Warner & Van Meter
DERMATOLOGY

Larry J. Warner, MD • Charles J. Van Meter, MD • Jonathan R. Van Meter, MD • Kirk M. Volker, MD

Insurance Form

Patient Name: _____ Date _____
Last First Middle

Social Security Number _____ Do you have Medical Insurance? ☐ No ☐ Yes:

Primary Insurance Carrier	Secondary Insurance Carrier
Insured Name & Date of Birth	Insured Name & Date of Birth
Relationship	Relationship
Member Identification Number	Member Identification Number
Group Number	Group Number

PLEASE NOTE: All charges or co-payments are due at the time of service, when applicable. **Please present your insurance card(s) and driver's license to the office staff with this completed form.** We will copy them for our records and return them to you immediately. We reserve the right to add reasonable collection fees on any account over 60 days past due.

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with (Name of Insurance Company) _____

And assign directly to Warner & Van Meter M.D, P.A. all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured or Guardian or POA Date

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Warner & Van Meter, M.D., P.A. for any services furnished me by their physicians. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the Medicare carrier.

_____ _____
Beneficiary Signature Date

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Office Policy Information Sheet

OUR PRACTICE FINANCIAL POLICY

We are dedicated to providing you with the best possible care and service, and regard your understanding of our financial policies as an essential element of your care and treatment. To assist you, we have the following financial policy. If you have any questions, please feel free to discuss them with our staff.

YOUR INSURANCE & PAYMENT

- We will be happy to bill your insurance carrier for you; however due to contractual obligation as Policy Holder and our contractual obligation as Provider, copay's are due at the time of service. No exception will be made to this policy.
- In some circumstances we will request a Deductible prepayment for services.
- In the event your health plan determines a service to be "not covered," you will be responsible for the complete charge.
- Payment is due upon receipt of statement.

MINOR PATIENTS

For all services rendered to minor patients, the adult accompanying the patient is responsible for payment.

RETURNED CHECKS

It is our office policy to charge a fee of $25.00 for any returned checks.

NO SHOW & CANCELLATION POLICY

We kindly ask for a 48 hour notice if you cannot make your appointment. We may charge a fee of $50 to those who repeatedly do so without notice. This fee will be collected in advance at the time of scheduling.

COMPLETION OF FORMS

We will be happy to complete insurance/disability forms for our patients; however our fee for this service is $10.00 per form. This fee is waived for patients who have had surgery.

DELINQUENT ACCOUNTS

We reserve the right to add reasonable collection fees to any account over 60 days past due.

I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.

_____ _____

Signature of Patient or Responsible Party if a Minor Date

_____

Please Print the Name of the Patient

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Registration Form

Patient Name_____
Last First Middle

Patient Address_____
Street/Apt# City State/Zip Code

Home Phone _____ Email address: _____
Work Phone _____
Cell Phone_____ How do you prefer to be contacted? _____

Sex ☐ M ☐ F Date of Birth_____ Social Security _____

Occupation_____ How did you hear of our practice? _____

Please list family members or other persons, whom we may inform about your general medical condition and your diagnosis (including treatment, payment and health care operations)

Name Relationship Date of Birth Phone #

_____

_____

_____

Referring Physician_____

Primary Care Physician &
Address/Location:_____

Emergency Contact
Person_____
Name Phone Number

I authorize Warner & Van Meter Dermatology to leave messages as it pertains to my health or appointments on:

☐ My home answering machine ☐ My work answering machine ☐ My cell phone
☐ With my family members or others residing in my household

_____ _____
Signature Date

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Patient: _____ Date: _____

Height: _____ Weight: _____ Date of Birth: _____

FEMALE Patients: ☐ Irregular Periods ☐ On birth control ☐ Pregnant ☐ Nursing

Reason for visit: _____

Duration of problem: _____ Prior treatment of the problem: _____

_____

Has anyone in your family suffered from the same problem? _____

Have you ever had a bad reaction to dental anesthesia (Novocain) ☐ YES ☐ NO

Do you have now, or have you ever had diseases or conditions of: (Check all that apply)

Describe

☐ Lungs: _____

☐ Cardiovascular: _____

☐ Other Systemic: _____

☐ Artificial Joint ☐ Blood Clots ☐ Pacemaker ☐ Fainting ☐ Convulsions, Epilepsy or Seizures

☐ High Cholesterol ☐ Lupus ☐ Diabetes ☐ Depression

Have you ever had any of the following reactions when taking antibiotics? (Check all that apply)

☐ Nausea, vomiting, diarrhea ☐ Yeast infection

Check any of the following that apply to you:

☐ HIV positive, AIDS ☐ Tobacco user, frequency: _____

☐ History of blistering sunburns ☐ History of tanning bed use

Check any of the following that apply to you and your skin:

☐ Have/had skin cancer, specifically:
- ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Malignant Melanoma

☐ Family member has/had skin cancer, specifically:
- ☐ Basal Cell Carcinoma ☐ Squamous Cell Carcinoma ☐ Malignant Melanoma

☐ Have/had problems with healing

☐ Develop keloids (scars) after surgery

☐ Mouth/throat sores

☐ Bleed easily

☐ Develop skin rash reactions, specifically to:
- ☐ Medications ☐ Food ☐ Environment ☐ Bandages ☐ Topical Neosporin

What is your occupation? _____ Hobbies? _____

_____ _____

Patient Signature Physician Initials

63 Thomas Johnson Drive • Suite A • Frederick, MD 21702 (301) 663-0400 www.warnervanmeterderm.com

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Warner & Van Meter, M.D., P.A. may use the disclosed protected health Information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Warner & Van Meter, M.D., P.A. Notice of Privacy Practice for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. Warner & Van Meter, M.D., P.A. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practice may be obtained by contacting Warner & Van Meter, M.D., P.A. at 301-663-0400.

With my consent, Warner & Van Meter, M.D., P.A. may call my home or other designated location and leave a message or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. With my consent, Warner & Van Meter, M.D., P.A. may mail to my home or other designated location any items that assist the practice to carrying out TPO, such as appointment reminder cards and patient statements.

With my consent, Warner & Van Meter, M.D., P.A. may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Warner & Van Meter, M.D., P.A. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

With my consent, Warner & Van Meter, M.D., P.A. may contact me in writing or electronically regarding surveys, specials or other marketing events.

If paying out of pocket for services, I may request for Warner & Van Meter, M.D., P.A. not to disclose my PHI to my health plan. I choose to restrict disclosure to my health plan if paying out of pocket for services:
☐ Yes ☐ No

By signing this form, I am consenting to Warner & Van Meter, M.D., P.A. use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Warner & Van Meter, M.D., P.A. may decline to provide treatment to me.

_____ _____

Signature of Patient or Legal Guardian Date

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ATTENTION: The Northbound US 15 left-turn cross over to Hayward is permanently closed. **Proceed to exit 18,** making a left on Christopher's Crossing to access Thomas Johnson Drive.

70 East (Hagerstown area)

❶ Exit 52B US-15 N/US 340 E towards Gettysburg
❷ Merge onto 340 East
❸ Exit 12B merge onto US-15 N
❹ Exit 16 Motter Avenue
❺ Keep right and cross over bridge
❻ At the 3rd light make a right onto Thomas Johnson Drive
❼ Approximately 1 mile on left arrive at 63-65 Thomas Johnson Drive
❽ Enter building 63, suite A

340 North (Charles Town WV area)

❶ Continue 340 East
❷ Exit 12B merge onto US-15 N towards Gettysburg
❸ Exit 16, Motter Avenue
❹ Keep right and cross over bridge
❺ At the 3rd light, make a right onto Thomas Johnson Drive
❻ Approximately 1 mile on left arrive at 63-65 Thomas Johnson Drive
❼ Enter building 63, suite A

270 North (Washington) and 70 North (Baltimore)

❶ Follow US- 15 N towards Gettysburg
❷ Exit 16 Motter Ave
❸ Keep right and cross bridge
❹ At the 3rd light, make a right onto Thomas Johnson Drive
❺ Approximately 1 mile on left arrive at 63-65 Thomas Johnson Drive
❻ Enter building 63, suite A

15 South (Gettysburg area)

❶ Take exit 18
❷ At first light, make a right onto Christopher's Crossing
❸ At 2nd light make a left, going South on Thomas Johnson Drive
❹ Proceed South on Thomas Johnson at 4-way stop to 63-65 Thomas Johnson Drive
❺ Enter building 63, suite A

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Please list ALL known prescriptions, over- the-counter, herbals, and vitamin/mineral/dietary (nutritional) supplements or attach a list. **Patient Name/DOB:**

Medication Name (Reported by Patient)	**Dosage**	**Frequency**	**Route** (Oral, Sub-Q)

Are you ALLERGIC to any drugs or materials? ❒ YES ❒ NO If yes, list below:

Allergy or Sensitivity (Reported by patient)	**Reaction**

LATEX ALLERGY ❒ YES ❒ NO **Patient Initials** _____ **Staff Initials** _____

_____ (Physicians Initials)

_____ (Patient signature)

_____ (Date)

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My signature confirms that I have reviewed the original list of prescriptions/medications. I have marked and dated all changes, and to the best of my knowledge, is up-to-date and inclusive.

Date	Patient/Guardian Signature	Physicians Initials

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