Joyce Lender, M.D., Inc.
Joyce A. Lender, M.D.
Dermatology
1268 E. Broad Street Ste 1
Elyria, Ohio 44035
Phone: 440.284.1400 Fax: 440.366.1888

Patient Information Sheet

Patient Name:_____ Date:_____

Social Security Number:_____ DOB:_____ Age:_____

Sex: ☐ Male ☐ Female Status: ☐ Single ☐ Married ☐ Widowed

Address:_____ City:_____

State:_____ Zip:_____

Home Phone:_____ Work Phone:_____ Cell Phone:_____

Primary Care Physician:_____ Referring Physician:_____

Employer:_____Occupation: _____Phone:_____

Emergency Contact Name:_____Number:_____Relationship:_____

Primary Insurance

Insurance Company Name& Address_____

Policy #:_____ Group #:_____

Policy Holder's Name: _____ Sex: ☐ Male ☐ Female

Policy Holder's Social Security #:_____ DOB:_____

Employer:_____ Phone:_____

Secondary Insurance

Insurance Company Name & Address_____

Policy #:_____Group #_____

Policy Holder's Name:_____ Sex: ☐ Male ☐ Female

Policy Holder's Social Security #_____ DOB:_____

Employer:_____ Phone:_____

Preferred Contact Information

Email: _____

Home Phone #:_____

Mobile Phone #:_____

**** Outstanding balances have to be paid prior to medication refills and/or future appointments.** A 22% SURCHARGE WILL BE ADDED TO OUTSTANDING BALANCES SUBMITTED TO COLLECTIONS.**

No Show Policy

You will be charged $25.00 should you fail to keep your scheduled appointment. Payment for cosmetic services are due at the time of service. I understand that there will be a $10 surcharge (IE, additional charge) for each and every time a copay is not paid at the time of service. You will be responsible to pay your deductible per your insurance company.

Signature:_____Date:_____

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Patient Name:

AUTHORIZATION TO TREAT

I give consent for myself/or dependent and authorize Joyce A. Lender, M.D and/or employees & nurses to administer such medical care as they deem appropriate. I understand that:

A) Absent emergency or extraordinary circumstances, no substantial procedures are performed unless there is discussion of the treatment with the physician or other health professional.
B) Each patient or appropriate patient representative has a right to refuse consent for treatment.

Signature of Patient or Responsible Party _____ Date _____

FOR PATIENTS WITH INSURANCE:

I understand that I am responsible for the terms and conditions of my individual insurance plan. Due to the vast number of different insurance policies that (Joyce A. Lender, M.D.) accepts, personnel are not responsible for informing me which tests and or procedures are covered by my insurance company (i.e. allergy testing, lab work, removals, destructions etc.), or where these services can be performed. Joyce A. Lender, M.D. is also not responsible for obtaining authorized referrals from my insurance company if required to be seen in her practice.

I authorize Joyce A. Lender, M.D. to submit any and all health care information to my health care insurer and to take all activities necessary to have my insurance carrier reimburse Joyce A. Lender, M.D. for medical services rendered under this consent. I understand that while I have health care insurance, I remain primarily liable for the payment of all medical services rendered by Joyce A. Lender, M.D. which are not covered by my insurance under this consent.

Signature of Patient or Responsible Party _____ Date _____

FOR PATIENTS WITH NO INSURANCE (SELF-PAY):

I have no health care insurance and I understand that I am personally responsible for any medical services rendered by Joyce A. Lender, M.D. under this consent.

Signature of Patient or Responsible Party _____ Date _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

☐ I have received the Notice of Privacy Practices from Joyce A. Lender, M.D.

Signature of Patient or Responsible Party _____ Date _____

In lieu of patient signature, I, _____, a staff member of Joyce A. Lender, M.D. state that this patient has been given our current Notice of Privacy Practices.

Signature of Staff Member _____ Date _____

FINANCIAL/BILLING INFORMATION

Billing Company: Modernizing Medicine Patient Support 1-866-410-2026
Outstanding balances have to paid prior to medication refills and/or future appointments. A 22% surcharge will be added to outstanding balances submitted to collections.

You will be charged $25.00 should you fail to keep your scheduled appointment.
There will be a $10 surcharge for each and every time a co-pay is not paid at the time of service.

Joyce Lender MD Inc.

Financial Policy

Effective Jan 1, 2020

Patient Name:_____

Thank you for choosing Joyce Lender MD Inc. as your health care provider. **Please carefully read and initial by each statement and sign below.** This policy has been put in place to ensure that financial payments due are recovered to allow us to continue to provide quality medical care for our patients. It is important that we work together to assure that payment for services is as simple and straightforward as possible. Our practice manager or billing company will be glad to discuss these policies with you.

1. _____ I understand that if I do not have my insurance card, referral, and / or co-payments, that my appointment may be rescheduled until such time that I can provide the required documents or payments.

2. _____ I understand that Joyce Lender MD Inc. will collect all copayments at the time of visit and any procedure deductibles and coinsurance up to an amount equal to payment in full for the planned procedure code. Payment in full and expected coinsurance payment responsibility are determined by the anticipated billing code(s), details of your insurance policy, and agreement between your insurance company and Joyce Lender MD Inc. Any overpayment to your account will be refunded to you at your request after payment and/or remittance has been received from your insurance company.

3. _____ I understand that a $50 payment will be required at the time of service should I have high deductible insurance and my deductible has not been met.

4. _____ I understand that if I am unable to make a scheduled appointment I need to contact Joyce Lender MD Inc. at least 24 hours before my scheduled appointment time. Due to a high demand for appointments, missed appointments prevent us from scheduling appropriately and keep others in need of urgent care from being seen. A $25 FEE WILL BE ASSESSED FOR ALL MISSED APPOINTMENTS & $50 FOR MISSED PROCEDURES NOT CANCELED WITH AT LEAST 24-HOUR ADVANCED NOTICE.

5. _____ I understand that if my account is not paid in full within 90 days of a statement date, a 28% collection agency processing fee will be added to the outstanding balance and will be turned over to collections for further processing. No additional appointments will be made for delinquent accounts until they are brought current.

6. _____ Joyce Lender MD Inc. will allow 60 days from the date of filing for my insurance company to process or pay a claim. State law allows insurance companies operating in the state no more than 60 days to process claims. It is my responsibility to provide my insurance company with requested information needed to process a claim for services. It is also my responsibility to notify Joyce Lender MD Inc. if there is any change in my insurance coverage, residence, or phone number. ULTIMATELY, IT IS UP TO ME TO KNOW MY INSURANCE BENEFITS.

7. _____ Outstanding balances have to paid prior to medication refills and/or future appointments.

I have read and agree to all the provisions of the above financial policy. I understand that I am ultimately responsible for all professional fees incurred for professional services performed by the attending physician.

Signature of Responsible Party:_____ **Date:**_____

ASSIGNMENT OF BENEFITS

We require insured patients to complete assignment of benefits authorizing insurance to remit payment to physician's office.

I hereby assign all medical and /or surgical benefits to include major medical benefits to which I am entitled, private insurance, and any other health plans to: Joyce Lender MD Inc. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges where or not paid by said insurance. I hereby authorize said assignee to release all medical information necessary to secure the payment.

Signature of Responsible Party:_____ **Date:**_____

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PATIENT COMMUNICATION FORM

Family and Friends. It is the office policy of **Joyce Lender, M.D., Dermatology** not to release confidential medical information regarding your treatment to family members or friends, except for (i) parent/legal guardian, (ii) other persons authorized by the patient, (iii) as we may reasonably infer from the circumstances (for example, if you bring a family member or friend into the exam room, we will assume, unless you object, that that person is entitled to receive information regarding your treatment), (iv) in emergency situations, or (v) other as otherwise permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

If you anticipate that you will need or want your medical information to be provided to family members, friends, or caretakers/babysitters, please indicate that below, so that we may best serve you. If you do not want any of your medical information provided to a family member, please put a check mark on the line next to the "no" response. By signing below, you authorize the following people to receive information regarding your treatment or care. If any changes need to be made by adding or deleting authorized persons, you must do so in writing.

Spouse: _____ _____ yes _____ no

Parent: _____ _____ yes _____ no

Other: _____ _____ yes _____ no

Alternative Communications: You are also entitled to specify alternative, reasonable means of communication, if you do not wish to be contacted by us in a certain way.

However, this office for Joyce Lender, M.D., Dermatology, NEVER communicates through emails or texts with regards to patient information as an added safeguard to the patient. We use our phones to communicate with patients and we fax information directly to referring doctor's offices, hospitals, labs, and pharmacies only.
****If a breach occurs to a patient's protected information (PHI), patients will be notified directly in writing from this office****

I hereby request the following means of contact only: _____
I agree to a phone call or email confirmation: _____

PRINTED NAME: _____

Patient/Parent/Guardian signature: _____ DATE: _____