

**Esti G. Gumpertz, M.D.      Atrium Dermatology®**  
**Hillcrest Medical Building #2**  
**6801 Mayfield Road, Suite 244, Mayfield Heights, Ohio 44124**  
**Telephone (440) 646-1600**

Date: \_\_\_\_\_, 2010

**PRINT CLEARLY - THIS INFORMATION IS USED TO SUBMIT INSURANCE CLAIMS ON YOUR BEHALF**

<u>Person Responsible For Bill</u>	<u>Patient</u>	
Relationship to Patient: Self: <input type="checkbox"/> Spouse: <input type="checkbox"/> Parent: <input type="checkbox"/> Other: _____		
<b>Social Security No:</b>	<b>Social Security No:</b>	
<b>Name:</b> Last	<b>Name:</b> Last	
First: _____ Middle Initial: _____	First: _____ Middle Initial: _____	
Marital Status: M: <input type="checkbox"/> W: <input type="checkbox"/> S: <input type="checkbox"/> D: <input type="checkbox"/>	Marital Status: M: <input type="checkbox"/> W: <input type="checkbox"/> S: <input type="checkbox"/> D: <input type="checkbox"/>	
Address:	Address:	
Apartment #:	Apartment #:	
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____	
Home Phone #: (     ) _____	Home Phone #: (     ) _____	
Cell phone #: (     ) _____	Cell phone #: (     ) _____	
<b>Date of Birth:</b> _____ <b>Age:</b> _____	<b>Date of Birth:</b> _____ <b>Age:</b> _____	
Sex: Male: <input type="checkbox"/> Female: <input type="checkbox"/>	Sex: Male: <input type="checkbox"/> Female: <input type="checkbox"/>	
<b>Employer Name:</b>	<b>Employer Name:</b>	
Address:	Address:	
City: _____ State: _____ Zip: _____	City: _____ State: _____ Zip: _____	
Work phone #: (     ) _____ Extension: _____	Work phone #: (     ) _____ Extension: _____	
Referred by:		
Primary Care Doctor:		
List all medicines taken by Patient:		
Patient's <b>Relationship to Holder of Insurance Policy:</b> Self: <input type="checkbox"/> Spouse: <input type="checkbox"/> Child: <input type="checkbox"/> Other: <input type="checkbox"/>		
<b>Emergency Contact:</b>	Relationship: _____ Tel #: (     ) _____ Extension: _____	
Insurance <b>Co-Pay amount due</b> at each visit: \$ _____		
Names of Insurance Companies where claims should be filed:	<u>Primary Insurance Company</u>	<u>Secondary Insurance Company</u>
<b>Name of Policy Holder</b> (Person who carries the insurance):		
<b>His/her Social Security Number</b>	Social Security No:	Social Security No:
<b>His/her Date of Birth</b>		

I am authorized to sign on behalf of the above-named Responsible Party (and guardian, if patient is a minor). I understand that the patient (unless a minor), the above-named Responsible Party and I (herein collectively referred to as "We") are each individually personally responsible for all charges incurred for medical services rendered to Patient, and for all additional costs, fees and commissions paid or incurred by Dr. Esti Gumpertz ("Provider"), her employees and her agents to collect payment from me. We further understand that claims are submitted to insurance only as a courtesy and in Provider's discretion, and that if after 45 days insurance has not paid in full We will be responsible for payment. We agree to fully cooperate with Provider in timely providing information necessary to process a claim. We give permission for insurance benefits to be sent directly to Provider. We authorize the release of Protected Health Information (in compliance with Provider's Privacy Practices Policy) to third party payors and to anyone assisting Provider in providing medical treatment or obtaining payment as set forth above. We understand that **unless at least 24 hours prior notice is given to cancel an appointment, we may be charged a missed appointment fee.** We further agree to pay Statement Billing Fees where applicable co-payments and/or prior balances have not been paid in full when due. Provider is hereby authorized to provide medical services to patient, if a minor.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_, 2010  
Date

**Summary of Atrium Dermatology Financial Policy: See [www.AtriumDermatology.com](http://www.AtriumDermatology.com) for details and to download a full copy of our current Financial Policy**

**Payments and Annual Deductibles:** Some plans have an annual deductible that must be met before these insurance companies will pay for services. In the event there is a balance due we will bill you. Payments will be applied to your account as our staff deems appropriate. In order to keep our costs down, we ask that you pay your bill on receipt. We will only send out three statements. Along with the third statement we will advise you that no further statements will be sent. We may then turn the account over to a collection service. A \$25.00 re-billing fee may be added to accounts that remain unpaid after a second statement has been sent to you. You are responsible for all our collection costs on delinquent accounts.

**Co-Payments:** If you are an enrollee of a managed care plan (HMO or PPO) with which we have contracted, you are required to pay the co-pay each time you are seen. This must be paid before you see Dr. Gumpertz, or we may add a \$5.00 fee to your account.

**Referrals:** If you are enrolled in an HMO that requires a referral from your primary care physician, you must have a current referral before Dr. Gumpertz will see you. It is your responsibility to make sure that you have the referral. However, if you elect not to reschedule, you can pay for the visit. The amount paid will be credited to your account after our office receives a valid referral.

If you have any questions regarding your bill, please call us as soon as possible after your receipt of the bill. We can explain any discrepancies and clear up any misunderstandings or errors at this time. Prompt action on your part allows us to serve you more efficiently.

\_\_\_\_\_  
Signature of Patient / Responsible Party

\_\_\_\_\_, 2010  
Date

#### **ACKNOWLEDGEMENT OF NOTICE OF OUR PRIVACY PRACTICES**

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our office manager. Our Privacy Policy, which can be reviewed on line at [www.AtriumDermatology.com](http://www.AtriumDermatology.com), describes in detail how your health information may be used and disclosed, and how you can access your information.

\_\_\_\_\_  
Patient or legally authorized individual signature

\_\_\_\_\_, 2010  
Date

\_\_\_\_\_  
Printed name (if signed on behalf of the patient) Relationship (parent, legal guardian, personal representative)

Patient Visit Information Form

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_, 2010

What are the main reasons for your visit today? (*specify*) \_\_\_\_\_  
\_\_\_\_\_

Please tell us about your present condition: \_\_\_\_\_  
\_\_\_\_\_

Where on your body does the problem occur? (*specify*) \_\_\_\_\_

How long have you had the problem? \_\_\_\_\_

What are the symptoms you can see or feel?  *itching*,  *burning*,  *pain*  
(*specify*) \_\_\_\_\_  
\_\_\_\_\_

How bad is the problem?  *mild*  *moderate*  *severe*

Does it seem to be getting worse?  *yes*  *no* please explain: \_\_\_\_\_  
\_\_\_\_\_

Did the problem start suddenly?  *yes*  *no*

Does your condition change depending on what you are doing?  *yes*  *no*

Please explain: \_\_\_\_\_  
\_\_\_\_\_

Does your condition change depending on where you are?  *yes*  *no*

Please explain: \_\_\_\_\_  
\_\_\_\_\_

List any medications, foods, lotions and anything else that make the problem better or worse  
\_\_\_\_\_

Does your problem seem to affect anything besides your skin (*e.g. feeling tired, sleep, appetite*)?  
 *yes* (*specify*) \_\_\_\_\_  *no*

Have you had surgery or been diagnosed with a new illness recently or since we last saw you?  
(*specify*) \_\_\_\_\_

Please list diseases that have been diagnosed in your immediate family

*skin cancer*  *melanoma*  *psoriasis*  *eczema*  *abnormal mole*  *cancer*  
 *other* (*specify*) \_\_\_\_\_

Patient Visit Information Form

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_, 2010

Please list all medications and supplements you are currently taking:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list all allergies that you believe you have: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What type of work do you do? \_\_\_\_\_

Any hobbies or other activities? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Do you smoke?       never       occasionally       frequently

Do you drink alcohol?       never       occasionally       frequently

Please check the following conditions or areas of your body where you are experiencing problems:

Rest of Skin       Hair       Nails       Inside Nose       Fever

Chills       Night Sweats       Fatigue       Loss of Weight       Chest

Joint Pains       Nerves       Genital Area       Stomach       Bowel

Other area (specify) \_\_\_\_\_

Do you have any other comments or concerns to be addressed by the doctor?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*Thank you for taking the time to assist us in helping with your health concerns today*