Matthew J. Reschly, M.D. PC
GENERAL AND AESTHETIC DERMATOLOGY

# Patient Demographic Form

**Patient Name** Mr. Mrs. Ms. Dr. _____
LAST NAME FIRST NAME MIDDLE NAME

**Date of Birth** _____ **Age** _____ **Gender** M F _____
XX / XX / XXXX SOCIAL SECURITY NUMBER

**Birthplace** _____ **Primary Language** _____

**Marital Status** Single Married Widowed Divorced Partnered (CIRCLE)

**Address** _____
STREET APT/UNIT # CITY STATE ZIP CODE

**Telephone** _____ _____ _____
HOME MOBILE WORK

**Email Address** _____

**Employer** _____
EMPLOYER NAME EMPLOYER ADDRESS

**Emergency Contact** _____
FULL NAME RELATIONSHIP TO PATIENT PHONE NUMBER

**Primary Care Physician** _____
LAST NAME FIRST NAME PHONE NUMBER

**Referring Physician** _____

If you were not referred by a physician, how did you hear about our office?

MJR Derm Website Social Media ZocDoc Insurance Carrier Patient Other _____

**Parent/ Guardian** _____
NAME RELATIONSHIP TO PATIENT PHONE NUMBER

**PRIMARY INSURANCE**

_____
INSURANCE COMPANY NAME

_____
SUBSCRIBER'S NAME / RELATIONSHIP TO PATIENT / DOB

_____
ID NUMBER / GROUP NUMBER

**SECONDARY INSURANCE**

_____
INSURANCE COMPANY NAME

_____
SUBSCRIBER'S NAME / RELATIONSHIP TO PATIENT / DOB

_____
ID NUMBER / GROUP NUMBER

Patient or Guardian Signature _____ Date _____

Matthew J. Reschly, M.D. PC
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PATIENT NAME _____ DOB _____

## Patient Acknowledgment and Authorizations

I authorize Matthew J. Reschly, M.D., PC to conduct examinations, perform procedures and administer medications as deemed medically necessary or advisable.

Matthew J. Reschly, M.D., PC is hereby authorized to release a complete report of services rendered, diagnosis, findings and details of treatment and progress for the purpose of receiving payment for such services rendered. Recipients of such information may include authorized billing agents, insurance carriers, employer's workers' compensation insurance company, other third-party payers, the Social Security Administration under Title XVII (18) of the Social Security Act, Professional Review Organizations or other intermediaries responsible for payment of services rendered. The release of information consent may be revoked at any time by giving written notice.

If release of information Is refused, the patient will be held responsible for payment of all charges for services rendered in consideration of medical goods and services provided by Matthew J. Reschly, M.D., PC, I give all rights, title and interest to the medical/surgical/supply reimbursement in accordance with the terms and benefits of the patient's insurance policy of other health benefits including Medicare Part B. I remain fully responsible for payment of any and all charges not covered by insurance or Medicare.

## Patient Assignment of Benefits

Matthew J. Reschly, M.D., PC will bill all primary and secondary insurance carriers, but I am ultimately responsible for payment for services rendered and any supplies/equipment that I receive.

I hereby assign to Matthew J. Reschly, M.D., PC all insurance or other third-party benefits available for healthcare services provided to me. I understand that Matthew J. Reschly, M.D., PC, has the right to refuse or accept assignment of such benefits. If these benefits are not assigned to Matthew J. Reschly, M.D., PC, I agree to forward to Matthew J. Reschly, M.D., PC all health insurance and other third-party payments that I receive for services rendered to me immediately upon request.

I understand that my signature requests payment be made directly to Matthew J. Reschly, M.D., PC. I authorize the release of medical information necessary to pay the claim. A photocopy of this assignment is to be considered as the original.

## Patient Financial Policy

Thank you for choosing Matthew J. Reschly, M.D., PC, as your healthcare provider. We are committed to your treatment being a pleasant and successful experience. Please help us maintain accurate records by completing all forms legibly and informing us of any changes or updates to your information (i.e., address, telephone number, medical insurance, etc.). We require credit or debit card information maintained on file for future balance billing purposes. Copayments are due at the time of service. Matthew J. Reschly, M.D., PC reserves the right to forward specimens to an outside laboratory for pathologic interpretation. Matthew J. Reschly, M.D., PC is not responsible for outside laboratory fees that may be incurred. It is your responsibility to know and understand your specific insurance plan benefits. There is a $75 fee if appointments are not canceled or rescheduled within 24 hours of your scheduled appointment. Cosmetic appointments longer than 30 minutes require a minimum $150 deposit (excluding prepaid packages), applicable to the treatment cost. This fee is forfeited without cancellation or rescheduling with a minimum of 24 hours' notice. We accept all major credit cards, checks and cash. Please review Matthew J. Reschly, M.D., PC's complete Patient Financial Policy attached for more information.

**I have read and agree with the Patient Acknowledgment and Authorizations, Assignment of Benefits and Financial Policy. I understand the terms and conditions outlined herein as confirmed by my signature below.**

PATIENT OR GUARDIAN SIGNATURE _____ DATE _____

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PATIENT NAME _____ DOB _____

# Channel of Communication Request

You have the right to request how we communicate with you. We may communicate with you by phone, text, email or US Mail including use of automated communication devices. I hereby request the use of the following communication channels for information related to my personal health, treatment or payment. This request supersedes any prior request for confidential communication I have made. This permission is valid for one year from the date signed. You may revoke your authorization to receive further calls or messages at any time. The revocation does not have to be in writing. The ability to receive treatment from Matthew J. Reschly, M.D., PC is not contingent upon your communication choices.

Please circle all that apply and indicate with option(s) you prefer:

Preferred Contact Method (Circle all that apply): Phone Email Text

Primary Phone _____ Alternate Phone _____

_____ DO NOT leave messages on my voicemail.

_____ OKAY TO leave message on my voicemail.

If you are not available MJR has permission to speak with: _____

Email for Marketing Purposes: Yes / No Preferred Email Address _____

# Notice of Privacy Practices

I hereby acknowledge that I was offered and/or received a copy of Matthew J. Reschly, M.D., PC's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area and that a copy of any amended Notice of Privacy Practices will be available at each appointment. Any questions regarding the Privacy Practices of Matthew J. Reschly, M.D., PC should be directed to our Practice Administrator, Garnetta Peterson. She can be reached via email at gpeterson@mjrderm.com.

I would like to receive a copy of any amended Notice of Privacy Practices (circle one): Yes No

I prefer to receive a copy of via (circle one): Email Handout US Mail Fax

**Patient or Guardian Signature**: _____ **Date**: _____

## Discrimination is Against the Law

Matthew J. Reschly, M.D., PC complies with applicable Federal Civil Rights Laws and does not discriminate on the basis of race, color, national origin, age, disability, gender identity or sex. MJR does not exclude people or treat them differently because of race, color, national origin, age, disability, gender identity or sex.

Matthew J. Reschly, M.D., PC:

1. Provides free aids and services to people with disabilities to communicate effectively with us, such as:
    a. Qualified sign language interpreters
    b. Written information in other formats (large print, accessible electronic formats, etc.)
2. Provides free language services to people whose primary language is not English, such as:
    a. Qualified interpreters
    b. Information written in other languages

If you need these services, please call our office and ask to speak with the Practice Administrator. If you believe that MJR has failed to provide these services or discriminated against you on the basis of race, color, national origin, age, disability or sex, you can file a grievance with: Garnetta Peterson, 2000 Riverside Pkwy, Ste 100, Lawrenceville, GA 30043. 678-535-0079

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PATIENT NAME _____ DOB _____

# Patient Medical History Form

Are you in good health now? Yes _____ No _____

Have you ever had any of the following?

| | | | | | |
|---|---|---|---|---|---|
| Asthma | Yes _____ | No _____ | Diabetes | Yes _____ | No _____ |
| Chronic Hay Fever | Yes _____ | No _____ | Internal Cancer | Yes _____ | No _____ |
| Hives | Yes _____ | No _____ | High Blood Pressure | Yes _____ | No _____ |
| Sinus Problems/Migraines | Yes _____ | No _____ | Heart Trouble | Yes _____ | No _____ |
| Eczema | Yes _____ | No _____ | Rheumatic Fever | Yes _____ | No _____ |
| Boils | Yes _____ | No _____ | Jaundice/Hepatitis | Yes _____ | No _____ |
| Food Allergies | Yes _____ | No _____ | Kidney Disease | Yes _____ | No _____ |
| Allergy to Local Anesthetics | Yes _____ | No _____ | Glaucoma | Yes _____ | No _____ |
| Bleeding Ulcer | Yes _____ | No _____ | Epilepsy | Yes _____ | No _____ |
| HIV Infection | Yes _____ | No _____ | Tuberculosis | Yes _____ | No _____ |
| Do you smoke? | Yes _____ | No _____ | Organ Transplant | Yes _____ | No _____ |
| Joint Replacement | Yes _____ | No _____ | | | |
| Do you take blood thinners? | Yes _____ | No _____ | (Aspirin, Advil, Ibuprofen, Motrin, Coumadin) | | |
| Have you ever taken Penicillin? | Yes _____ | No _____ | | | |

What disease, if any, runs in your family?

_____

_____

Have you ever been treated for skin cancer?

Yes _____ No _____

Serious illness? If so, please describe below:

_____

_____

Previous skin problems? Please describe below:

_____

_____

Any hospitalizations? If so, describe below:

_____

Any surgeries? If so, please describe below:

_____

**Women only, please answer the following.**

| | | | |
|---|---|---|---|
| Are you pregnant? | Yes _____ | No _____ | If yes, the expected delivery date is _____ |
| Are you breast feeding? | Yes _____ | No _____ | |
| Do you take birth control pills? | Yes _____ | No _____ | Name of brand? _____ |

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PATIENT NAME _____ DOB _____

# Patient Medication List

| Medication Name | Dosage | Frequency | Route of Administration (e.g., oral, topical, inhaled) |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

If allergic to any medication(s), please list and state the reaction(s):

_____

_____

# Patient Skin Concerns

Skin Concerns (check all that apply)

| | | | |
|---|---|---|---|
| ____ Psoriasis | ____ Rashes | ____ Ringworm | ____ Shingles |
| ____ Skin Cancer | ____ Skin Infections | ____ Sun Damage | ____ Warts |
| ____ Acne | ____ Accutane | ____ Actinic Keratosis | ____ Birth Marks |
| ____ Dry Skin | ____ Eczema | ____ Fungal Infection | ____ Growths |
| ____ Hair Loss | ____ Hair/Scalp Problems | ____ Moles | Other _____ |

Specialty Services (check those you are interested in)

____ Botox® & Dysport® ____ Restylane®

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## Insurance and Insurance Collection

If you are unable to present an insurance card at the time of service or you are covered by an insurance company that we are not contracted with, you will be required to pay for your services at the time of your service. If we are able to collect from your insurance company, a refund will be issued. As a courtesy, If contracted, we will forward claims and bill your insurance company. In the event that your insurance company does not reimburse us within ninety (90) days, the balance will be transferred to you and a statement will be sent.

## Know Your Plan Benefits – Non-Covered Services Are Your Responsibility

Each insurance carrier, including Medicare has various plans, each with different benefits. Because your health insurance is an arrangement between you and your insurer, you should review and confirm covered and non-covered services/products under your specific plan. Your insurer can assist you with questions regarding your benefits. All co-payments, coinsurance and/or deductibles are your responsibility. Co-payments are due at the time of service. This is a requirement of your insurer.

We may decline to see patients for non-emergent visits if co-payments are not paid at the time of the visit. In addition, please be aware that Matthew J. Reschly, M.D., PC may provide services that may not be a covered benefit of your insurance plan. Patients or Guarantors are financially responsible for any and all services not covered by your insurance plan. It is your responsibility to know and understand your specific insurance plan and what benefits are covered.

Some procedures may involve the removal of tissue. The charge for this process is known as laboratory/pathology charges and will appear on your statement if performed. MJR reserves the right to send specimens to an outside facility for pathologic interpretation. MJR is not responsible for any outside laboratory charges that may be incurred.

## HMO Plans

If your care and treatment is the result of a referral from your HMO plan/HMO provider, a written authorization/referral is required. It is your responsibility to verify that your care and treatment are properly authorized in advance. Any co-payment required will be your responsibility at the time of your visit.

## Secondary Insurance

Having multiple insurance plans does not guarantee 100% coverage. We will bill your secondary carrier as a courtesy. You are responsible for any balances after your insurance carriers have processed our claims.

## Medicare

You are responsible for your annual deductible and 20% of the allowable fee for covered services. We are happy to bill your secondary (and tertiary) insurance companies, if the information has been provided. If any balance remains after your claims have been processed, we will transfer the balance to you and a statement will be sent.

*Important Reminder for Medicare Enrollees: If you qualify for Medicare coverage and decided to enroll in a Medicare+ Choice/Medicare Advantage plan (e.g. Humana Gold, Blue Cross Senior Secure, etc.) a referral may be required from your Primary Care Physician (PCP) before your visit with us will be covered. Please call the number listed on your insurance card for more information.*

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## Minor Patients

The adult accompanying a minor and the minor's parents or guardians are responsible for full payment for services rendered. If a minor is unaccompanied, consent for treatment and payment arrangements must be provided in advance of treatment. Payment may be by pre-authorized credit card, payment on account in advance or check or credit card at the time of service.

## Divorce Decrees

Matthew J. Reschly, M.D., PC is NOT a party to any divorce decrees. Adult patients are responsible for their bill at the time of service. Financial responsibility for a minor receiving medical services rests with the accompanying adult.

## Credit Card on File

We require a credit/debit card on file for payment of co-payments, coinsurance amounts, deductibles, and charges not otherwise covered by your insurance carrier. The card will not be charged until the claim has been processed and we have received an Explanation of Benefits (EOB) detailing the amount of the charges that you are responsible for. You will also receive a copy of the EOB directly from your insurance carrier or Medicare. Once your credit card payment has been processed, you will receive a statement reflecting the payment. Credit card information will be held securely, with a process similar to that of a car rental or hotel stay. For additional information, please contact our Billing Department.

## Return Check Fee

There is a $25.00 banking fee for all returned checks. This sum will offset the fees incurred by Matthew J. Reschly, M.D., PC by our banking institution. If your check is returned from the bank, we may NOT ACCEPT an additional check as payment on your account. Future payments must be made with cash, money order or credit card.

## Collections

Matthew J. Reschly, M.D., PC will send you a statement after your insurance carrier(s) has been billed and the charges have been considered. We will charge interest of 1.5% (18% annually) on all outstanding balances after thirty (30) days. If payment has not been received after 120 days, your account may be forwarded to outside collections.

## Missed Appointments

There is a $75.00 missed appointment fee if you cancel or reschedule an appointment with less than 24-hour advance notice, or if you fail to arrive for your appointment. Please do not rely on our automated appointment reminder service as your only reminder to keep your scheduled appointment, as we cannot guarantee this service or that the phone number provided is accurate or functional for this purpose.

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# Consent for Treating a Minor

If patient is a minor (under the age of 18), the parent or legal guardian must read, complete and sign the following:

This form is required for evaluation, treatment and billing for medical goods and services provided to a minor.

I consent to Matthew J. Reschly, M.D., PC conducting examinations/procedures as medically necessary and administer treatment and medications as deemed necessary or advisable to the minor child noted below.

I am an adult who is the:

**Parent:** _____ Mother _____
Printed Name of Parent/Guardian

_____ Father

**Legal Guardian:** _____ Guardian _____
Contact Telephone Number

In my absence, I consent to Matthew J. Reschly, M.D., PC conducting examinations/procedures as are medically required and administer treatment and medications as deemed necessary or advisable to the minor child as noted below.

I would: ____ Like ____ Not Like

to be consulted prior to minor procedures such as mole removal, acne treatment and wart treatment.

Parent/Guardian Signature: _____ Date: _____

Minor Child/Patient's Printed Name: _____ Age: _____

Witness /Signature: _____ Date: _____

Witness Printed Name: _____