Debra Tanner Abell, MD
Dermatology & Cosmetic Skin Care
11676 Perry Hwy. Building II, 3Rd Floor
Wexford, PA 15090
724-935-9133

Dear Patient:

Enclosed are the new patient forms for you to complete before your visit. **Please fill out the paperwork completely and bring your insurance card (s) with you to your appointment. Also, you will be asked to provide a photo ID so that we comply with Identity Theft Red Flags and address discrepancies under the Fair and Accurate Credit Transaction Act of 2003.**

- If your insurance requires a referral, please call your referring physician and request the referral at least one week prior to your appointment. We will not be able to call from our office for it.
- If you do happen to have a long list of medications, please feel free to bring the list with you and we will make a copy for your chart. You do not need to list them on the history form.

If you are unable to keep your appointment, please call our office as soon as possible or at least 24 hours prior to the appointment.

Sincerely,
Debra Tanner Abell, M.D. & Staff

PLEASE PRINT CLEARLY

Name ____ Soc. Sec#_________________________

Address _______________________________ City _____________ State________ Zip____________

Phone Home_____________________ Work ___________________ Cellular _____________

EMAIL ADDRESS ____

Date of Birth _______________ Age _______ Sex M / F Marital Status ________________________

Occupation ____

Employer Name and Address ____

____

Primary Care Physician _____________________________________ Phone__________________

May our office leave a message on your answering machine ( ) Home ( ) Work ( ) Cell

(PATHOLOGY AND LAB RESULTS WILL NOT BE LEFT ON THE ANSWERING MACHINE)

If unable to reach you, who, if anyone, may we release medical and/or billing information to?

Name ________________________ Relationship _______________ Phone________________

INSURANCE INFORMATION

Primary Insurance Company ____

ID# ____________________________________ Group # ________________________

Policy Holder ____________________________ Relationship to patient _____________

Policy Holder's Address____

Phone__________________ Birthdate ___________________ Effective Date______________

Secondary Insurance Company ____

ID# ____________________________________ Group # ________________________

Policy Holder ____________________________ Relationship to patient _____________

Policy Holder's Address____

Phone__________________ Birthdate ___________________ Effective Date______________

I authorize the release of any medical or other information necessary to process insurance claims. I authorize payment of medical benefits to the undersigned physician or supplier for services performed. Health insurance will only pay for services which are considered "reasonable and medically necessary." If the carrier determines that a service is non-covered, I understand that I am financially responsible for all charges for services performed.

PLEASE NOTE THERE WILL BE A $15 PER MONTH MAINTENANCE FEE FOR ACCOUNT BALANCES PAST 60 DAYS

X ____ ______________________________

Signature of Patient or Legal Representative Date

*****PLEASE BRING INSURANCE CARDS TO FRONT DESK WITH THESE FORMS*****

HEALTH HISTORY

Name: ______________________________ **DOB:** _____________________

Medical History: Please list any health problems you have (such as diabetes, high blood pressure, etc.)

____

____

Surgical History: Please list any surgeries or hospitalizations within the past 3 years

____

____

Review of Systems: Have you recently had any of the following conditions? If yes, please provide additional details.

Problems with healing	NO YES	Problems with scarring	NO YES
Rash	NO YES	Immunosuppression	NO YES
Hay fever	NO YES	Chest pain	NO YES
Fever or chills	NO YES	Night sweats	NO YES
Unintentional weight loss	NO YES	Thyroid problems	NO YES
Sore throat	NO YES	Blurry Vision	NO YES
Abdominal Pain	NO YES	Bloody stool	NO YES
Bloody urine	NO YES	Joint aches	NO YES
Muscle weakness	NO YES	Neck stiffness	NO YES
Headaches	NO YES	Seizures	NO YES
Cough	NO YES	Shortness of breath	NO YES
Wheezing	NO YES	Anxiety	NO YES
Depression	NO YES	Other new health issues: ______________________	

____

Any new skin condition? NO YES if yes, please explain: ____

Have you ever been diagnosed with MRSA? NO YES

Do you get cold sores? NO YES

WOMEN: Are you pregnant or trying to become pregnant? NO YES

Are you nursing/breast feeding? NO YES

Medications (Please list all current prescription and OTC medications, vitamins, and supplements)

1.____________________________ 4.__________________________ 7.________________________

2.____________________________ 5.__________________________ 8.________________________

3.____________________________ 6.__________________________ 9.________________________

Allergies (Please list all allergies)

____

____

Pharmacy name: ____ Phone: __________________________________

Address____

Mail Order Pharmacy Name: __________________________________ Phone: __________________________________

Patient signature: ____ **Date:** _____________________

Reviewed by (Provider signature): ___________________________________ **Date:** __________________

Office Policies

Debra T. Abell, MD & Staff welcome you to our office. We appreciate that you have chosen us for your skin care needs. We truly enjoy what we do and hope to provide the best quality of care. In order to serve you in an efficient manner, we have instituted the following policies. We recognize the importance of your time and try our best to stay on schedule. If, however, we are running behind due to special circumstances, we apologize for any inconvenience we may have caused.

No Show/Cancellation Policy for Medical and Surgical Appointments

We provide appointment reminders via phone calls or text messages. If you must cancel your medical or surgical appointment, we require at least 24 hour notice so that the time can be given to a patient with an immediate problem. **In the event of a no-show or same day cancellation, you will be charged a *$50* fee that must be paid prior to making additional appointments.** For repetitive no-show or same day cancellations, we reserve the right to terminate the patient-doctor relationship. Please be prompt, as a sincere attempt is made to see our patients at their scheduled time.

Cosmetic Appointments

We offer free 15 minute cosmetic consultations with a member of our aesthetic staff. **A deposit of $150 is required to schedule a cosmetic procedure; this deposit is applied to the cost of the procedure.** A 48-hour notice of cancellation is required or the deposit will be forfeited. Full payment for services is required at the time of the visit. We accept cash, check, Visa, MasterCard, and Discover. If financing is desired, please contact Care Credit prior to the scheduled visit.

Prescription Refill Policy

The prescriber will give you enough refills to last until your next appointment. **Please note that it is office policy not to authorize refills if a patient has not been seen in the office in over 6 months or if appointments have been missed.** Special circumstances will be individually reviewed by the medical provider. Certain medications, such as Enbrel, require periodic visits for refills.

Medical Forms

For your safety, we require your medical history forms be updated yearly. Insurance forms are also updated yearly to ensure accuracy of billing. We appreciate your cooperation in this matter.

ID

All patients must present a valid photo ID and insurance card at the time of appointment. If these are not available, you will be asked to reschedule your appointment. If you do not have insurance, a photo ID and credit card will be required.

Medical Records Request

If you wish to transfer to another provider, the first set of records is provided at no charge. All subsequent requests will incur a prepaid charge in accordance with state approved/mandated copying fees. Please allow 10-14 days for medical record requests to be completed.

Finance Charge

PLEASE NOTE THERE WILL BE A $15 PER MONTH MAINTENANCE FEE FOR ACCOUNT BALANCES PAST 60 DAYS

By signing below, I indicate that I have read, and I understand the above office policies.

X____ ____________________

Signature of Patient or Legal Representative Date

Financial Policies

Insurance Filing:
As a courtesy we will bill your insurance company for any charges incurred at our clinic. Remember, your health insurance is a contract between you and your insurance company. Our office will make **two attempts** to settle any outstanding bill with your insurance company. If your insurance deems a procedure to be not covered by your insurance plan you will be responsible for the balance of this service and you expressly agree to pay for such non-covered services. Claims not paid by your insurance company within 90 days will become your responsibility as a non-covered service. We will furnish information required by the insurance company to receive payment. Benefits should be paid directly to Debra Tanner Abell, M.D. & Associates from your insurance company, if your insurance company pays copays, coinsurance, or other similar charges. I hereby assign to Debra Tanner Abell M.D. & Associates all my rights and claims for reimbursement under my health insurance policy. I agree to provide information as needed to establish my eligibility for such benefits.

Bad Debt & Bankruptcy Account Status:
I realize that if my account is in bad debt or bankruptcy status I will have to pay the outstanding debt before I am able to book my next appointment. I realize that if my account is sent to collections, Debra Tanner Abell M.D. & Associates may alternatively elect to dismiss me as a patient from the practice. If I pay off my account with Credit Collections U.S.A, L.L.C., my account will be returned to good standing status.

Non-Sufficient Funds:
A $35.00 charge will be added for any non-sufficient funds notice from the bank. If your account is sent to collections and we have to litigate in court, your visit(s) with our office may become a matter of public record.

Non-Insured Patients:
Non-insured patients will be charged a fee prior to seeing a provider on the date of service. These funds will be allocated to the services rendered by the provider for that day. However, these fees serve only as a down payment and are not considered payment in full. The down payments are as follows:

New Patient Office Visit $170 **Established Patient Office Visit $150** **Excision Visit $800**

Final charges will be determined after the provider sees the patient and a complete assessment is made. The provider may require payment in full for procedural services prior to rendering such a service. Additional fee information is available upon the patient's request. A statement with the balance due for services provided will be mailed to you within a few days. At which time the balance due should be paid upon receipt.

Co-payments, Co-insurance, Deductible, & Cosmetic Procedures:
Payment is due on the date of service prior to seeing the provider. Deductible amounts may be collected prior to the physician completing the service. Payments for a cosmetic procedure is due in full prior to treatment.

Procedure Pricing:
I understand that procedure estimates will be provided in writing and are estimates only. Once the procedure is completed and the provider notes have been submitted to insurance for billing will the final cost be known.

X____ ________________________
Signature of Patient or Legal Representative Date