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Thank you for choosing Dermatology Associates of Indiana. Included are forms that will give us information that we need at the time of your initial appointment. Please complete these forms prior to your visit and bring them with you to your appointment. We will require a copy of your current medical insurance card and photo identification at the time of your appointment.

Appointment Date /Time _____ for _____
With _____

If your insurance requires a referral from your primary care physician (PCP) please be sure to contact them for prior authorization information as soon as you schedule your appointment with our office. Please call your insurance to verify if a referral is needed for insurance purposes. Should your insurance require a prior referral and you fail to obtain one prior to your appointment, you will be responsible for payment of all services provided on that day of service. We would recommend that you contact your Primary Care Physician twenty-four hours before your appointment to verify that the prior authorization/referral is ready for your appointment.

We request that you bring the written referral with you at the time of your appointment. Please note that the treatment your insurance and PCP has requested will be the only treatment provided unless you agree to accept responsibility for other treatment given.

Co-Payments must be made at the time of your visit. Cosmetic Procedures must be paid in full at the time of your visit. We take Master Card, Visa and Discover.

As a courtesy to the physicians and other patients, please notify our office 24 hours before your scheduled appointment should it be necessary for you to cancel or reschedule.

We look forward to seeing you.

Dermatology Associates of Indiana
Office Staff



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A MESSAGE TO OUR PATIENTS

We are pleased that you have chosen **Dermatology Associates of Indiana** to provide your care. It is important that our patients are aware of the financial policies of our practice, and we encourage you to discuss any questions you may have.

We will file a claim promptly to your primary insurance company for you, provided that you have a current copy of your insurance card with the correct mailing address on it. We cannot guarantee payment of your claim. If your insurance company pays only a portion of the bill or rejects your claim, your insurance should send an explanation to you, the policyholder. Reduction or rejection of the claim does not relieve you of your financial obligation. Per insurance, all claims must be filed within 90 days of the date of service to avoid denial.

If you do not have health insurance, payment is expected at the time of your visit, unless prior arrangements are made with our Patient Accounts Representatives who can be reached at (317) 338-9391. We accept Visa, MasterCard and Discover. All cosmetic procedures must be paid in full at time of visit. Insurance claims will not be filed for cosmetic procedures.

Identity Theft Protection: We are required to have the most current information on our patients, including insurance information, address and phone. We will be asking for your Photo ID and Insurance Card at EVERY visit. Please bring these cards to avoid a delay in being seen. We will also be confirming this information each time you call our office.

Co-Pays: Co-Payment is due at the time of service. This is a requirement by your insurance company.

Referrals: There are many insurance companies that now require you to have an authorization number or referral form from your Primary Care Physician in order to see a specialist. We ask that you please obtain this from your Primary Care Physician **prior** to your visit and bring it to the appointment. This is a requirement by your insurance company.

Blue Shield/Anthem: We are Preferred Providers of Blue Shield/Anthem. If you have this coverage, we will file a claim with them for office visits as well as other services (excluded are cosmetic procedures). The patient will be responsible for any deductibles, co-insurance, and non-covered services.

Medicare: We are participating physicians with Medicare. Charges for services rendered to Medicare patients will be filed with the Indiana carrier. Medicare patients are responsible for the deductible, 20% co-insurance and any non-covered services.

Medicaid: We are no longer Medicaid providers. Patients who are covered by Medicaid (as primary or secondary insurance) must seek medical care by an Indiana Medicaid provider.

Treatment of Minors: We realize that many families are in a state of change. In many of these families the question of who is financially responsible for the child's care is complicated. In the case of either sole legal custody or joint legal custody arrangements, the parent who presents the child for treatment will be considered the financially responsible party for the minor child.

Account Balances and Returned Checks: If a check is returned to us for insufficient funds, an additional \$20.00 fee will be applied to your account. Unless payment is received within 2 weeks of the insufficient funds notice, your account will be referred to our collection agency with an additional fee attached. As a courtesy, our office will mail out monthly statements of balances due. Accounts with a balance due after 90 days will be considered delinquent and will be sent to a collection agency with an additional interest fee attached.

Cosmetic Procedures: Cosmetic procedures must be paid at the time of service. We do not file claims to your insurance for cosmetic procedures. ***There will be a \$100 charge for all COSMETIC appointments that are not cancelled 24 hours prior to the scheduled time.***

**There will be a \$30.00 charge for all MEDICAL appointments
and a \$100 charge for all SURGERY appointments
that are not cancelled 24 hours prior to the scheduled time.**

NEW PATIENT INFORMATION

PATIENT

LAST	FIRST	MIDDLE INITIAL
STREET ADDRESS		
CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE M / F
EMPLOYER / SCHOOL	SEX	
SOCIAL SECURITY #	MARITAL STATUS	DATE OF BIRTH

REFERRING PHYSICIAN	ADDRESS	PHONE
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POLICYHOLDER OF INSURANCE

LAST	FIRST	MIDDLE INITIAL	
ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIPCODE
HOME PHONE	WORK PHONE	CELL PHONE	
EMPLOYER	RELATIONSHIP TO PATIENT		
SOCIAL SECURITY NUMBER	DATE OF BIRTH		

GUARANTOR OF PATIENT (IF NOT POLICYHOLDER) (PERSON BRINGING CHILD IN ie: PARENT, GUARDIAN, POWER OF ATTORNEY)

LAST	FIRST	MIDDLE INITIAL	
ADDRESS (IF DIFFERENT FROM PATIENT)	CITY	STATE	ZIPCODE
HOME PHONE	WORK PHONE	CELL PHONE	
EMPLOYER	RELATIONSHIP TO PATIENT		
SOCIAL SECURITY NUMBER	DATE OF BIRTH		

Dermatology Associates of Indiana – HEALTH HISTORY

Welcome to our office! Good skin health requires a broad understanding of your past and present health. Please complete the following questionnaire. Thank you!

Name: _____	DOB: _____	Age: _____	Sex: M F
What is the reason for your visit today? _____			
Occupation: _____		Today's Date _____	

Have you had any of the following conditions in the past? Please place a check mark next to them.			
Skin Cancer		Melanoma	Atypical Moles
Basel Cell Carcinoma		Squamous Cell Carcinoma	Actinic Keratosis
T-Cell Lymphoma		Other Cancer	Diabetes
Sarcoid		Heart Disease	Stroke / TIA
Seizures / Epilepsy		Thyroid Disease	Lupus
Hepatitis / Liver Disease		Herpes Simplex	Bleeding Disorder
Chrohn's / Colitis Disease		Heart Valve	Pacemaker
Hip Replacement		Cataracts	Glaucoma
Kidney / Renal Disease		GYN Problems	Depression

Do you currently have any of the following conditions? Please place a check mark next to them.			
Itchiness		Dry Skin	Oily Skin
Irritated Lesions		Changing Lesions	Fever
Fatigue		Sweats	Dry Eyes
Nose Bleeds		Swelling in Hands or Feet	Wheezing
Abdominal Pain		Joint Pain	Headache
Depression		Recent Weight Gain	Recent Weight Loss
Swollen Glands		Itchy Eyes	

Please check any of the following conditions a family member (parent, children, grandparent) may have had			
Skin Cancer		Melanoma	Atypical Moles
Acne		Eczema	Psoriasis
Lupus		Other Cancer	Diabetes
Sarcoid		Heart Disease	High Blood Pressure

ALLERGIES: Do you have any medication allergies? Y N _____
 Do you have any other allergies? Y N _____

HEALTH HABITS: Do you smoke? Yes _____ No _____ How Many Per Day? _____ Quit Date _____

Do you drink alcohol? Yes _____ No _____ How Much? 0-1 _____ 2+ _____

Do you spend long hours in the sun? Yes _____ No _____

Have you ever had a blistering sunburn? Yes _____ No _____

Female Only: Pregnant? Yes ___ No ___ Nursing? Yes ___ No ___ Trying to get Pregnant: Yes _____ No _____

CURRENT MEDICATIONS	REASON FOR TAKING MEDICATION

PAST OPERATIONS – DATE AND REASON	



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ASSIGNMENT & RELEASE:

I, THE UNDERSIGNED, HAVE INSURANCE COVERAGE WITH _____ AND ASSIGN DIRECTLY TO **DERMATOLOGY ASSOCIATES OF INDIANA** ALL MEDICAL BENEFITS, IF ANY, OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED. I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT PAID BY INSURANCE. I HEREBY AUTHORIZE THE PHYSICIAN TO RELEASE ALL INFORMATION NECESSARY TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL MY INSURANCE SUBMISSION:

MEDICARE AUTHORIZATION:

I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO **DERMATOLOGY ASSOCIATES OF INDIANA** FOR ANY SERVICES FURNISHED BY THE PHYSICIAN. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OR THE BENEFITS PAYABLE FOR RELATED SERVICES. I UNDERSTAND MY SIGNATURE REQUESTS THAT PAYMENT BE MADE AND AUTHORIZES RELEASE OF MEDICAL INFORMATION NECESSARY TO PAY THE CLAIM. IF "OTHER HEALTH INSURANCE" IS INDICATED IN ITEM 9 OF THE HCFA-1500 CLAIM FORM, OR ELSEWHERE ON OTHER APPROVED CLAIM FORMS, OR ELECTRONICALLY SUBMITTED CLAIMS, MY SIGNATURE AUTHORIZES RELEASING THE INFORMATION TO THE INSURANCE AGENCY SHOWN. IN MEDICARE ASSIGNED CASES, THE PHYSICIAN OR SUPPLIER AGREES TO ACCEPT THE CHARGE DETERMINATION OF THE MEDICARE CARRIER AS THE FULL CHARGES, AND THE PATIENT IS RESPONSIBLE ONLY FOR THE DEDUCTIBLE, CO-INSURANCE, AND ANY NONCOVERED SERVICES. CO-INSURANCE AND THE DEDUCTIBLE ARE BASED UPON THE CHARGE DETERMINATION OF THE MEDICARE CARRIER.

PATIENT RESPONSIBILITY (ALL INSURANCES):

I UNDERSTAND THAT I WILL BE HELD FINANCIALLY RESPONSIBLE FOR ANY BALANCES INCURRED IN THIS OFFICE OR CHARGES THAT ARE NOT PAID BY MY INSURANCE COMPANY DUE TO ANNUAL DEDUCTIBLES, CO-PAY AMOUNTS, CO-INSURANCE AMOUNTS, MISSED APPOINTMENT CHARGES, OR NSF/ACCOUNTS CLOSED. THERE WILL BE A **\$20.00** SERVICE CHARGE FOR ANY RETURNED CHECKS. IF ANY BALANCE IS NOT PAID WHEN DUE, I AGREE TO PAY ALL COSTS OF COLLECTIONS; INCLUDING REASONABLE ATTORNEY FEES, COURT COSTS, AND THE COLLECTION AGENCIES FEES. IF MY INSURANCE PLAN REQUIRES A PRE-AUTHORIZATION/REFERRAL FROM MY PRIMARY CARE PHYSICIAN, I AM RESPONSIBLE FOR OBTAINING THE PRE-AUTHORIZATION/REFERRAL INFORMATION PRIOR TO MY APPOINTMENT. IF I DO NOT OBTAIN PRE-AUTHORIZATION/REFERRAL INFORMATION, I MAY BE ASKED TO RESCHEDULE MY APPOINTMENT UNTIL I RECEIVE THIS INFORMATION, OR I MAY CHOOSE TO PAY FOR SERVICES PROVIDED.

PREFERRED LAB:

CHECK WITH YOUR INSURANCE COMPANY TO DETERMINE IF LAB WORK MUST BE DONE WITH A SPECIFIC LAB. THIS INFORMATION IS DUE AT THE TIME OF THE APPOINTMENT. IT IS OUR OFFICE POLICY THAT ALL SPECIMENS REMOVED WILL BE ANALYZED IN THE LAB.

Preferred Lab: _____

**SIGNATURE OF
PATIENT OR LEGAL
GUARDIAN:** _____

DATE: _____

**PRINT
PATIENT'S NAME:** _____



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Patient Consent for Use and Disclosure of Protected Health Information

With my consent, Dermatology Associates of Indiana may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Dermatology Associates of Indiana's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dermatology Associates of Indiana reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Dermatology Associates of Indiana, Privacy Officer at 8433 Harcourt Road, Suite 310, Indianapolis, Indiana 46260.

With my consent, Dermatology Associates of Indiana may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, Dermatology Associates of Indiana may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential.

With my consent, Dermatology Associates of Indiana may e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dermatology Associates of Indiana restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Dermatology Associates of Indiana's use and disclosure of my PHI to carry out TPO. By signing this form, I am confirming that I have received a copy of Dermatology Associates of Indiana's Notice of Privacy Practices.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Dermatology Associates of Indiana may decline to provide treatment to me.

Patient's Name

Signature of Patient or Legal Guardian

Print Name of Patient or Legal Guardian

Date