

This form should be filled out completely

Patient Name _____ / _____ / _____
First Name Middle initial Last Name

(Circle One) Male Female

***Date of Birth _____ / _____ / _____

Address _____ / _____ / _____
Street Address City State Zip Code

Phone #'s Home () _____ Work () _____ Cell () _____

Have you been known by another name? _____

Insurance Information:

Co-pay amount if known _____

Primary Ins Carrier Name _____

Please present insurance card(s) with this completed form along with picture ID for scanning and identification purposes

Subscriber Name _____ Subscriber Date of Birth _____ / _____ / _____

Subscriber's Contract Number _____ Group Name or Number _____

Subscriber's Employer _____

Subscriber Relationship to Patient (Circle One) Self Spouse Dependent

Secondary Insurance Carrier (if applicable) _____

Subscriber Name _____ Subscriber Date of Birth _____ / _____ / _____

Please present insurance card

Subscriber's Contract Number _____ Group Name or Number _____

Subscriber's Employer _____

Subscriber Relationship to Patient (Circle One) Self Spouse Dependent

Responsible Party Name, Address and phone (if different from patient) _____

Name of person responsible for bill if other than yourself or subscriber, or if address is different.

Name of Local Pharmacy (will use for "e-prescribe") _____

City and Cross Streets of Pharmacy _____

Emergency Contact Name _____ Phone () _____

Primary Care Physician _____ Phone () _____ Address _____

Referred by _____ Phone () _____

X _____ / _____
Signature of Patient (or patient parent/guardian if the patient is under 18) *Date of signature*

Associated Dermatologists of W. Bloomfield & Commerce
Ronald D. Kerwin, M.D., Michael A. Dorman, M.D., Suzanne R. Merkle, M.D., Leonard M. Cetner, M.D.
Stacy Madany, PA-C, Maria Ammori PA-C
Commerce Center for Skin Surgery
Aaron S. Cetner, M.D., F.A.A.D.

Dear Patient:

We appreciate your confidence in choosing the Practitioners at Associated Dermatologists of W. Bloomfield & Commerce. Please, take a moment to review our **financial policy** below:

About Co Payments:

If you are an enrollee of a Health plan (HMO, PPO, POS, MC etc), you are required to pay your co-payment: your responsibility for any Office Visit, each time an office visit is billed. This must be paid on the date of service. If you are not prepared to pay on the date of service, you must reschedule.

About Annual Deductibles:

In addition to co-pays for office visits, most health care plans have annual deductibles. If you have not met that deductible, you will be billed for your portion after your insurance company rejects the claim. You should receive an "Explanation of Benefits" that will tell you what your financial responsibility is for any visits or procedures done in this office. If you have Master Medical, you are responsible for payment since you will receive a check from your insurance company, payable to you.

In the event there is a balance due from YOU after your insurance company has paid it's portion, we will bill you. We would appreciate prompt payment of your bill after the first statement. The name of the practice (and the name appearing on the bill is: **RONALD D KERWIN MD, PC**)

If you are unclear as to the reason (remember to check your Explanation of Benefits, provided by your insurance company) do not hesitate to contact the office and leave a message for our biller. She will investigate your concerns and return your call promptly to answer any questions you might have. If you have questions regarding a laboratory bill, please direct your billing questions to the laboratory, not our office.

About Self-Pay (No insurance or NON-covered services such as cosmetic procedures or products):

If you do not have insurance or you are have non-covered procedures performed or purchasing products from our office, you must pay at the time of service or purchase. We cannot bill you. We accept cash, checks and Visa, Master Card, Discover and American Express.

About Referrals:

Many HMO's now allow self-referrals to Specialists (such as Dermatology) and you do not need a written referral to be seen as long as your plan is with in the same network. Otherwise, if your insurance plan requires that your Primary Care Physician (Internal Medicine, General Practitioner, Pediatrician, etc) issues a referral to be seen in our office, please check with the office staff to determine which physicians participate with your plan and either bring a referral with you or have your PCP fax over your referral prior to your visit. If you arrive for your office visit without a referral you have two options:

1. Reschedule
2. You may pay for the visit at the end of your visit.

Treatment will only be provided for the specific procedures requested by your primary physician.

About the Laboratories Used and Your responsibilities:

Your insurance carrier has agreements with laboratories as well as physicians. It is your responsibility to know which laboratory your insurance company requires us to use. Most carriers participate with all of the Labs that we prefer, but if you KNOW that you must have lab work or pathology submitted only to a particular lab without incurring extra costs to you, please advise the Medical Assistant of this information. We submit to many labs for blood, cultures and pathology. Often times your physician chooses a laboratory because of the expertise of a particular pathologist, so if you prefer that we not send your specimens to that lab, please let the doctor know! The following labs are the preferred laboratories of this practice:

PINKUS (Pathology only), BEAUMONT (JVHL LAB), DMC (JVHL LAB), QUEST, LAB CORP, ST. JOSEPH HOSPITAL, ANN ARBOR

Our staff is dedicated to working with you and your insurance carrier to get the best possible re-imburement. Patients also have, however, a certain responsibility to be aware of the scope of their coverage. In addition, to make sure that billing is done appropriately please update the office with ANY changes to your insurance (new card, new numbers, different co-pays), your address and phone information. We will verify this information at each visit by asking to see your insurance card and inquire about any changes in your demographics. We appreciate your patience in working with our staff.

Please sign below and return this prior to your visit.

I have read the above and understand my obligations.

X _____ / /
Signature of Patient (or parent/ guardian if the patient is a minor) *Date signed*

I hereby authorize Ronald D Kerwin, M.D, Michael A. Dorman, M.D, Suzanne R. Merkle, M.D. Leonard M. Cetner, M.D. to release to my insurance company/companies or it's representatives any information including my diagnosis and medical records of any treatment or examination rendered.

X _____ / /
Signature of Patient (or parent/ guardian if the patient is a minor) *Date signed*

Finally, in the unlikely event that an employee of this practice is stuck by a needle or another sharp instrument during or following a procedure that involves your blood, you will be asked to submit to a blood test for diseases contracted through contact with body fluids (blood). This is MANDATED by OSHA and is meant to protect you and our staff. Any procedure that involves cutting or injecting into the skin requires that you sign this, otherwise, no procedure can be performed.

X _____ / /
Signature of Patient (or parent/ guardian if the patient is a minor) *Date signed*

Medical History
Please fill out COMPLETELY!

Are you currently being treated for any of the following Medical conditions or do you have a past history of any of the following Medical conditions? (Please CIRCLE all that apply)

Conditions related to:

- | | | |
|-------------------------------------|---------------------------|--|
| 1) Autoimmune Disorders | 7) STD's | 13) Heart Disease |
| 2) Hepatitis or Liver Disease | 8) Allergies/Asthma | 14) High Blood Pressure |
| 3) Kidney Disease | 9) Stroke | 15) High Cholesterol |
| 4) Arthritis | 10) Cancer
Type: _____ | 16) Ulcers/Irritable Bowel/
Stomach Disorders |
| 5) Diabetes - Insulin / Non Insulin | 11) Fainting/ Seizures | 17) HIV/AIDS |
| 6) Bleeding Disorders | 12) Headaches | |
- Any other serious disorders NOT LISTED ABOVE: _____

Do you have a history of any skin diseases? (PLEASE- circle all that apply)

Eczema Psoriasis Acne Fungus

Skin Cancer? (PLEASE- circle all that apply)

Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma Pre-Cancerous growths: Actinic Keratosis Unkown Type

Have you ever had an adverse skin reaction or rash from any product or medication applied to your skin? Yes NO

Have you experienced Keloids or Abnormal Scarring from procedures or trauma to your skin? Yes NO

Do you have a family history of Skin Cancer? YES NO

If so, type of Skin Cancer? Melanoma Basal Cell Carcinoma Squamous Cell Carcinoma Unkown Type

Relationship to you? _____

Current or Recent Medications (Please list including topical medications, especially for problems related to today's visit)

Yes _____ or NONE

Allergies to Medications or other Pertinent Products (Latex?)

Yes _____ or NONE

Are you pregnant? YES NO N/A **Nursing?** YES NO N/A **On Birth Control?** YES NO N/A

Who is your appointment with today?

Ronald Kerwin, M.D.	Michael Dorman, M.D.	Suzanne Merkle, MD
Leonard Cetner, MD	Stacy Madany PA-C	Maria Ammori PA-C
Laser	Mohs Skin Cancer Surgery	Aaron Cetner, M.D.

Briefly- Main Reason for visit: (circle one) Rash Acne/Pimples Fungus Psoriasis Discoloration Cosmetic
History of Skin Cancer- Skin Exam Wart
Concerns about new or changing Growths/moles

Other: _____

Your signature is an acknowledgement that you are aware of the posted "Notices of Privacy Practices" of Associated Dermatologists of West Bloomfield & Commerce and that a copy is available upon request.

x _____
Signature of Patient (if patient is under 18, must be signature of parent/guardian)

_____/_____/_____
Date signed

May we discuss your medical information with another person? YES NO

If YES, Please print the name of person and their relationship to you:

Name of Person

Relationship to you