DR. DEBORAH
LONGWILL

Patient Information Form

Please complete both sides of this form in ink and sign where indicated.

PATIENT INFORMATION

Date ____ /____ /_____

Patient Name (last, first, middle initial) _____ Preferred Name _____

Date of Birth: ____ / ____ /_____ Social Sec. # _____ Gender: Male Female

Race _____ Ethnicity _____ Language _____ ☐ Decline

Mailing Address: Street _____

City _____ State _____ ZIP _____

Alternate Address: _____

Cellular Phone (_____) _____ Alternative Phone (_____) _____

Email Address: _____

Please check yes or no to authorize Deborah Longwill DO PA to contact you via email for appointment reminders, practice updates and informational promotions.

Yes_____ No_____

Preferred method of contact: ☐ Phone ☐ Email ☐ Letter ( ) Text

Primary Care Physician: _____ Referring Physician: _____

Marital Status: (Circle one) Single Married Divorced Widowed Separated

Parent, Spouse or Responsible Party (If different from patient)

Name (last, first, middle initial) _____

Date of Birth ____ / ____ / _____ Social Sec. # _____ Gender: Male Female

Mailing Address: Street _____

City: _____ State: _____ ZIP: _____

Alternate Address _____

Primary Phone (_____) _____ Alternative Phone (_____) _____

Email Address _____

INSURANCE INFORMATION

Insurance Company Name _____

Name of Policy Holder (Insured) _____ Date of Birth ____ / ____ / ____

Relationship to Insured: Self Spouse Child Other _____

Employer _____ Employer Address _____

Insurance Coverage - Secondary (If applicable)

Insurance Company Name _____

Name of Policy Holder (Insured) _____ Date of Birth ____ / ____ / ____

Relationship to Insured: Self Spouse Child Other _____

Employer _____ Employer Address _____

Emergency Contact Information

Name of Friend or Relative: _____

Relationship to Patient: _____

Address: _____

_____

Daytime Phone: (___) _____

Evening Phone: (___) _____

Pharmacy Information

Pharmacy Name: _____

Address/cross roads: _____ zip code: _____

Phone: (___) _____ Fax: (___) _____

How did you learn about us?

- ☐ Newspaper (specify)
- ☐ Magazine (specify)
- ☐ Physician Referral (specify)
- ☐ Family/Friend (specify)
- ☐ Phone Book (specify)
- ☐ TV Network (specify)
- ☐ Website/Search Engine (specify) _____
- ☐ Other (specify) _____

RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of medical information to my primary care or referring Physician, to Consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to Deborah Longwill DO PA if applicable.

Responsible Party Signature: _____ **Date** ____ /____ /_____

FOR MEDICARE PATIENTS ONLY

Medicare Authorization

I request that payment for authorized Medicare benefits be made on my behalf to Deborah Longwill DO PA for any services furnished to me by providers of Deborah Longwill DO PA. I authorize Deborah Longwill DO PA to release to the CMS and its agents any information needed to determine these benefits payable for related services.

Medicare is not always the Primary insurance. Federal regulations REQUIRE that we obtain information to determine if another insurer may be primary to Medicare;

Yes	No	
☐	☐	Do you or your spouse work in a company which has more than 20 employees and have coverage through the insurance at the job?
☐	☐	Are you covered by an HMO/PPO which makes Medicare secondary?
☐	☐	Is this illness/injury covered by the VA (Veterans Administration)?
☐	☐	Is this illness/injury covered by the Federal Black Lung or End Stage Renal Disease Program?
☐	☐	Is this illness/injury due to an automobile accident?
☐	☐	Is this illness/injury due to work related causes?

Patient Signature: _____ **Date** ____ /____ /_____

Deborah Longwill DO PA

Notice of Privacy Practices
Acknowledgement & Authorization

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

MAY WE CALL YOUR HOME AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK?	☐ YES	☐ NO
MAY WE PHONE YOU AT WORK AND LEAVE A MESSAGE TO CALL OUR OFFICE BACK?	☐ YES	☐ NO
DO WE HAVE YOUR PERMISSION TO TALK TO FAMILY MEMBERS OR OTHER INDIVIDUALS	☐ YES	☐ NO

IF YES, PLEASE PROVIDE THE NAMES, PHONE NUMBER & RELATION TO YOU:

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

Name: _____ Phone: _____ Relation: _____

By signing this form, I acknowledge that I have received or have been given the opportunity to receive a copy of the Deborah Longwill DO PA Notice of Privacy Practices and have also been given an opportunity to ask questions. A copy of this consent will be included in my chart for future reference.

I acknowledge of being advised that if I need assistance with any language other than English or Spanish that it would be provided.

SIGNATURE: _____ DATE: _____

POS Reorder # 1011573

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FINANCIAL POLICY

Understanding your financial responsibility is an essential component in establishing and maintaining a strong patient/practice relationship. In order to achieve this, we offer the following information regarding our insurance and financial policies.

Your insurance is a contract between your insurer and you. t is your responsibility to know and understand the terms, guidelines and limitations of your plan. It is also your responsibility to advise us of any changes in your insurance, your address or your employer.

Contracted Insurance Plans

If you are a member of a health plan that we participate with, we will submit your claim to your insurance company. Our staff will verify your benefits and collect any co- payment, co-insurance and/or deductible at the time services are rendered as required by your insurance carrier. You will be billed in full for any services not covered under your policy.

Secondary/Supplemental Insurance Plans

We are happy to file secondary and supplemental claims as a courtesy one time if no payment is received within 60 days it will be your responsibility.

Non-Contracted Insurance Plans

If we do not participate with your insurance carrier, payment in full will be required by you at the time services are rendered.

Minors

A parent or legal guardian must accompany all patients under the age of 18 to authorize treatment and financial arrangements.

Missed Appointments

Missed appointments represent a cost to us, to you and to other patients who could have been seen in the time set aside for you. Cancellations must be made 24 hours in advance of the scheduled appointment or we reserve the right to assess a $30 fee.

Medical Records

Copies of pathology reports are provided to you or another physician at no charge. Any additional medical records requests and/or completion of forms (e.g. disability, life insurance, cancer policies, etc.) are subject to processing fees determined by state law and contractual agreements. Please be advised that medical records requests require time to be processed and cannot be provided the same day requested.

Collection Fees

Statements are sent out monthly for patients with personal balances. Payment is due upon receipt of the statement. If you are unable to pay the balance in full, please contact our billing department at 1-877-215-9330. Personal balances over 90 days from the date of service will be sent to our collection agency. In the event an account is turned over to an outside collection agency, patients will be responsible for any collection fees including court costs, attorney fees and collection agency charges.

No Check Policy

We do not accept checks only payment via cash or credit card.

Pathology Fees

I understand that I will be billed by an outside laboratory for work that is performed in this office, Biopsies done are sent to a contracted lab with my insurance company and I will be billed separately by the lab. I will notify my provider of any special requests on sending pathology or specimens to specific labs, and understand that it is my responsibility to notify the provider each time I have an appointment.

Deborah Longwill DO PA providers reserve the right to send their patients specimens to the most qualified dermatopathologist of his or her choosing. Therefore, if you're insurance requires the use of a specific lab it is your responsibility to provide us with that information prior to being seen. Failure to do so may result in additional out-of-pocket costs to you.

Name of required lab (if applicable) _____

Cosmetic Service

Patients are financially responsible for all cosmetic procedures at the time of service. This office does not bill insurance companies for cosmetic procedures.

My signature below indicates that I have read, understand and will comply with the information contained within this financial policy. A copy of this policy is available upon request.

Signature of Patient/Guardian _____ Date _____

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EXPRESS WRITTEN CONSENT TO RECEIVE TELEMARKETING CALLS & TEXTS

By signing below, patient authorizes Deborah Longwill DO PA and or its service providers, to deliver, or cause to be delivered to patient, at the telelphone numbers provided by patient in this agreement, telemarketing calls, informational calls, telemarketing texts and similar communications using an automatic telephone dialing system or an artificial prerecorded voice. Patient acknowledges that he/she is not required to execute or initial this consent, directly or indirectly, as a condition of purchasing any goods or services.

Patient Name: _____ Date: _____

Signature: _____

Home Phone: _____

Cellular Phone: _____

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Deborah Longwill DO PA offers comprehensive services and plans of treatment that may include care from multiple providers (Phsycians, Physician Assistants or Nurse Practitioners). Some insurance policies may dictate that an additional copay be collected higher out of pocket costs, or higher deductible than anticipated.

Ultimately, it is the policy holder's responsibility to know and understand the terms, guidelines, and limitations of the individual plan they have selected with their chosen Health Insurance Carrier.

You are responsible for knowing your insurance policy. For example, you will be responsible for any charges if any of the following apply: (i) your health plan requires prior authorization or referral by a Primary Care Physician (PCP) before receiving services at Deborah Longwill DO PA, and you have not obtained such an authorization or referral; (ii) you receive services in excess of such authorization or referral; (iii) your health plan determines that the services you received at Deborah Longwill DO PA are not medically necessary and/or not covered by your insurance plan; (iv) your health plan coverage has lapsed or expired at the time you receive services at Deborah Longwill DO PA; or (v) you have chosen not to use your health plan coverage. Should any questions arise regarding the specific terms of the selected policy you purchased, or any additional fees determined to be "member responsibility," please contact the Member Service line, set in place by your Health Insurance Carrier.

Pathology Notice

Please note: Additional pathology charges may be incurred in the event specialized testing is required to make a definitive diagnosis. Often this decision is determined by the dermatopathologist at the time of processing the lab specimen. These additional tests or staining procedures are done to ensure the most complete and accurate diagnosis is achieved.

Signature: _____ Date: _____