges for all visits will be billed to your designated insurance carrier for services rendered by Associates in Dermatology providers.
  - The pre-payment will be applied to the account and any remaining balance, as determined by the insurance carrier will be billed to the responsible party on the account.
  - This does not apply to Original Medicare or Medicaid patients.
- **Prior Balances -** Prior balances, including those resulting from care to your dependent/minor, are due upon receipt of a statement or at the time of a scheduled appointment, whichever comes first. If you are unable to make payment at the time of the scheduled appointment, please contact the billing office to make arrangements for the balance. If you are unable to remit payment, the practice reserves the right to reschedule your appointment for another day/time that is convenient for you.
- **Missed Appointments/No show -** There will be a $25 charge for missed appointments in addition to any other charges you may incur (This policy does not apply to state plan beneficiaries). The Practice reserves the right to discharge any patient for missing an appointment (This policy applies to all patients)
- **Insurance and Billing -** It is your responsibility to provide us with accurate and complete information concerning your primary, secondary (if applicable), and tertiary (if applicable) insurance medical benefits, including referral documents from other providers. Current identification and insurance benefit cards are to be presented at each office visit. Associates in Dermatology bills insurance as a courtesy to our patients. Services that have not been paid by your health insurance carrier will become the guarantor's responsibility to pay in full, which shall include charges incurred for any laboratory testing and pathology. The patient acknowledges and understands that the laboratory/pathology services are separate from the provider's fee. The guarantor is responsible for all charges and fees associated with denied claims from incorrect or incomplete insurance information. It is the guarantor's responsibility to ensure our Practice's network status/participation with your insurance plan. Questions regarding coverage should be directed to your insurance company.
- **Credit Card on File –** Associates in Dermatology implemented a credit card on file policy as a convenient method of paying for the portion of your services that your insurance policy requires you to pay such as copay, deductible, and co-insurance. Your credit card information will be kept confidential and secure.
- **Self-Pay Patients -** It is our policy to collect payment at the time of service, this includes physician fees and/or pathology fees, if this is not collected at the time of service, you will be billed for the balance.
- **Phone Calls -** For any phone number provided by you to the practice at which you may be contacted, you consent to receive calls or text messages, included but not restricted to communications regarding billing and payment for items and services, unless you notify the practice to the contrary in writing. Calls and text messages include but are not limited to pre-recorded messages, artificial voice messages, automatic telephone dialing devices, or other computer assisted technology, or by electronic mail, text messaging, or by any other form of electronic

communication used by the practice and/or its affiliates, contractors, servicers, clinical providers, attorneys, or its agents, including collections agencies.

- **Collections and Legal Activity -** If Associates in Dermatology does not receive prompt payment, we reserve the right to transfer your balance to outside collections after being 90 days past due. If an account is referred to outside collections, we reserve the right to dismiss the patient from the practice. The account is subject to additional fees incurred by the practice and/or related to the collections activity. Pursuant to Kentucky Revised Statutes (KRS 411.195), if your account requires the practice to use an attorney to recover the amount you owe, either by legal action or by other means, you will be responsible for payment of the practice's reasonable attorney fees and court costs.
  - o I authorize all Providers associated with Associates in Dermatology to release information for the purpose of payment, treatment, and routine healthcare operations, including medical research studies.
  - o I authorize payment of medical benefits to all Providers associated with Associates in Dermatology.
- **Consent to Treat -** I voluntarily request a physician, and/or Advanced Practice Provider (Nurse Practitioner or Physician Assistant), and other health care providers or designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

Your signature indicates your understanding and compliance with this policy.

Print Patient Name	**Patient Signature / Date**
Print Guardian Name (If patient is under 18 years of age)	**Guardian Signature / Date** (If patient is under 18 years of age)

ASSOCIATES IN DERMATOLOGY, PLLC

RECEIPT OF NOTICE OF PRIVACY PRACTICES WRITTEN ACKNOWLEDGEMENT

I have received a copy of the Privacy Practices provided by Associates in Dermatology, PLLC.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Signature of Patient / Parent or Guardian Date

My Protected Health Information may be disclosed to:

Self_____ Phone:_____

Spouse / Significant Other_____ Phone:_____

Parent / Guardian_____ Phone:_____

Roommate_____ Phone:_____

Other_____ Phone:_____

Children_____ Phone: _____

_____ Phone: _____

_____ Phone: _____

Igive permission for Associates in Dermatology tocontact or leave a messageregarding test results on the following:

HomePhoneVoiceMail Home#_____

Cell Phone Voice Mail Cell # _____

Work Phone Voice Mail Work # _____

ASSOCIATES
IN DERMATOLOGY

PATIENT REGISTRATION

(Please Print)

DATE: _____

PATIENT INFORMATION

Patient's Name: _____ SS #: _____
(First) (Middle) (Last)

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Male Female Age: _____ Patient's Date of Birth: _____

Home Phone: (_) _____ Cell Phone: (_) _____

Email Address: _____

Race: _____ Ethnicity: Hispanic / Latino Language: _____
Non-Hispanic / Latino
Other

Marital Status: Married Single If Married, Name of Spouse: _____

If Child - Name of Mother and Father or Legal Guardian: _____

Person Responsible for bill if different than patient:

Name: _____ SS #: _____
(First) (Middle) (Last)

Street Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone: (____) _____ Cell Phone: (____) _____ D.O.B. _____ Age: _____

INSURANCE INFORMATION

Primary Insurance	**Secondary Insurance**
Name of Insurance: _____	Name of Insurance: _____
Subscriber Name: _____	Subscriber Name: _____
Subscriber's Date of Birth: _____ Sex: _____	Subscriber's Date of Birth: _____ Sex: _____
Policy or ID #: _____	Policy or ID #: _____
Group #: _____	Group #: _____

ASSOCIATES IN DERMATOLOGY

HISTORY AND INTAKE FORM

PATIENT NAME: _____

DOB: _____ DATE: _____

Height:_____ Weight:_____

PAST MEDICAL HISTORY

(please circle all that apply)

Anxiety
Arthritis
Asthma
Atrial fibrillation
Benign prostatic hyperplasia (enlarged prostate)
Cerebrovascular accident (stroke)
Chronic obstructive lung disease (COPD)
Arteriosclerosis (heart disease)
Depressive Disorder
Diabetes
Elevated Blood Pressure (Hypertension)
End stage renal disease (kidney)
Epilepsy
Gastroesophageal reflux disease (GERD)

Other :

Hearing loss
Hypercholesterolemia (high cholesterol)
Hyperthyroidism (high thyroid level)
Hypothyroidism (low thyroid level)
Inflammatory disease of liver
Leukemia
Malignant Lymphoma
Malignant tumor : lung /breast /colon
Pacemaker
Prostate cancer
Radiation therapy / treatment /management
Transplant of Bone Marrow

None:

PAST SURGICAL HISTORY

(please circle all that apply)

Abdominal resection
Bilateral replacement of knee joint
Biopsy of breast
Biopsy of prostate
Coronary artery bypass graft
Entire transplanted kidney
Excision of basal cell / melanoma/squamous cell
Colostomy
Tubal ligation
Appendectomy (appendix removal)
Cholecystectomy (gallbladder removal)
Colectomy (colon removal)
Liver excision
Percutaneous transluminal coronary angioplasty (heart stent)
Tissue graft heart valve replacement
Total cystectomy (bladder removal)
Transurethral prostatectomy (resection of prostate)
Hysterectomy (uterus removal)
Kidney biopsy
Low anterior reaction of rectum
Lumpectomy breast left / right
Mastectomy breast left/ right
Mechanical heart valve replacement
Oophorectomy (ovary removal)
Pancreatomy
Percutaneous extraction of kidney stone with fragmentation procedure
Portosystemic shunt operation
Prostatectomy
Prosthetic arthroplasty of bilateral hips
Splenectomy
Surgical biopsy of skin
Total nephrectomy (kidney removal)
Total orchidectomy (testicle removal)
Total replacement of hip joint left/ right
Total replacement of knee joint left/ right
Transplantation of heart
Transplantation of liver
Other :

SKIN DISEASE HISTORY

(please circle all that apply)

Acne
Actinic keratoses (precancer lesions)
Asteatosis cutis
Basal cell skin cancer
Contact dermatitis due to poison ivy
Dysplatic nevus of skin (precancerous moles)
Eczema
History of allergies / hayfever
Melanoma
Itchy scalp (puritus of scalp)
Psoriasis
Squamous cell skin cancer
Sunburn of second degree
Other:

None :

Do you wear sunscreen? Yes No SPF #: _____

Do you tan in a tanning salon? Yes No

Do you have a family history of melanoma? Yes No

If yes, which relative(s)? _____

Any other pertinent family history? _____

ASSOCIATES IN DERMATOLOGY

Referring Physician: _____

Phone Number for Referring Physician: _____

Primary Physician: _____

Phone Number for Primary Physician: _____

MEDICATIONS

MEDICATION: (Please PRINT all currentmedications)	DOSAGE:	HOW OFTEN:	REASON FOR TAKING:
	____ mg		
	____ mg		
	____ mg		
	____ mg		
	____ mg		
	____ mg		
	____ mg		
	____ mg		
	____ mg		
	____ mg		

MEDICATIONS YOU ARE ALLERGIC TO

(Please enter all allergies)

_____ _____

_____ _____

_____ _____

SOCIAL HISTORY

(Please circle all that apply)

Cigarette Smoking:

- Never smoked
- Quit: former smoker
- Smokes less than daily
- Smokes daily - if yes, how many?_____

Alcohol use:

- None
- Less than one drink per day
- One to two drinks per day
- Three or more drinks per day

What is your occupation? _____

Pharmacy Name: _____ **Phone:** _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____