Elmhurst Dermatology

103 N. Haven Rd., Ste. 7, Elmhurst, IL 60126

Dear New Patient,

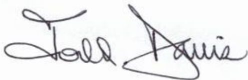
Welcome! Thank you for choosing Elmhurst Dermatology. We provide expert skin care with the utmost attention, respect and effort in a caring and professional environment. We value our patients and will strive to ensure you receive the highest quality of medical services. The following information is provided to help you with planning your office visits. Please feel free to call for any questions or for additional information.

Clinic Office Hours are	Monday	12pm-8pm	Dr. Davis
	Tuesday	7am-3pm	Dr. Davis
		8am-4pm	Dr. Eng
	Wednesday	8am-4pm	Dr. Davis
	Thursday	8am-4pm	Dr. Davis
	Friday	7am-3pm	Dr. Davis
	Saturday	8am-12pm	Dr. Davis

- You will receive a reminder call 2-3 days prior to your appointment. We request a 24 hour notice to cancel or reschedule your appointment.
- Bring your completed Patient Packet, picture ID, insurance card, and either your social security number or credit card for billing purposes to your appointment. If you have access to a fax machine, please fax them to 630-832-5199.
- If your insurance requires a referral, please present it at the time of your appointment.
- If you have an urgent issue and need to contact the doctor immediately call the office for his/her phone number at any time.
- Parking, including handicap parking is available in the parking lots in front and on the side of the building.
- There is an elevator at the main entrance. It is small, but it can accommodate a wheelchair.
- We accept cash, checks and Visa, MasterCard and Discover.
- Co-pays and any balance on your account are due and payable at the time of the appointment.
- As a courtesy we bill your insurance; however, the balance due is your responsibility. Bills are payable within 30 days of receipt.

For more information about Elmhurst Dermatology visit our website at www.elmhurstdermatology.com. Thank you for choosing Elmhurst Dermatology. We appreciate the opportunity to serve your healthcare needs and wish you continuing good health.

Sincerely,



Todd T. Davis, M.D.

Elmhurst Dermatology

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Patient Demographics

Patient Name:				
Referred By:	☐ **Physician:**			☐ **Patient:**
	☐ **Insurance Website**	☐ **Yellow Pages**	☐ **Newspaper**	☐ **Other:**

Mailing Address:	**Apt:**	**City:**	**Zip:**

Home Phone:	**Cell Phone:**	**Work Phone:**
Select Primary Phone: ☐ **Home** ☐ **Cell**	**Email Address:**	
Social Security Number:	**Date of Birth:**	**Marital Status:**

Primary Insurance:		**Insured Name:**	
If Insured is other than self:	**DOB:**	**SSN:**	**Relationship to Pt:**

Secondary Insurance:		**Insured Name:**	
If Insured is other than self:	**DOB:**	**SSN:**	**Relationship to Pt:**

Emergency Contact Name:	**Relationship:**
Home Phone:	**Work Phone:**

Pharmacy Name:	**Intersection and Town:**

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this page you acknowledge that you received a copy of our Notice of Privacy Practices.

____ _________________

Signature of Patient or Authorized Representative Date

Disclosure of Information

In the event that Elmhurst Dermatology is unable to contact me, I give full permission to Elmhurst Dermatology to contact the individuals that I have designated below for the purpose of disclosing information pertinent to my case. This would include, but not be limited to information regarding pathology reports, laboratory tests, scheduling, and business information. By my signature below, I agree to hold harmless and waive any liability against Elmhurst Dermatology for the disclosure of information to the individual(s) designated below.

Name	**Date of Birth**	**Phone Number**
____________________	____________	______________
____________________	____________	______________

____ _________________

Signature of Patient or Authorized Representative **Date**

OR

I do **not** agree to allow Elmhurst Dermatology to disclose any medical information regarding myself to any individual other than myself.

____ _________________

Signature of Patient or Authorized Representative Date

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Medical History

Patient Name:			**Date:**
Reason for today's visit:			**Referring Doctor:**

Medications: Names only. Include prescriptions, over-the-counter drugs, vitamins, herbals, supplements, oral contraceptives, etc.

1.	2.	3.

Are you taking more medications than the space provided? (If yes, bring a list to your appointment.)

Past Medical History: ☐ None (I have no significant medical problems)

☐ High Blood Pressure	☐ Diabetes	☐High Cholesterol/Lipids	☐Asthma
☐ Seasonal Allergies	☐ Environmental Allergies		

List Others:

Past Dermatologic History: ☐ None (I have no history of significant skin diseases) If yes, mark below

☐ Melanoma	☐ Squamous Cell Carcinoma	☐ Basal Cell Carcinoma		☐ Skin Cancer (unknown type)
☐ Actinic Keratosis	☐ Atypical/Dysplastic Moles	☐ Psoriasis	☐ Keloid/Scars	☐ Eczema/Atopic Dermatitis

List Others:

Allergies: Are you allergic to any medication? ☐ No If yes, please describe below
(if more than space allows bring a list to your appointment)

Name of Medication:	Reaction:
Name of Medication:	Reaction:
Name of Medication:	Reaction:

Past Surgical History: ☐ None (I have had no significant surgeries) If yes, list with dates below

Family History: If known, identify conditions that have occurred in your blood relatives

☐ None (no significant history of disease in the family or history unknown)

☐ Melanoma	☐ Squamous Cell Carcinoma	☐ Basal Cell Carcinoma	☐ Skin Cancer (unknown type)
☐ Psoriasis	☐ Eczema	☐ Hay Fever	☐ Asthma
☐ High Blood Pressure	☐ High Cholesterol/Lipids	☐ Diabetes	☐ Other Cancer (list below)

List Others:

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Medical History

Social History:	Occupation:	Hobbies:
Do you Drink Alcohol? ☐ No ☐ Yes	Do you smoke? ☐ No ☐ Yes	Do you use drugs (including marijuana)? ☐ No ☐ Yes
Regular Use of Sunscreen? ☐ No ☐ Yes	Use tanning beds? ☐ No ☐ Yes	History of blistering sunburns? ☐ No ☐ Yes
Significant sun exposure at work? ☐ No ☐ Yes		Travel outside the USA in past 6 months? ☐ No ☐ Yes
Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐Widowed		Children: ☐ None ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 or more

General Health: ☐ None (I am not experiencing any of these symptoms)					
☐ Unexplained weight gain or loss	☐ Fever or Chills	☐ Loss of appetite	☐ Weakness	☐ Night Sweats	☐ Breast Feeding (if applicable)

About the main reason for today's visit:				
☐ Rash	☐ Dry/Sensitive Skin	☐ Itching	☐ Suspicious Lesions	☐ Suspicious Moles
☐ Acne	☐ Hives		☐ Excessive Sweating	☐ Excessive Hair
Other:				
General description of problem:				
How long has the problem been present? ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ Unknown Duration				
☐ Days	☐ Weeks	☐ Months	☐ Years	
Location of the problem/spread:				

Onset of the problem:	☐ Gradual	☐ Intermittent	☐ Insidious	☐Sudden	
Current Severity:	☐ Mild	☐ Mild to Moderate	☐ Moderate	☐ Moderate to Severe	☐ Severe
Nature/Symptoms of problem:	☐ Itchy	☐ Tender	☐ Painful	☐ Asymptomatic	
Things that aggravate/worsen the condition:	☐ Nothing	☐ Sun	☐ Heat	☐ Exercise	
Other:					
Treatments that improved the condition:	☐ Over the counter treatments	☐ Prescriptions	☐ Nothing		
Other:					
Any associated symptoms (things that seem related to the problem)? ☐ No, none					
Other:					

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Financial Policy

Thank you for selecting Elmhurst Dermatology, P.C. for your dermatologic care. In order to prevent any misunderstanding concerning the responsibility regarding payment for medical/surgical care and/or any laboratory fees, the following information is provided:

HMO/PPO/Other Insurance Coverage: If you have insurance through a company we have contracted with, we will require a copy of your insurance card and a driver's license. **All co-payments are due prior to seeing the physician. All co-insurance and deductibles are due at the time of service.** If your insurance carrier requires a referral from your primary care physician, this must be present at the time of service. Failure to provider all necessary information may require you to pay in full on the date of the visit. It is your responsibility to keep track of the referral expiration dates and the number of visits given by your primary care physician. You will be responsible for any services by your insurance carrier as not medically necessary and/or not covered.

Medicare: Our physicians are participating Medicare providers and accept Medicare assignment, which is the ALLOWABLE charge approved by Medicare. Medicare will pay 80% of the allowable charges after you pay for your annual deductible. You are responsible for any amounts applied to your deductible and the 20% co-insurance. If you have a secondary insurance, as a courtesy we will submit to that particular carrier any remaining balance. You will also be responsible for any services denied by your insurance carrier as not medically necessary and/or not covered.

Laboratory: Depending on your insurance carrier's policy, you may be required to pay a separate co-payment for any specimen taken during your visit.

Self-Pay Patients (Will Pay): For patients with no insurance, payment in full is due at the time of service/visit.

Cosmetic Patients: Deposits are required prior to the date of the procedure. The balance of the charge is required prior to the procedure being performed.

Payments: Payments can be made by cash, check, VISA, MasterCard, or Discover.

Appointment Cancellation Fee: If you are unable to keep your appointment, please call at least 24 hours in advance and speak with a front desk representative or leave a message. If you do not give sufficient notice you may be subject to a $35 fee.

Financial Policy:
Financial Information: Either your social security number or credit card on file is required. Subsequent to your visit a claim will be processed thru your insurance. Any remaining balance (resulting from deductible, co-insurance, etc.) is then billed to you or charged to your credit card. Balances under $250 will be a one-time charge per date of service. For balances over $250, monthly increments of $250 will be charged until the balance is paid in full. All patient balances are due and payable within 30 days after insurance explanation of benefits has been received. Unpaid balances will be turned over to a collection agency after 60 days. The patient or patient guarantor, if patient is a minor, is responsible for all collection costs including agency fees, attorney's fees and any costs incurred by Elmhurst Dermatology in collecting for services rendered.

Returned Checks and Collections: A charge of $20 will be made for all returned checks. In the event that any action is brought to collection, I agree to pay the 50% fee for collections cost and/or any reasonable attorney fees.

My signature below indicates my understanding and full responsibility for the balance on my account for any professional services.

Note: Signature obtained at appointment.

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Notice of Privacy Practices

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Our Pledge Regarding Your Health Information

We understand that information about you and your health is personal. We are required by law and committed to maintaining the privacy of this information. Each time we provide services, we create a record of the care and services you receive. We need this record to provide quality care and to comply with certain legal requirements. This notice applies to all of your information and the records of your health care generated by us or received by us from you or others.

Along with safeguarding your personal health information, we must also make available this notice of our legal duties and privacy practices, and we must follow the terms of the notice currently in effect. This notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights of access, amendment, control, and other rights concerning the use and disclosure of your health information. Elmhurst Dermatology is also required to notify you if your health information is breached.

If you are the parent, legal guardian, or personal representative of the patient, the references herein such as "...your personal health information..." shall be understood to refer to that patient.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with us, directly to our Privacy Officer: Stephanie S. Meyers, 103 N. Haven Road, Suite 7 Elmhurst, IL 60126, 630-832-2111. You can also file a complaint with the Secretary of the Department of Health and Human Services at www.hhs.gov or in writing to any regional HHS office. There will be no retaliation for filing a complaint.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we may USE your health information within Elmhurst Dermatology, and DISCLOSE your health information to persons and entities outside of Elmhurst Dermatology. We have not listed every use or disclosure within the categories, but give some examples for understanding.

Common Uses and Disclosures Allowed by Law

Treatment: We may use your health information to provide you treatment and services. We may disclose health information about you to others who are involved in your care.

Payment: We may use and disclose your health information so the treatment and services you receive at Elmhurst Dermatology may be billed to and payment collected from you, an insurance company or a third party. We may also disclose health information to your insurance plan to obtain prior authorization for treatment and procedures.

Health Care Operations: We may use and disclose your health information for health care activities such as: quality assurance; administration; Elmhurst Dermatology financial and business planning and development; and customer service (including investigation of complaints). These uses and disclosures are necessary to operate our health care facility and make sure patients receive quality care.

Business Associates: Some services may be provided to our organization through contracts with business associates, such as: accountants; consultants; quality assurance reviewers; billing and transcription services. We may disclose your health information to our business associates so that they can perform the job we've asked them to do. Business associates are required to sign a contract that states they will appropriately safeguard your information.

Contacting You About Your Health: We may use and disclose health information to contact you, such as a reminder about an appointment or other treatment options at Elmhurst Dermatology.
Fundraising: If we are going to contact you as part of a fundraising effort, you will have a simple way to opt out of these contacts.
Individuals Involved in Your Care: We may disclose health information about you to a friend or family member who is involved in your care, unless you tell us in advance not to do so.

Other Laws: At times there may be federal, state or local laws that require us to use or disclose health information in other ways, or give you additional privacy protections. We will obey those laws.

Special Situations Which Do Not Require Your Authorization

The following disclosures of your health information are permitted by law without any oral or written permission from you:

Public Health Activities: We may disclose health information about you for public health activities, including:
* To prevent or control disease, injury or disability.
* To report births and deaths.
* To report child abuse or neglect.
* To report reactions to medications, problems with products or other adverse events.
* To notify people of recalls of products they may be using.
* To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
* To avert a serious threat to you or others. These disclosures would be made only to someone able to intervene.
* To notify the appropriate government authority if we believe a patient has been the victim of abuse (including child abuse), neglect or domestic violence.
* Immunization records to a school requiring such for entry, provided informal approval is given by a parent, guardian, or the patient if the patient is an adult or emancipated minor.
* To Disaster Relief agencies (such as the Red Cross) for notification as to your location and condition.
* If you are an organ donor, we may release health information to the organizations that handle the process, as necessary to facilitate the donation.

Military and Veterans: If you are a member of the armed forces, we may release health information about you as required by military command authorities.

Worker's Compensation: We may release health information about you for worker's compensation or similar programs if you have a work related injury.

Health Oversight Activities: Elmhurst Dermatology may disclose health information to a health oversight agency for activities authorized by law. These include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may be required to disclose your health information in response to a court order, administrative order, subpoena, discovery request or other lawful process by someone involved in the dispute.

Law Enforcement: We may disclose health information to law enforcement officials for reasons such as:
* In response to a court order, subpoena, warrant, summons or similar process.
* To identify or locate a suspect, fugitive, material witness or missing person.
* About the victim of a crime if, under certain circumstances, we are unable to obtain the person's agreement.
* About a death we believe may be the result of criminal conduct.

* About criminal conduct at our facility.
* In emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Health Records of Deceased Patients: We may disclose health information to a coroner or medical examiner, to identify a deceased person or determine the cause of death. We may also release health information about patients to funeral home directors as necessary to carry out their duties. We may disclose to relatives or close personal friends who were involved with the patient's care prior to death, health information relevant to their involvement. HIPAA privacy protections continue until 50 years after the patient's death.

National Security and Intelligence Activities: We may disclose health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Legal Requirements: We will disclose health information about you without your permission when required to do so by federal, state or local law.

Other Uses and Disclosures Require Your Authorization

Other uses and disclosures of health information not covered by this notice or applicable laws will be made only with your written permission (called "authorization"). If you do give authorization in some instance, you may revoke that authorization in writing at any time. Uses and disclosures of your personal information that require your authorization include marketing functions, and most disclosures that involve sale of health information.

Your Health Information Rights

You have the following rights concerning your health information:

1. **Request a restriction on certain uses and disclosures of your information.** We may agree to your request but are not required by law to do so, with the one following exception...
2. **Restricting disclosures to health plan or insurance for treatment you pay for in full.** If you pay in full at the time of service and request we not disclose the information to your health plan or insurer, we must and will comply.
3. **Obtain a copy of this Notice of Privacy Practices upon request.**
4. **Inspect and/or request a copy of your health record.** You must make the request in writing, and we have 30 days to comply.
5. **Request an amendment to your health record** if you feel the information is incorrect or incomplete. Elmhurst Dermatology may deny your request if, for instance, we believe it is accurate and complete as it stands.
6. **Obtain an accounting of disclosures of your health information.** This will include the times when someone used or disclosed your health information other than the allowed common uses and disclosures, or uses and disclosures that you authorized.
7. **Request communication of your health information by alternative means or locations.** For instance: an address or phone number other than your home.
8. **Revoke a previously agreed upon authorization** except to the extent that action has already been taken.

For more information contact our privacy officer: Stephanie S. Meyers, 103 N. Haven Road, Suite 7 Elmhurst, IL 60126, 630-832-2111.

We reserve the right to change this notice, and to make the revised or changed notice effective for health information we already have about you as well as any information we receive in the future. A copy of the current notice in effect will be available at Elmhurst Dermatology.

Elmhurst Dermatology

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Credit Card on File FAQs

Frequently Asked Questions about our Credit Card Policy:

Why is Elmhurst Dermatology requiring a credit card agreement from patients?
This practice will improve efficiency for everyone, and lower total costs of providing service to our patients. It will also allow us to focus our energies on providing dermatologic care, rather than patient billing.

When will my credit card be charged?
As a courtesy to our patients, we submit claims to their insurance within a few days of providing the patient service. Claims are typically settled by insurance companies within 2 – 8 weeks after service was provided. Once a claim is adjudicated, your card will be charged for your portion.

How will I know how much the charge will be?
Insurance typically sends an Explanation of Benefits (EOB) to both the patient and the provider after claims have been settled that explains the contracted fees agreed between our office and the insurance. The EOB also shows whether any of the agreed upon fee must be paid by patient in the form of co-pay, co-insurance, or deductible. At that time, any patient balance is due in full.

What if I do not agree with the patient portion as specified by my insurance?
As the customer of the insurance company, patients can exercise procedures with their insurance for handling disputes as to whether insurance or patient is responsible for a particular fee. These procedures are typically regulated by state governments.
Our office's position is that the patient is ultimately responsible for the cost of the service provided, up to the amount allowed by an insurance plan that our office accepts. We are not a party to disputes involving what portion of payment is the patient's versus the insurance's. Nonetheless, we will provide our expertise to our patients as a resource to help facilitate understanding of what their insurance company communicates to them about their contract.

What if I still do not agree with the charge applied to my card?
Our office's billing staff will review each patient's situation before applying a charge. In the event of any question or issue, please do not hesitate to contact our billing staff or office manager and we will work to resolve it as quickly as possible.
As a last resort, our patients should rest assured that credit card issuers typically have procedures for a cardholder to dispute a charge applied by any merchant. Credit card companies can typically suspend or reverse charges if they determine it was not appropriate.

What if I don't have a credit card, or do not want to participate? Is this mandatory?
Either your social security number or credit card on file is required. Subsequent to your visit a claim will be processed thru your insurance. Any remaining balance (resulting from deductible, co-insurance, etc.) is thenbilled to you. Obtaining your security number or credit card helps avoid any financial issues

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Credit Card on File

In our efforts to continuously improve our patient service and office efficiency, you will be asked for a credit card number at the time you check in. That information will be held securely until your insurances have paid their portion and notified us how much, if any, is your portion. **Any remaining balance after insurance pays that is less than $250 will be charged to the authorized card. Monthly increments of $250 will be charged for any larger balances until account is paid in full.**

This will be an advantage to you, because you will no longer have to write out and mail us a check. It will be an advantage to us as well, because it will greatly decrease the number of statements that we have to generate and send out. The combination will benefit everybody in helping to keep the cost of health care down.

You can think of this as much like when you check into a hotel or rent a car; you are asked for a credit card which is imprinted and later used to pay your bill.

This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.

If you have any questions about this payment method, do not hesitate to ask.

Sincerely yours,

Elmhurst Dermatology

I authorize Elmhurst Dermatology to charge outstanding patient portion balances for me and my dependents to the following credit card:

Signature ____ Date ___________________

Full name on card (please print) ____

Patient name (if other than cardholder) ____

Bottom portion is shredded after entry into encrypted password-protected file.

☐ Visa ☐ MasterCard ☐ Discover (please select one)

Account number __ __ __ __ / __ __ __ __ / __ __ __ __ / __ __ __ __ Expiration Date __ __ / __ __