WESTERVILLE
dermatology

614.895.0400

Kevin Karikomi, D.O. **Rosina Lin, M.D.** **Joshua Grosshandler, M.D.**
235 West Schrock Rd. Westerville, OH 43081

Thank you for choosing us for your care. We have enclosed the initial paperwork for a new or previosu patient. To help keep your appointment as timely as possible, please fill these out.
Please arrive 15 minutes ahead of your appointment and allow approximately an hour for your entire visit. You may also want to check the following information:

Bring your insurance card and license with you as these will need to be scanned.

Call your insurance or check your provider book to make sure that the provider you are scheduled with is in you insurance plan. An HMO insurance plan does require a referral, you will need to contact your primary care physician with this request and give then the date of your appointment

All co-pays and deductibles required by your insurance, or any cosmetic service are due at the time of the visit. We do not accept checks for cosmetic services.

If the patient is under 18 years of age, a parent or legal guardian must be present.

Directions: Our address is 235 W. Schrock Rd, Westerville, OH 43081

Our office is located on the south side of Schrock Rd, our driveway is directly off of Schrock Rd and is the only driveway between the lights for brooksedge and Park Meadow.

From the West: Take 270 East to Cleveland Ave. N. Go to the second traffice light and turn right onto Schrock Rd. Follow until you go through the 3rd traffic light for Park Meadow. Our driveway is the next right. Our building is immediately on the near right.

From the East: Take 270 West to State street exit (Rt 3). Turn right as you come off the ramp. Go to the 3rd traffic light and make a left onto Schrock Rd. Once on Schrock Rd., go through the 2nd traffic light for Charring Cross. After going through this light, you will want to be in the left lane as you will need to get in to the turn lane. You will be making the next left into our driveway. Our building in immediately on the near right

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PATIENT INFORMATION

as of ________________mm/dd/yy

(Please Print Legibly & Fill In or Correct All Fields)

Patient's Name ____________________
First Middle Last

Address ____________________
Street & Apt # City State Zip

Home Phone ____________ Cell Phone ____________ Other Phone ____________

Confirmation by Text Message: No Yes
If yes, text will be sent to mobile number provided.

E-mail ____________________

Would you like to receive our monthly cosmetic newsletter? No Yes

Birthdate ____________ SS# ____________ Sex Female _ Male

Marital Status Single Married to: ____________ Other: ____________

Referred by: ____________ **Primary Care Provider:** ____________

Patient's Employer ____________ Occupation ____________

Work Phone ____________ Ext: ______ Is it okay to call you at work? Yes No

Address ____________________
Street & Suite # City State Zip

Primary Health Insurance Company ____________________

Mem ID# ____________ Group# ____________ Relation to Insured: ____________

Referral Required? No Yes

Insured: Name ____________ DOB ____________ Employer ____________

Secondary Health Insurance Company ____________________

Mem ID # ____________ Group # ____________

Referral Required? No Yes

Insured: Name ____________ DOB ____________ Employer ____________

I understand that office visit charges are payable on the day service is rendered. I authorize *Westerville Dermatology, INC.* and associates to bill my insurance company. Regardless of insurance coverage, I am responsible for all bills being paid in a timely manner. I understand that this contract is between Westerville Dermatology, Inc. (WD) and myself.
I acknowledge and understand that WD reserves the right to charge a fee for appointments cancelled or rescheduled without a 24 hour advanced notice.
Initial ________

Signature ____________________ **Date** ____________

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PATIENT ACKNOWLEDGMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

Our Notice of Privacy Practices (Notice) provides information about how we may use and disclose protected health information about you. You have the right to receive and review our Notice before signing this acknowledgment. As provided in our Notice, the terms of our Notice may change. If we change our Notice, you may obtain a revised copy.

By signing this form, you acknowledge that you have been informed of our uses and disclosures of protected health information about you for all of the purposes set out in our Notice.

By signing this form, you also acknowledge that a copy of our Notice has been provided to you, that you understand the contents of our Notice and how it applies to you, and that all of your questions regarding the contents of our Notice have been answered.

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on behalf to Westerville Dermatology, Inc. for any services furnished tome by that physician. I authorize any holder of medical information about me to release to **Westerville Dermatology,** 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 insurance 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.

* **MINOR CONSENT:** If the patient is under 18 yrs. old, they must be accompanied by a legal guardian for the initial visit/initial accutane or any surgical appointment needed, **no exceptions.** The consent indicated below can be used for future visits and would be valid until the patient is 18 y.o.

I authorize Westerville Dermatology to perform follow up office visits, treatments or prescriptions that they deem necessary at the time of the appointment without a guardian present. 0 YES 0 NO

Contact Phone Numbers:

I understand that any of the phone numbers given on my information sheet can be used to reach me or leave a message. With this consent results of surgery and/or tests can be given to family members listed:

* Name: ______________________________ Relationship: ________________Phone: ______________________________

Name: ______________________________ Relationship: ________________Phone:______________________________

By:____

Print Patient's Name

By:____

Patient or Patient Representative's Signature/ Date

Financial Policy

Please read and sign. Let us know if you have any questions. Thank you

Cosmetic

- Payment is due in full at the time of service.
- We accept Cash/Check/Visa/MasterCard/American Express/CareCredit.
- Under no circumstances will cosmetic procedures be billed to your insurance plan.
- We DO NOT accept checks for cosmetic services.

Appointment Policy

- If you need to reschedule or cancel an appointment, we require notification 24 hours prior to your appointment.
- If less than 24 hour notice or fail to no show, you will be subject to a last minute/ or no show cancellation fee. (Cosmetic no show/last minute cancellation fee $75)
- This policy applies to all providers.

Laboratory

- Path Dermpath Labs/DLCS Labs will bill you and/or your insurance plan directly for laboratory services rendered such as cultures, biopsy specimens, etc.

Medical/Insurance

- We are contractually obligated to collect co-payments, co-insurance, and deductibles that are required by your plan at time of service.
- As a courtesy, we will submit insurance claims directly to the PPO/Medicare insurance carrier.
- It is your responsibility to be aware of any restrictions, limitations, and requirements outlined by your insurance policy. As well, as updating our office when your insurance has changed.

Your signature below:

Authorizes assignment of benefits to be made to Westerville Dermatology, Inc
Accept full financial responsibility for all expenses incurred and agree that you are responsible for any portions not paid by your insurance
Authorize the release of any information required to obtain payment of medical benefits.
You have read and understand this policy in its entirety and that your questions have been adequately answered.

______________________________	______________________________	________________
Print	Signature	Date

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NOTICE OF PRIVACY PRACTICES

All Patients will be asked to sign acknowledging the receipt of this Notice of Privacy Practices from us. This notice describes how your medical information may be used and disclosed by us and how you may gain access to your medical information. Please review the following carefully so that you may understand your rights as a patient under the federal Health Insurance Portability and Accountability Act (HIPAA).

Our Responsibilities to You Under HIPAA:

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you provide written consent. Once consented, you may still change your mind at any time. Should you wish to do so you must inform us with written consent.
- For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Your Rights as a Patient Under HIPAA – You May:

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have on file. Ask us how to do this.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this.
- We may say "no" to your request, but we will inform you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address.
- We will say "yes" to all reasonable requests.

Ask us to limit what we use or share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information

- You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you requested we make) We will provide a yearly disclosure for free but will charge a reasonable, cost-based fee if you ask for a secondary copy within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.
- We will make sure the person has this authority and can act for you before we take any action.

File a complaint if you feel your rights are violated

- You can file a complaint if you feel we have violated your rights by contacting our office.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.**
- We will not retaliate against you for filing a complaint.

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