PLEASE COMPLETE THE FOLLOWING DEMOGRAPHIC INFORMATION:

Patient's Full Name AS IT APPEARS ON THE INSURANCE CARD:

First _____M.I. _____ Last _____

Biologic Sex (please circle): M F Preferred Gender Identity (please circle) M F

Date of Birth _____ Social Security Number _____

Race _____ Language _____

Home Address _____

City _____ State _____ Zip Code _____

Home Phone ( ) _____ Work Phone ( ) _____

Cell Phone ( ) _____ Cell Phone Company _____

Would you like to receive appointment reminders on your cell phone vis text messaging? If yes, please provide us with your cell phone company above. (please circle) yes no

email address _____
This email address will be used only to send you a link to join our online Patient Portal.

Referring/Primary Care Physician _____

Name of Responsible Party/Guarantor _____

Guarantor's Place of Employment _____

Date of Birth of Guarantor _____ Relation to Patient _____

Address of Guarantor _____

City _____ State _____ Zip Code _____

Dermatology Associates of Erie
Pediatric Dermatology Initial History Questionnaire

Name _____

Date of Birth _____

Form Completed By _____ Age _____ Male/ Female_____

Date _____

Household

Please list all persons living in the child's home.

Name	Relationship	Age	Health Problems

Past History

Has the new patient ever had any of the following conditions?

	Yes	No	Explain
Allergies			
Asthma			
Anemia			
Bleeding Problem			
Cancer			
Crohn's Disease			
Depression			
Early Puberty			
Eczema			
Headaches			
Heart Problems			
Kidney Problems			
Muscle Weakness			
Seizures			
Skin Infections			
Thyroid Disease			
Other (Specify)			

Biological Family History

Have any family members had any of the following conditions?

	Yes	No	Who?
Acne			
Anemia			
Allergies			
Arthritis			
Asthma			
Basal Cell Cancer			
Bleeding Problems			
Blood Clots/Stroke			
Celiac Disease			
Crohn's Disease			
Depression			
Early Puberty			
Eczema			
Hair Loss			
Lupus			
Melanoma			
Muscle Weakness			
Pre Cancer Moles			
Psoriasis			
Squamous Cell Cancer			
Skin Infections			
Thyroid Disease			
Other (Specify)			

I have read & reviewed the above history. Date.

PEDIATRIC DERMATOLOGY ASSOCIATES OF ERIE
CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS (TPO)

I. CONSENT TO TREATMENT This consent cannot be modified. Any handwritten changes to the form shall not be legally binding or enforceable.

1. I, _____ (print name) on behalf of _____ (patient name and relationship) consent to the provision of treatment that may include diagnostic procedures and medical treatment which Dr. Wendy Ripple or her authorized agent of Pediatric Dermatology Associates of Erie may consider necessary or advisable. I understand that special consent forms may need to be signed for specific procedures. If I have a religious, or other, objection to specific care to be provided, I may ask Dr. Ripple not to provide such care.

2. I understand that my/my child's care may include examinations and diagnostic tests including, but not limited to skin biopsies, medical treatment, and taking photographs that may be used for my/my child's care as well as for health care operation purposes.

3. I understand and agree that others, under the direction of the physician, may assist or participate in providing medical care to me/my child. These people may include but are not limited to physician assistants and certified nurse practitioners.

4. I give Pediatric Dermatology Associates of Erie LLC and its designees permission to use my/my child's information as described in the Pediatric Dermatology Associates of Erie Notice of Privacy Practices.

5. If applicable, I give Pediatric Dermatology Associates of Erie permission to properly dispose of any specimen/tissue (such as skin tags, warts, etc.) taken from my body/my child's body. Once disposed of, these specimens/tissues cannot be retrieved. I understand that these specimens/tissues will never be used for research or any other purposes.

6. I acknowledge that no guarantees have been given to me/my child as to the outcome of any examination or treatment.

III. RECEIPT OF NOTICE OF PRIVACY PRACTICE/RELEASE OF INFORMATION

1. I have been offered/provided the Pediatric Dermatology Associates of Erie Notice of Privacy Practices, which may have been provided to me during a previous visit and are available as individual copies, in the waiting room Policy Binders, and on the PDAE website at PDAErie.com. _____ Patient/Parent Initials **(required)**

2. I consent to access by Dermatology Associates of Erie (including their physicians, physician assistants, and certified nurse practitioners) to my medical or other information/my child's medical or other information related to my/my child's treatment and/or services for the purpose of on call coverage and treatment. I consent to Pediatric Dermatology Associates of Erie providing such information to my/my child's primary care physician and other physicians as necessary for referral, consultation, treatment to me/my child. However, my specific consent to release behavioral health information will be obtained as required by law.

3. I understand that I may be contacted my Pediatric Dermatology Associates of Erie by cellular phone, which may include the use of prerecorded/artificial voice messages, and/or an automated dialing

device or by text message or e-mail in connection with any communication made to me/my child or related to my appointments and accounts. _____ Patient/Parent Initials **(required)**

4. I understand that my information/my child's information may be released if required by local, state or federal law.

5. I authorize PDAE to leave confidential messages such as appointment reminders and normal test results via the following methods **(please check all that apply)**:
   - ☐ Correspondence may be sent to my attention in sealed envelope marked "Confidential."
   - ☐ Confidential messages such as appointment reminders, normal test results may be left on my home answering machine or voicemail.
   - ☐ Confidential messages such as appointment reminders, normal test results may be left on my work voicemail.
   - ☐ Confidential messages such as appointment reminders, normal test results may be left on my cell phone voicemail.
   - ☐ Appointment reminders may be texted to my cell phone.

6. Please list all of those individuals to whom you authorize PDAE to disclose personal health information, such as spouse, family members, friends, and other caregivers, as necessary for your/ your child's continuous healthcare services.

_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Name	Phone Number	Relationship to Patient
_____	_____	_____
Name	Phone Number	Relationship to Patient

IV. FINANCIAL POLICY and ARRANGEMENTS

I agree to the following terms related to payment for services provided by Pediatric Dermatology Associates of Erie LLC.

1. I understand that it is my responsibility as guarantor, or the person responsible for patient of an account and the individual that gives consent for treatment, to know the coverage and limitations of my/my child's health insurance coverage. It is my responsibility to verify that my/my child's care provided by the service of Wendy Ripple, MD and/or her associates at PDAE, will be covered benefits under the existing insurance policy, I acknowledge that it is NOT the responsibility of PDAE to verify insurance coverage for any visit and/or procedure. **I understand that if services rendered are NOT covered by my/my child's insurance, I am fully responsible for payment of all uncovered charges.** _____ Patient/Parent Initials **(required)**

2. I understand that any amounts not paid by my insurance are my responsibility, including, but not limited to copays, co-insurance, and/or deductibles. **I understand and agree that I am responsible for payment of the copayment at the time of service. I understand that a $5.00 billing fee will be applied to my account if the copay is NOT paid at the time of the appointment.** _____ Patient/Parent Initials **(required)**

3. I understand that the amounts of my deductible and/or co-insurance, when applicable, may not be known at the time of service and will be billed to me after the claim is processed by me insurance company, and that I am responsible for the payment of this balance. **I understand that failure to pay any balance within 60 days of service will result in a $25 administrative fee applied to my account.** _____ Patient/Parent Initials **(required)**

4. I understand and agree that I must bring my/my child's insurance card to **EVERY APPOINTMENT**. Without an insurance card, PDAE has no way to bill the insurance company or to recognize changes to the carrier or policy. **I understand that if I arrive for an appointment without an insurance card, I will be asked to PAY THE FULL AMOUNT of the charges for the appointment which are due AT THE TIME OF SERVICE, or TO RESCHEDULE.** _____ Patient/Parent Initials **(required)**

5. I understand that PDAE accepts cash, personal checks, Master Card, Visa, American Express and Discover for payment of services. Cash and personal checks are preferred. **Due to escalating administrative costs, a $2.00 service charge will be added to all credit, debit and other card transactions, including FLEX spending accounts.** Likewise, for **checks returned for insufficient funds, a $25.00 fee will be added to any account balance, as permitted by the state of Pennsylvania. Payment for insufficient fund check is to be made within 14 days** of the check return, and must be paid in cash or by credit. _____ Patient/Parent Initials **(required)**

6. At PDAE we understand that sometimes appointments will need to be cancelled or rescheduled due to illness, school responsibilities, or other unforeseen events, However, missed appointments represent a cost to us. Due to the high demand for pediatric dermatology appointments, I understand that all cancellations must be made 24 hours in advance of the scheduled appointment. **PDAE reserves the right to charge a $50 fee for all missed appointments that are not cancelled at least 24 hours in advance of the scheduled appointment time**. Furthermore, I understand that PDAE reserves the right to dismiss from the practice patients/families who reschedule, cancel or fail to show up for three or more scheduled appointments. _____ Patient/Parent Initials **(required)**

7. Families experiencing financial difficulties can contact Leah Motzing, office manager, to discuss financial assistance and payment arrangements.

8. I authorize Pediatric Dermatology Associates of Erie LLC to bill my insurance carrier and request such payments to be made directly to Pediatric Dermatology Associates of Erie LLC. I certify that the information I have given about my insurance coverage or other payment sources is correct.

9. I assign to Pediatric Dermatology Associates of Erie LLC all rights to insurance payments or benefits to which I may be entitled for services provided to me/my child by Pediatric Dermatology Associates of Erie LLC. I also authorize submission of a claim for payment on my behalf/my child's behalf to my insurance carrier. I authorize Pediatric Dermatology Associates of Erie to act on my behalf and as my representative to request reconsideration (internal and/or external review process) by my/my child's managed care plan or utilization review entity for coverage or grievance review.

10. I authorize Pediatric Dermatology Associates of Erie to release any medical or other information about provided services by them, or services provided by third parties, if required to obtain payment from my insurer or other payer or their agents. I also authorize Pediatric Dermatology Associates of Erie to release medical or other information required by my insurer, other payers and their agents, government agencies or their designees for review of the care provided to me.

11. If I choose to pay for certain services out of pocket and exercise my right to limit disclosure of the information to my payer regarding those services, I understand that a separate financial agreement

will be put into place regarding the self-pay services and this section will not apply to such services. I also agree that all self-pay payments are due in full at the time that the service is performed.

V. AGREEMENT TO MEDIATE CLAIMS

I agree that any claim which may result from the care provided to me by the doctor and other health care providers at Pediatric Dermatology Associates of Erie shall be subject to the laws of Pennsylvania. I also agree that before any lawsuit is filed related to the care provided to me, I must attempt to resolve any claim through mediation, which must take place in the Commonwealth of Pennsylvania. I am not waiving my right to a jury trial. Mediation is a process in which a neutral third person tries to settle a claim. This agreement is binding on me and any person making a claim on my behalf. _____ Patient/Parent Initials **(required)**

MINOR ABLE TO CONSENT FOR CARE (IF APPLICABLE)

I am under 18 years of age and for the following reason(s) _____.
I am entitled under Pennsylvania Law to consent to medical services for myself, and if applicable, for my minor children without the consent of any other person. _____ Patient/Parent Initials **(required)**

My signature below attests that I have read this Authorization/Consent for Treatment, Payment and Health Care Operations form or have had it read to me, and it has been explained to my satisfaction and I agree to all conditions therein contained. I understand the consent for treatment. I understand the HIPAA Privacy Policy. I understand all financial policies and I understand that it is my responsibility for payment for all medical treatment provided by Pediatric Dermatology Associates of Erie regardless of coverage provided by the insurance carrier; this includes, but is not limited to, copayments, deductible, billing and administrative fees for untimely payments and insufficient fund checks, and/or services that are not covered by my insurance. I understand that this consent for Treatment, Payment and Health Care Operations form is valid until I withdraw my consent by written notification to Pediatric Dermatology Associates of Erie.

Patient/Parent/Guardian Signature	Date	Time	Signature of PDAE Representative
Relationship to Patient	Date	Time	Signature of PDAE Representative

ATTENTION: If you are OVER 18, but still on your parents' insurance, you MUST HAVE YOUR PARENTS complete and sign this agreement.