PATIENT INFORMATION ☐ New Patient ☐ Name Change ☐ Address Change ☐ Insurance Change

ALL SECTIONS MUST BE COMPLETED FOR ALL PATIENTS: Today's Date____/____/____

Patient Name: ____
Last First Middle Initial

Date of Birth: ____/____/____ Age: _____ Social Security #: ____________________ Sex: ☐ Male ☐ Female

ADDRESS:

Mailing Address: ____
Street City State Zip

Secondary Address: ____
Street City State Zip

Home Phone: ( ) ______________ Work Phone: ( ) ______________ Cell Phone: ( ) ______________

Emergency Contact Phone: ( ) ______________ Email Address: ______________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Occupation: ____

Primary Care Physician: ______________________ Referred by: ______________________

PARENT OR RESPONSIBLE PARTY (if different from patient)

Name: ____
Last First Middle Initial

Address: ____
Street City State Zip

Home Phone: ( ) ______________ Work Phone: ( ) ______________ Cell Phone: ( ) ______________

Date of Birth: ____/____/____ Age: _____ Social Security #: ____________________ Sex: ☐ Male ☐ Female

INSURANCE COVERAGE – PRIMARY HOLDER INFORMATION

Insurance Co. Name: ______________________ Phone: ( ) ______________ Ext: _____

Address of Claim Center: ____

City, State, Zip: ____

Policy Type: ☐ HMO ☐ PPO Policy #: ______________________ Group Name or #: ______________________

Name Policy Holder (Insured): ______________________ Date of Birth: ____/____/____ Social Security #: ______________

Address: ____
Street City State Zip

Check relationship: ☐ Mother ☐ Father ☐ Other______________________ Sex: ☐ Male ☐ Female
Identify

INSURANCE COVERAGE – SECONDARY

Insurance Co. Name: ______________________ Phone: ( ) ______________ Ext: _____

Address of Claim Center: ____

City, State, Zip: ____

Policy Type: ☐ HMO ☐ PPO Policy #: ______________________ Group Name or #: ______________________

Policy Holder (Insured): ______________________ Date of Birth: ____/____/____ Social Security #: ______________

Address: ____
Street City State Zip

ATTACH A COPY OF PATIENT'S INSURANCE CARD (BOTH SIDES)

DERMATOLOGY OF THE BERKSHIRES, P.C.

VICTORIA R. CAVALLI, M.D.

PATIENT NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be disclosed. Please review it carefully.

Dermatology of the Berkshires, P.C. will use your medical information for the following:

1. TREATMENT: Including providing your medical records to consulting clinicians and insurance companies.

2. PAYMENT: We will file necessary claims to insurance companies in your name to obtain payment. They may request part or all of your medical record to pay the claim.

3. HEALTH CARE OPERATIONS: Any others involved in your healthcare.

The entire PRIVATE POLICY NOTICE of Dermatology of the Berkshires, P.C. is posted in the waiting room for your perusal.

In conjunction with these privacy practices you will need to provide us with the following information:

1. Name of person(s) we may speak to regarding your health (i.e. spouse, child, etc. including phone number.)

   ____

   ____

2. May we leave a message regarding your health or an upcoming appointment on your answering machine?

   YES ____________ NO ____________

Signature of Patient or Legal Guardian	Relationship to Patient
Print Patient's Name or Legal Guardian	Patient's Date of Birth
Witness	Date

REFERRAL INFORMATION
PATIENT FINANCIAL POLICY AND SIGNATURE ON FILE

Patient Name: ____Date: ________________
Other family members that are patients: ____
Referred by: _______________________________________ Primary Care Physician: ______________________
Primary Physician Address: ____
Pharmacy of choice: ____ Phone: ________________________
In case of Emergency, who should be notified? ________________________ Phone: ________________________

RELEASE OF INFORMATION:

I authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of medical benefits to the physician.

Patient or Responsible Party Signature _______________________________________ Date: _________________

PAYMENT POLICY:

In order to establish optimal relations with our patients and avoid misunderstanding and confusion regarding our payment policies, our staff is trained to consistently inform you of the financial payment policies of this office. Payment is required for all services at the time they are rendered unless you are in a prepaid plan in which we participate. For those patients, applicable copayments and deductibles will be collected. We accept payment in the form of cash, check or credit card. In the event of hospitalization or major procedures, our office may file with the appropriate insurance. However, before such claims are filed, coverage will be preverified and you will be asked to pay any unmet deductible, non-covered services and copayments. In the event that your account must be turned over to collections, a $20.00 collection fee will be added to your account. Your signature below signifies your understanding and willingness to comply with this policy.

Patient or Responsible Party Signature ____ Date: ________________

MEDICARE PATIENTS ONLY:

This office is required to keep your signature on file authorizing us to file claims to Medicare for you and to release information to that payor if they require it for the proper consideration of a claim. Please read and sign the following statement:

I authorize any holder of medical or other information about me to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

Signature as it appears on Medicare Card ____ Date ______________

If you have a supplemental policy and it is a MEDIGAP policy which your Medicare carrier automatically "crosses over", we are required to keep a separate signature on file:

I request the authorized MEDIGAP benefits to be made on my behalf for any services furnished to me. I authorize any holder of medical information to release to the above MEDIGAP carrier any information needed to determine those benefits or the benefits payable for related services.

Signature as it appears on MEDIGAP Card _______________________________________ Date ______________

Thank you for choosing this office to assist in caring for your skin.

DERMATOLOGY OF THE BERKSHIRES, P.C.

VICTORIA R. CAVALLI, M.D.

40 Main Street · North Adams, MA 01247 · (413)663-6769

69 Union Street · Manchester, VT 05254 · (802) 362-0653

Patient Name: ______________________________________ DOB: _____________________

INSURANCE INFORMATION

Thank you for choosing Dermatology of the Berkshires, P.C. for your health care needs. Along with providing you with quality service, Dermatology of the Berkshires, P.C. would also like to assist you with your billing needs. Please read the provisions below and mark the billing class that represents you:

____1. Medicare only. Dermatology of the Berkshires, P.C. will file Medicare for you. Dermatology of the Berkshires, P.C. accepts assignment; however, you will still be responsible for the 20% that Medicare does not cover.

____2. Medicare/Supplement. Dermatology of the Berkshires, P.C. will file both insurances. However, claims denied, rejected or partially paid by your supplement carrier will be your responsibility in 30 days.

____3. HMO. Dermatology of the Berkshires, P.C. will file to your insurance carrier. It will be your responsibility to obtain the necessary authorization by your primary care physician. Visits not authorized will be your responsibility. You will be responsible for your copayment.

____4. PPO. Dermatology of the Berkshires, P.C. will file to your insurance carrier. You will be responsible for any coinsurance, copayments and deductibles. Patients going out of their network will be responsible for the payment at a higher rate.

____5. Self-Pay. Payment is due at the time services are rendered unless prior arrangements have been made. Dermatology of the Berkshires, P.C. will accept cash, checks, Visa and MasterCard.

Monthly statements will be sent to advise patients as to the status of their account.

I understand the billing procedures of Dermatology of the Berkshires, P.C. and agree to pay any balances that are my responsibility. Balances unpaid will result in collection actions.

***You will also be billed by the laboratory for any procedures involving pathological evaluation.

Signature: ____ Date: __________________

Witness: ____

Dermatology of the Berkshires, P.C.

Victoria R. Cavalli, M.D.

40 Main Street · North Adams, MA 01247 · (413)663-6769

MEDICAL INFORMATION SHEET

Name: ______________________________________ DOB: ___________ Age: ________ Date: ___________

Primary Care Physician: ____

Reason for dermatology visit: ____

Do you have a current history or past history of any of the following medical conditions? Check any that apply.

□Heart disease	□High blood pressure	□Lung disease	□Liver disease	□Arthritis
□Kidney disease	□Peptic ulcers	□Diabetes	□Eye diseases	□Cancer
□Depression	□Anxiety	□Blood	□Autoimmune	□Lymph disease

Other: ____

Have you ever tested positive for Hepatitis, HIV, Tuberculosis or Syphilis? ______________________________

Please list any surgeries with approximate dates: ____

____

What prescription medications, over-the-counter remedies, herbal or dietary supplements do you take? _______

____

Are you allergic to any drugs? __________ If yes, please list: ____

Occupation: _____________________________________ Hobbies: __________________________________

Do any diseases run in your family (skin cancer, eczema, asthma, hay fever, psoriasis)? ___________________

____

Do you smoke tobacco? __________ If so, how much? ____

Do you drink alcohol? ___________ If so, how much? ____

For women: Are you pregnant or nursing? _____________

Date of your last period: _________________

Please inform the doctor if you plan to or become pregnant during treatment.

I have come to this office for evaluation of a skin condition and give permission for examination and treatment by Victoria Cavalli, M.D. and/or Amy Gumprecht, PA-C.

Signature: ____ Date: _____________________________