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: _____ Date: _____

Medical History (please circle)

Anxiety	Depression	Hyperthyroidism
Arthritis	Diabetes	Hypothyroidism
Asthma	End Stage Renal Disease	Leukemia
Atrial fibrillation	GERD	Lung Cancer
Bone Marrow Transplant	Hearing loss	Lymphoma
BPH (enlarged prostate)	Hepatitis	Prostate Cancer
Breast Cancer	Hypertension (high blood pressure)	Radiation Treatment
Colon Cancer	HIV/AIDS	Seizures
COPD	High cholesterol	Stroke
Coronary Artery Disease		

Other _____

Surgical History

Please list all surgeries: _____

_____

_____

Skin Disease History

Acne Hay	Fever/Allergies
Actinic Keratosis	Melanoma
Asthma	Poison Ivy
Basal Cell Skin Cancer	Precancerous Moles (Atypical/dysplastic)
Blistering Sunburns	Psoriasis
Dry Skin	Squamous Cell Skin Cancer
Eczema	NONE
Flaky or Itchy Scalp	

Other _____

Do you wear sunscreen? Yes No

SPF _____

Do you tan in a tanning salon? Yes No

Have you ever tanned in a tanning salon? Yes No

Do you have a family history of melanoma? Yes No

If yes, which relative(s)? _____

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)

_____

_____

Name: _____ DOB: _____ Date: _____

Social History (Please circle)

Cigarette Smoking	Alcohol Use
Never Smoked	Yes _____ drinks per day
Quit/Former Smoker	No
Current Smoker	
_____ Packs Per Day	Occupation _____

Family History (Please circle)

Asthma	Diabetes	Bleeding disorders	Eczema
Lupus	Psoriasis	Rheumatoid Arthritis	Thyroid disease

Other _____

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	_____

Name: _____ DOB: _____ Date: _____

Special Alerts

Do you take blood thinners	NO	YES
Do you have a history of MRSA?	NO	YES
Are you allergic to lidocaine?	NO	YES
Are you allergic to adhesives (such as bandages)?	NO	YES
Are you allergic to topical antibiotic ointments?	NO	YES
Do you have an artificial heart valve?	NO	YES
Have you had an artificial joint surgery within the past 2 years?	NO	YES
Do you have a defibrillator?	NO	YES
Do you have a pacemaker?	NO	YES
Do you need to pre-medicate prior to procedures?	NO	YES
Do you get a rapid heartbeat with epinephrine?	NO	YES
Do you have a history of cold sores?	NO	YES

WOMEN: Are you pregnant or trying to become pregnant?	NO	YES
Are you nursing/breast feeding?	NO	YES

Language	Race (optional)	Ethnicity (optional)
English	White	Hispanic or Latino
Spanish	American Indian	Non-Hispanic or Latino
Other _____	Asian	
	Black or African American	
	Native Hawaiian or Pacific Islander	
	Other _____	

PHARMACY

Local Pharmacy Name: _____
Phone: _____ Mail Order Pharmacy Name:_____
Street: _____ Phone: _____

Cosmetic Interest: Please circle areas of concern or services of interest (optional)

Acne	Brown spots/Age spots	Chemical Peels
Facial wrinkles	Droopy or puffy eyelids	Botox
Thin lips	Dark circles under eyes	Microdermabrasion
Facial redness	Sagging skin of face/neck	Vbeam laser treatment
Short eyelashes	Loose abdominal skin	Thermage
Facial fillers – Juvederm, Restylane, Belotero		Facials

Patient signature: _____

Reviewed by (Provider signature): _____

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 CareCredit 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.

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

X_____ _____
Signature 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 $200 **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

Notice of Privacy Practices

Debra Tanner Abell, MD & Associates
11676 Perry Highway, Suite 2305, Wexford, PA 15090

724-935-9133

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED

AND HOW YOU CAN GET ACCESS TO THIS INFORMATION

PLEASE READ IT CAREFULLY

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your protected health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the HITECH Act of 2010 and the 2013 Privacy and Security Rules. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.
• Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.
• Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.
• Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.
• The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.
We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.
The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:
• Most uses and disclosure of psychotherapy notes;
• Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
• Disclosures that constitute a sale of PHI under HIPAA; and
• Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.
We follow laws that tell us when we have to share health information, even if you do not sign an authorization form. We may use or release your health information:
 For public health reasons, including to prevent or control disease or injury; or report births or deaths, suspected abuse or neglect, reactions to medications or problems with certain health-related products.
 To prevent serious threats to your health or safety or that of another person or the public.
 To help health oversight agencies monitor the health care system, government programs, and compliance with civil rights laws, including for audits, investigations, inspections, or licensing purposes.
 If a court orders us to, or if we receive a subpoena and receive certain assurances from the person seeking the information.
 To law enforcement officials, if we receive a proper request and the request meets all other legal requirements.
 To coroners, medical examiners or funeral directors, in order to help identify a deceased person, determine the cause of death, or perform other legally authorized duties.
 To organ procurement organizations, if you are an organ donor or as legally required.
 For health-related research that meets applicable legal requirements.
 To military authorities, if you were or are a member of the armed forces and the request is made by appropriate military command authorities.
 To authorized federal officials for national security purposes.
 To Workers Compensation for work-related injuries.
 To other government benefit programs in order to coordinate or improve administration and management of the programs.
 As otherwise required by law.

Additional Restrictions of Use and Disclosure

Certain federal and Pennsylvania state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. “Highly confidential information” may include confidential information under Federal laws governing alcohol and drug abuse and genetic information as well as state laws that often protect the following types of information:

1. HIV/AIDS; 2. Mental health; 3. Genetic tests; 4. Alcohol and drug abuse; 5. Sexually transmitted diseases and reproductive health information; and 6. Child or adult abuse and neglect, including sexual assault.
If a use or disclosure of health information described above in this notice is prohibited or materially limited by other laws that apply to us, it is our intent to meet the requirements of the more stringent law.
Except for uses and disclosures described and limited as set forth in this notice, we will use and disclose your health information only with a written authorization from you. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information.

Patient Rights
You may have the following rights with respect to your PHI:
• The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
• The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
• The right to inspect and copy your PHI.
• The right to amend your PHI.
• The right to receive an accounting of disclosures of your PHI.
• The right to obtain a paper copy of this notice from us upon request.
• The right to be advised if your PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.
We are required by law to maintain the privacy of your PHI and to provide you the notice of our legal duties and our privacy practice with respect to PHI.
This notice if effective as of March 1, 2015 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post a copy and you may request a written copy of the revised Notice of Privacy Practice from our office.

Complaints
You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with the practice and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact the Practice Compliance Officer, Amy Betschart, PA-C at 724-935-9133, for more information, in person or in writing.