L. WILLIAM NOWIERSKI, M.D., P.A.

FINANCIAL POLICY

Dr. Nowierski does not contract with every insurance plan. It is the patient's responsibility to understand their policy and Insurance benefits. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by your insurance. If your insurance has not paid in full within sixty days of billing, we will require the balance to be paid by you by cash, check or credit card.

PAYMENT IN FULL OR CO-PAYMENT IS DUE IN FULL AT TIME OF SERVICE UNLESS PRIOR ARRANGEMENTS ARE MADE THROUGH OUR BUSINESS OFFICE. We accept cash, check, Visa or Master Card. Interest will be charged on accounts with balances over 90 days at the rate of 1.5% monthly.

We do not accept Worker's Compensation patients.

MEDICARE PATIENTS: We do not accept assignment on Traditional Medicare. We submit all Medicare claims and any payment will be made to the insured.

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 benefits to which I am entitled including private insurance and other health plans to L. William Nowierski, M.D., P.A.. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I hereby authorize L. William Nowierski, M.D., P.A., to appeal any incorrect insurance payment. I release L. William Nowierski, M.D., P.A., from all legal responsibility or liability that may arise from this authorization.

I AGREE TO THE ASSIGNMENTS AND ACKNOWLEDGE MY FINANCIAL RESPONSIBILITIES DISCUSSED ABOVE.

X_____

Responsible Party's Signature Date

NAME _____

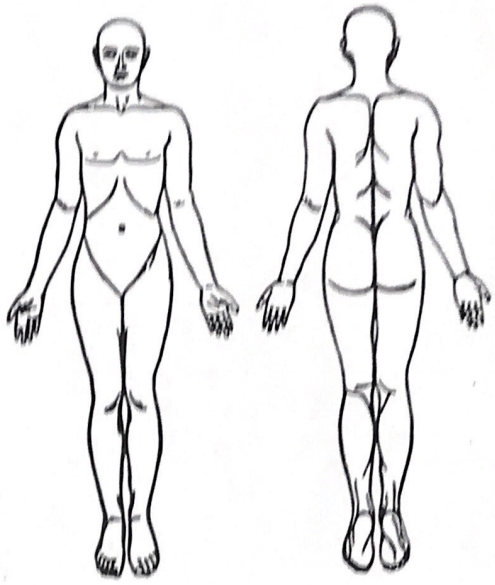
L. WILLIAM NOWIERSKI, M.D.

BRIEF MEDICAL HISTORY AND QUESTIONNAIRE (to provide you with more effective medical care)

A. What is your skin problem? (rash, growths, warts, etc.)

B. When did you first notice this skin problem?

C. Please ***draw*** on this chart where your present skin problem or rash is, by marking X's on the figure.



	YES	NO
D. Has a doctor given you anything for this skin condition? If yes, please give names of ***everything*** used.	☐	☐
E. Have you put anything else on the skin yourself? If yes, please give names of ***everything*** used.	☐	☐
F. Have you had any other skin problems? If yes, please list.	☐	☐
G. What have you treated these skin problems with?		
H. Does anyone in your family have skin problems or rashes?	☐	☐
I. Does anything ***touching*** your skin cause a rash or allergy? (jewelry, poison oak, etc.) If yes, please list.	☐	☐
J. Do you want a complete skin exam?	☐	☐

HAVE YOU EVER HAD ANY OF THE FOLLOWING?
(If yes, please explain below.)

	YES	NO
1. Heart Disease	☐	☐
Do you have a pacemaker?	☐	☐
2. High Blood Pressure	☐	☐
3. Lung Disease	☐	☐
4. Ulcers (stomach)	☐	☐
5. Liver Disease (including Hepatitis)	☐	☐
6. Chronic Infectious Disease (Syphilis, Hepatitis B, Mononucleosis, AIDS)	☐	☐
7. Kidney Disease	☐	☐
8. Diabetes	☐	☐
9. Cancer (skin or other)	☐	☐
10. Emotional Disorder	☐	☐
11. Hospital Surgery	☐	☐
12. Cold Intolerance	☐	☐
13. Glaucoma	☐	☐
14. Plastic Surgery	☐	☐
15. Arthritis	☐	☐
16. Lupus/Dermatomyositis	☐	☐
17. Anemia	☐	☐
18. Thyroid Disease	☐	☐

HAVE YOU OR ANY OF YOUR FAMILY HAD:	YES	NO
1. Asthma	☐	☐
2. Hay Fever	☐	☐
3. Hives	☐	☐
4. Hemophilia	☐	☐
5. Are you allergic to any medicines? (Penicillin, Aspirin, etc.)	☐	☐

(If yes, please list the medicine and reaction.)

HAVE YOU EVER HAD:	YES	NO
1. Excessive bleeding when cut	☐	☐
2. Difficulty with the healing of wounds	☐	☐
3. Overgrown scars (keloids)	☐	☐
4. Migration of Sutures to Surface	☐	☐
5. Surgical Wound Infection	☐	☐
6. X-ray Treatment to Your Skin	☐	☐

	YES	NO
Are you now being treated by a doctor?	☐	☐
If yes, for what? _____		
Are you taking any medicines, food supplements, or vitamins?	☐	☐
(If yes, please list all pills, medicines, or tablets you are taking.)		

Age _____ Gender: Female _____ Male _____

Occupation _____

For Females:

	YES	NO
Are you pregnant?	☐	☐
Are you taking hormone or birth control pills?	☐	☐

DATE:

REFERRING PHYSICIAN:

L. WILLIAM D NOWIERSKI, M.D.
DERMATOLOGY

PATIENT INFORMATION

DATE_____ REFERRING PHYSICIAN_____

NAME_____ DATE OF BIRTH_____
(PRINT)

ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

HOME PH (_____)_____ SOCIAL SECURITY #_____ MARITAL STATUS_____

EMPLOYER & ADDRESS_____

OCCUPATION_____ BUS. PHONE(_____)_____

SPOUSE'S NAME_____ EMPLOYER_____

OCCUPATION_____ BUS. PHONE_____

NEAREST RELATIVE NOT LIVING WITH YOU_____

ADDRESS_____ HOME PHONE(_____)_____

INSURANCE INFORMATION

MEDICARE NUMBER_____ MEDICAID NUMBER_____

PRIMARY INS. CO._____ POLICY# _____ GRP. #_____

ADDRESS:_____

SECONDARY INS. CO._____ POLICY#_____ GRP#_____

BILLING INFORMATION

PLEASE COMPLETE THE SECTION BELOW IF SOMEONE OTHER THAN THE PATIENT IS RESPONSIBLE FOR THE BILL

NAME_____ DATE OF BIRTH _____

ADDRESS_____ CITY_____ STATE_____ ZIP CODE_____

HOME PH (_____)_____ SOCIAL SECURITY #_____ RELATIONSHIP TO PATIENT _____

EMPLOYER_____ BUS. PHONE_(_____)_____

RELEASE OF BENEFITS AND INFORMATION:

I AUTHORIZE MY INSURANCE BENEFITS TO BE PAID DIRECTLY TO THE DOCTOR. I AUTHORIZE THE RELEASE OF ANY INFORMATION REQUIRED FOR A CLAIM TO BE PAID. I AM FINANCIALLY RESPONSIBLE FOR ANY BALANCE DUE REGARDLESS OF INSURANCE STATUS.

I ACKNOWLEDGE RECEIPT OF THE PRIVACY POLICIES AND PROCEDURES OF THIS PRACTICE.

SIGNATURE:_____ DATE:_____