

Clear Skin Dermatology & Cosmetic Surgery

Welcome To Our Practice!

Rany Jazayerli, M.D.

Jennifer Cunningham, PA-C

Main office: (630) 443-8855

Welcome! We are here to serve you, and we hope that you will be completely satisfied and comfortable with your visit to Clear Skin Dermatology. We ask that if you have any questions regarding your visit, treatment, procedures or bill for services that you let us know as soon as possible so that we can address your questions/concerns promptly. Listed below are some of our policies and procedures.

Insurance / Payment for Services

- CSD is contracted with most PPO/POS/EPO plans as well as Medicare, CSD is considered a specialist.
- CSD is currently closed to Medicaid.
- Office visit co-pays are due at the time of each office visit. We do not send statements for co-pays.
- In most of our visits, there will be an office visit charge which is a review of your medical history and medications. For those services that we know to be non-covered services, we will review the cost and procedure with you. Prior to performing the non covered service, payment in full will be expected. Please note this cost is for the actual procedure performed and does not include the office visit charge.
- Lesion removals: Whether your lesion is surgically removed or removed with cryotherapy or cantharadin, these procedures fall under your surgery benefits. Please check with your insurance for your surgery benefits, they differ for each insurance plan. CSD does not pre-certify procedures but upon request we will give you an estimate of what the charges will be. We will not be able to determine how your insurance will process the claim until it is actually submitted.
- Balances due: Claims are submitted promptly and resolved within 1-2 weeks. You will receive statements once your insurance has processed the claim. Payment for services rendered is expected upon receipt of statement. If you are having difficulty paying your bill, please contact our office or billing office to set up payment arrangements. Accounts that are sent to collection may be dismissed from the practice.
- In cases of divorce: The parent who brings the child is considered the Guarantor. They have accepted responsibility for the child and their charges. The statements will be sent to the guarantor. It is expected that in the case of divorce the 2 parties will handle payment arrangements without the involvement of the office.

Appointments

- At CSD, we offer a variety of hours and try to schedule appointments at your convenience. Therefore, we require **48-hour notice** for cancellation of surgery appointments, and **24-hour notice** for cancellation of all other appointments. We reserve the right to charge a fee for any missed appointments. As a courtesy, our office makes reminder phone calls (for appointments made 4+ days prior).
- Late arrivals: We ask if you are going to be late, that you call the office first. If it is more than 15 minutes, we may have to reschedule your appointment. Our office respects your time and arranges the schedule so wait times are a minimal. Please be respectful of our time and others at the office by arriving promptly and prepared.
- Parents must accompany children for their initial visit. This is for your child's safety. Teens + children must have a current minor consent form on file (see website) to be seen without a parent. The appointment will be cancelled if they arrive with a sibling or alone and no consent form is on file.

Prescription Refills

Prescription refill requests should be called during our regular business hours, and at least **48 hours** in advance of needing the prescription refilled. Our office electronically files prescriptions to most local pharmacies. If your pharmacy does not participate in e-prescription, please let our staff know so a phone call or print out of the prescription can be made.

For any medical emergencies, please call **911** or go to the nearest urgent care or hospital **emergency room**. For routine questions, please call our office during regular business hours and ask for the medical assistant **line x14**. During office hours you may need to leave a detailed message. All calls will be returned within 24-48 hrs, or sooner if possible.

Our offices

Main office: 2560 Foxfield Rd. Suite 100 ♦ St Charles, IL 60174
Phone: 630-443-8855 Fax: 630-443-8866

Darien 2861 83rd Street ♦ Darien, IL 60561
Darien phone: 630-985-1188

Sycamore: 1830 Mediterranean Drive ♦ Sycamore, IL 60178
Sycamore phone: 815-895-9100

I. Patient Information

Legal Name:(Last) _____ (First) _____ (MI) _____

Birthdate: ____ / ____ / ____ SSN: _____ Sex: Male Female
MM / DD /YYYY

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ WorkPhone: _____

Email: _____ Referred by a physician? Y Name: _____

In Case Of Emergency Call:

Name: _____ Phone: _____ Relationship(M/F) _____

Electronic Health Record reporting as requested by the Government

Ethnicity: Latino/Hispanic Other **Do not want to report**

Race: American Indian or Alaskan Native Asian Asian Pacific American Black
 Black Non-Hispanic Caucasian Hispanic Native American Native Hawaiian
 Pacific Islander Subcontinent Asian American White Non Hispanic Other Race or Ethnicity

Preferred Language: _____

II. Guarantor Information (Parent or person responsible for account)

Legal Name: _____ Social Security No: _____

Relationship to Pt: _____ Birthdate: _____ Sex: Male Female

Address: _____ City/State/Zip: _____

Home Phone: _____ Cell Phone: _____ WorkPhone: _____

III. Primary Insurance Information

Policy Holder Name: _____ Birthdate: _____ Relationship to patient: _____

Insurance Name: _____ **A copy of your insurance card will be taken at the office.

Employer: _____

IV. Secondary Insurance Information

Policy Holder Name: _____ Birthdate: _____ Relationship to patient: _____

Insurance Name: _____ **A copy of your insurance card will be taken at the office.

Employer: _____

V. How did you hear about us? (We'd like to thank who referred you) _____

I have reviewed the above registration information and find it to be correct. _____

(Signature / Date)

ASSIGNMENT OF BENEFITS

**West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology
Rany Jazayerli, M.D.
Jennifer Cunningham, PA-C.**

CONSENT FOR TREATMENT, RELEASE, ASSIGNMENTS AND FINANCIAL AGREEMENT:

I hereby voluntarily consent to care encompassing routine diagnostic procedures and medical treatment authorized by Dr. Jazayerli. I authorize any holder of medical or other information about me to release any information needed to process my insurance claims and to permit a copy of this authorization to be used in place of the original.

I authorize payment of medical benefits to West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology. I absolutely and unconditionally guarantee payment in full for clinical services rendered to me by West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology whether or not paid by insurance. **Please note that in the case of divorce; payment is expected from the parent/guardian who is with the patient. Parents/guardians are expected to work out payment arrangements with each other and not involve WSD/CSD in any disputes.

Signature

Date

MEDICARE PATIENTS ONLY:

**STATEMENT TO PERMIT PAYMENT OF MEDICARE BENEFITS TO
PROVIDER, PHYSICIANS, AND PATIENTS**

I request that payments of authorized Medicare benefits be made either to me or on my behalf for any services furnished to me by or in West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology, including my physician services. I authorize any holder of medical or other information about me 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.

Signature

Date

Printed Name

Medicare Number (HICN)

MEDIGAP

I request that payment of authorized MediGap benefits be made either to me or on my behalf to West Suburban Dermatology & Cosmetic Surgery / Clear Skin Dermatology for any services furnished to me by my physician. I authorize any holder of medical or other information about me to release to _____ (Name of Secondary) any information to determine these benefits or the benefits payable for related services.

Signature

Date

Patient Name: <i>(Please Print)</i>			Date of Birth: <i>(mm/dd/yyyy)</i>		
	Reason for Visit	How long have symptoms persisted?	Does anything make the condition better or worse?	Medications used ? (Rx and OTC)	Did they Help?

Would you like the provider to conduct a full skin exam? Yes No

Current Medications: (If you have more than 4 medications, please list all on the back of this page)

Name of Medication	Why are you taking it?	Dosage (Mg, Gm)	Directions: Take _ pills _ time(s) a day

Allergies:

What do you have an allergy to?	What is your reaction if you come in contact with it?

Past Medical History of Patient:

- | | |
|---|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Psoriasis | <input type="checkbox"/> Yes <input type="checkbox"/> No Diabetes |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Eczema | <input type="checkbox"/> Yes <input type="checkbox"/> No Hypertension |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Skin Cancer | <input type="checkbox"/> Yes <input type="checkbox"/> No Cancer |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other Skin disease_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No High Cholesterol |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Tobacco history (how often)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Drug history (how often)_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Alcohol history (how often)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Other history_____ |
- Prior Surgeries (year): _____

Past Family History of Skin Disease:

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Mother_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Father_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Siblings_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Grandparent_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Other (relation):_____ | |

Are you currently experiencing (or within the past week experienced):

- | | | |
|---|--|--|
| <input type="checkbox"/> Yes <input type="checkbox"/> No Fever | <input type="checkbox"/> Yes <input type="checkbox"/> No Chills | <input type="checkbox"/> Yes <input type="checkbox"/> No Shortness of Breath |
| <input type="checkbox"/> Yes <input type="checkbox"/> No Chest Pain | <input type="checkbox"/> Yes <input type="checkbox"/> No Nausea/Vomiting | <input type="checkbox"/> Yes <input type="checkbox"/> No Other_____ |

Current Pharmacy: (Our office sends electronic prescriptions to your pharmacy. Please fill out completely to ensure accuracy)

Name: _____ Phone: _____
 Address: _____

Referral

Were you referred to our office by...

- | | |
|---|---|
| <input type="checkbox"/> Yes <input type="checkbox"/> No a physician? (Whom)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No An Advertisement?_____ |
| <input type="checkbox"/> Yes <input type="checkbox"/> No a friend? (Whom)_____ | <input type="checkbox"/> Yes <input type="checkbox"/> No Online search?_____ |

CLEAR SKIN DERMATOLOGY & COSMETIC SURGERY
Request to Receive Confidential Communications of Protected Health Information

As stated in our Notice of Privacy Practices, you may request that we communicate confidential health information to you by alternative means or in alternative locations. The Privacy Rule requires us to accommodate requests if reasonable. Please indicate your request regarding communication below and answer ALL the questions listed. If it does not apply, please mark the NA field.

Patient Name: _____ Today's Date; _____ Account# _____

Home Phone: _____ Cell Phone: _____ Work Phone: _____

APPOINTMENTS AND BILLING INFORMATION

- Leave message on my home answering machine. Yes No NA
- Leave message with persons at my home. Yes No NA
- Call me on my cell phone. Yes No NA
- Leave message on my cell phone voice mail. Yes No NA
- Contact me at my work. Yes No NA
 If yes, OK to leave a message? Yes No

CONFIDENTIAL INFORMATION (including results, medical information)

- Contact me at my home. Yes No NA
- Leave message on my home answering machine. Yes No NA
- Leave message with persons at my home. Yes No NA
- Call me on my cell phone. Yes No NA
- Leave message on my cell phone voice mail. Yes No NA
- Contact me at my work. Yes No NA
 If yes, OK to leave a message? Yes No

➤ Do you have a Medical Power of Attorney Assigned? Yes No **If YES, please provide us with a copy**

➤ Do you want a family member to have access to your personal health information (spouse, parent, child)? If so, please list their name and relationship to you.

Name: _____ Relationship: _____

➤ Can we send sealed confidential information to your home address? Yes No

If NO, list another address _____

➤ Other requests for confidential communications: _____

Patient Receipt of Notice of Privacy Practices
I have received the Notice of Privacy Practices from my physician

Patient (if >18years old) or Parent **Signature**

Date