MICHAEL A. TOMEO, M.D.

PATIENT INFORMATION – PLEASE PRINT CLEARLY

LAST NAME _____ FIRST NAME _____ MI _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE # _____ CELL # _____

E-MAIL ADDRESS _____ PREFERRED CONTACT ☐ HOME ☐ CELL ☐ E-MAIL

BIRTHDATE _____ SOCIAL SECURITY # _____ SEX _____

MARITAL STATUS: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

EMPLOYER _____ ARE YOU A STUDENT? _____

PRIMARY CARE PHYSICIAN _____ PHONE # _____

PHYSICIAN'S ADDRESS _____

CURRENT MEDICATIONS _____

ALLERGIES _____

PURPOSE OF VISIT _____ WHO REFERRED YOU? _____

ASSIGNMENT AND RELEASE – ALL PATIENTS PLEASE READ AND SIGN:

I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable to which I am entitled including Medicare, private insurance and other health plans to Michael A. Tomeo, M.D. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. As described in the Billing and Payment Policy, I UNDERSTAND THAT I AM FINANCIALLY RESPONSIBLE FOR ALL CHARGES WHETHER OR NOT PAID BY MY INSURANCE.

SIGNATURE _____ **DATE** _____

PRIMARY INSURANCE:

PLAN _____
PATIENT'S RELATIONSHIP TO THE INSURED:
Self _____ Spouse _____ Child _____ Other _____

If not "SELF", please provide subscriber information.

NAME OF INSURED _____
ADDRESS _____

HOME PHONE _____
CELL PHONE _____
BIRTHDATE _____ SEX _____

SECONDARY INSURANCE (IF ANY):

PLAN _____
PATIENT'S RELATIONSIHP TO THE INSURED:
Self _____ Spouse _____ Child _____ Other _____

If not "SELF", please provide subscriber information.

NAME OF INSURED _____
ADDRESS _____

HOME PHONE _____
CELL PHONE _____
BIRTHDATE _____ SEX _____

PLEASE PRESENT INSURANCE CARDS(S) TO RECEPTIONIST

********** *FOR STAFF USE ONLY* **********

PRIMARY

GROUP # _____

ID # _____

COPAY $ _____ REF _____ NO REF _____

SECONDARY

GROUP # _____

ID # _____

COPAY $ _____ REF _____ NO REF _____

MICHAEL A. TOMEO, M.D.
BILLING AND PAYMENT POLICY

We are committed to providing you with the best possible medical care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your cooperation in supplying us with your ***current, accurate and complete insurance information and identification cards at each visit.***

It is also important that you understand our billing and payment policies. Please be aware that, as part of your visit, the doctor may do in-office procedures, such as the removal of a skin lesion. Many insurance companies (particularly PPO plans) apply the charge for these procedures toward a surgical deductible. This may result in out-of- pocket expense to you. Payment of office visit copays does not eliminate these costs.

Payment for copays and any non-billable service is due at the time of your visit. We accept checks and cash, but do not take credit or debit cards. The fee for a returned check is $30.00. If our services are billable to your insurance plan we will submit a claim on your behalf. After your insurance company pays us, we will bill you for any amount that is your responsibility. This may include deductible and/or coinsurance amounts that have been applied to the claim, or charges for services not covered by your plan. (You may also receive an Explanation of Benefits directly from your insurance plan explaining what has been paid and what you owe.)There is a $10 Billing Service Charge added to past due balances. If it becomes necessary to place your account with an attorney for collection of an unpaid balance, you would be responsible for payment of reasonable attorney's fees and costs of collection.

We will gladly answer questions relating to insurance billing. However, we are *not* able to determine your specific coverage and benefits, plan limitations, or plan provisions. For this information you should contact your insurance company directly, or the employer's group administrator for your plan.

We must emphasize that as a health care provider our relationship is with *you* and *not* the insurance company. While filing insurance claims is a courtesy we extend to our patients, all charges are your responsibility from the time the services are rendered.

MEDICARE:
We are participating with Medicare and therefore will submit claims for you. We will also bill your supplemental insurance plan. After we receive payment we will bill you for any remaining deductible or coinsurance. (Please note that many secondary plans do *not* pay the annual Medicare Part B deductible, and some pay only a percentage of the Medicare coinsurance.)

HMO PLANS (Health Maintenance Organization such as Aetna, Keystone, etc.):
At the present time we are participating in many of these plans. We will file your claim provided you have obtained a valid referral from your primary care physician, and paid your copay (if applicable), at the time of your visit. If there is no referral you may either reschedule the appointment, or pay at the time of the visit for care provided..

PPO PLANS (Preferred Provider Organization such as Personal Choice, Etc.):
At the present time we participate as a network specialist in many PPO insurance plans. If we participate, we will file insurance claims on your behalf. You may be responsible for deductible and/or coinsurance balances after our claim has been processed by your plan.

I have read and understand the above Billing and Payment Policy of Michael A. Tomeo, M.D. and agree to abide by this policy.

SIGNATURE _____ Date_____

PATIENT CONSENT TO USE AND DISCLOSE HEALTH INFORMATION

This consent authorizes Michael A. Tomeo, M.D. & Associates/Advanced Dermatology Center to use and disclose my health information for treatment, payment and health care operations.

EXPLANATION OF RIGHTS

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the opportunity to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Michael A. Tomeo, M.D. & Associates/Advanced Dermatology Center has the right to change its *Notice of Privacy Practices* from time to time and that I may contact you to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

CURRENT CONTACT INFORMATION FOR OUR PRIVACY OFFICER

Practice Name: Michael A. Tomeo, M.D.
Attention: Privacy Officer – Office Manager
Address: 1650 Huntingdon Pike, Suite 354, Meadowbrook, PA 19046
Telephone: 215-938-8771 FAX: 215-938-1121

CONSENT

I have read and understand the above Explanation of Rights prior to signing this consent.

Patient Name (please print): _____

Signature: _____ Date: _____

If Minor, relationship to patient: _____