Welcome to the Office of Dr. Lydia M. Evans

Please print all information clearly.

Patient: _____ _____ _____
Last name First name Middle Name

Home Tel. #_____ Cell #: _____

Address: _____ _____
Street City State Zip code

Date of Birth: _____ Male___ Female___ Soc. Sec. #_____

Primary Insurance: _____Policy# _____

Name of Policy Holder: _____

DOB of Policy Holder: _____ Relationship to pt: _____

Secondary Insurance_____ Policy # _____

Name of Policy Holder: _____

DOB of Policy Holder: _____ Relationship to pt: _____

Emergency contact: (If patient is a child, please list both parents/guardians)

Name: _____ Telephone#: _____

Relationship: _____

Name: _____ Telephone#: _____

Relationship: _____

Please indicate your email address if you would like to receive periodic information about

new products and services. _____

I authorize the release of any medical/other information necessary to process claims. I authorize payment of benefits directly to Dr. Lydia M. Evans for services. I understand that I am financially responsible for any balance not covered by my insurance plan. I also understand that if a referral is required and I did not supply one, that I am responsible for payment. I have been given the opportunity to read the Privacy Practices (HIPA) posted in the office.

_____ _____
Signature of Insured, Parent or Guardian Date

Medical History

Current medications:

_____
_____
_____
_____
_____
_____
_____
_____

Allergies to medications:

_____
_____
_____
_____

Are you pregnant or nursing?
Yes _____ No _____

Do you have a family history of: (circle if Yes)

Eczema Psoraisis Acne Cancer

If you have ever had a skin cancer, please describe when, what type of cancer, where was it on your body, and how it was treated:

_____
_____
_____

Have you ever been diagnosed with any of the following (please circle if yes):

Diseases of the heart, heart valve or irregular heart beat
High blood pressure
Diabetes, thyroid or other endocrine disease
Lung disease
Gastrointestinal disease (esophagus, stomach, liver, colon, etc)
Kidney or bladder disease
Hematologic disease
Neurologic disease or stroke
Psychiatric or emotional disorder
Severe infection
Cancer (please specify type)

Please list previous surgeries:

_____
_____
_____
_____

Do you take antibiotic prophylaxis prior to dental work? Yes _____ No _____

_____

Signature: Date:

Office of Lydia M Evans, M.D.

Effective 3/1/2012

Office Policy on Insurances and Payments

As a courtesy service to you, our office employs a billing service and participates with several insurance carriers. Please familiarize yourself with your insurance practices and policies.

1. If your insurance carrier requires you to pay a portion of your healthcare visits (i.e. copayment, deductible, co-insurance), we are legally required to collect these. You are required to pay your co-payment at the time of your visit.
2. If your insurance carrier requires you to have a referral to be seen in our office, you must provide a referral at time of visit, or you cannot be seen.
3. If your insurance requires you to meet an annual deductible before your healthcare is covered, you will be billed for the services rendered if you have not met your deductible.
4. You will be asked to leave a credit card number (Visa, Mastercard or HSA card) at the time of check-in. This will be held in a secured system off site until your insurances have paid their portion and notified us of your share. At that time, any remaining balance owed by you will be charged to your credit card and a copy of the charge will be mailed to you. Your credit card information will not be kept in this office or in your chart (except for the last 4 digits of your card for identification purposes only). Please note that this will not compromise your ability to dispute a charge or your insurance company's determination of payment.

I, _____ (print name clearly) authorize Lydia M. Evans M.D. to charge any outstanding balances to my credit card on file.

I have read the above and acknowledge these terms. I hereby assume all responsibility for any outstanding balances and understand that these charges will be applied to the credit card I have provided.

_____

Signature Date

Lydia M. Evans, M.D.
229 King Street
Chappaqua, NY 10514
914-238-1500

Credit Card Authorization Form

I, (Cardholder) _____ (please print clearly) authorize you to charge any balances due on my account after my insurance pays. I understand this charge is my responsibility.

Name as it appears on credit card: _____

Card Number: _____

Circle one: Visa Mastercard

Exp. Date: _____

Cardholder Billing Address: _____

_____

_____

I have read and understand the terms listed above.

_____

Signature Date

Dr. Lydia M. Evans
Office Policy & Financial Agreement

We are committed to providing you with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our office policy and financial policy are important to our professional relationship. Please ask us if you have questions about our fees, financial policy or your financial responsibility.

Patients must fill out patient information forms prior to seeing the doctor. We will need a copy of your insurance cards for our files. If you do not have it at the time of visit you will be responsible for payment at the visit. This is due to the short time frame most insurance companies have for filing a claim.

Co-Payments: By insurance policy rules we **MUST** collect your co-payment at the time of the visit (check, credit card or cash only). Should you not pay at the time of service, you will receive a statement from our billing company, and an administrative fee of $10.00 will be charged to you.

Self-Pay Patients: Payment is expected at the time of service unless other arrangements have been made prior to your visit. Should you not pay at the time of service, you will receive a statement from our billing company, and an administrative fee of $10.00 will be charged to you.

Medicare: We will submit claims. You are responsible for deductibles/co-insurance balances.

Secondary insurances: If we participate with your secondary insurance company we will send a claim to them. **However,** if we do not participate with your secondary insurance, we will not bill them for any balances; the patient will be responsible for payment to us. If the insurance company sends the check directly to us in error and you have paid the balance, we will reimburse you within a timely fashion.

Appointments: 24 hours notice would be appreciated for any cancellations.

Return Checks: There is a **$25.00** fee for all checks returned to us.

Referrals: The insurance companies which utilize referrals have become strict about their use. Referrals are being processed electronically and cannot be back dated. **This means that you must have the referral at the time of your visit or sign a waiver that you will be responsible for payment.**

Please be aware that most insurance companies have a 45 to 90 day filing period for claims. If we are not notified of any changes at the time of service (e.g., new insurance company, subscriber ID numbers, group numbers etc.), and the time limit has past for filing of your claim, you will be responsible for all balances not paid by your insurance company. There is a $.75 cents per page charge for copies of medical record.

You are responsible for the timely payment of balances. Should it become necessary for us to use an outside agency to collect payment from you, you will be responsible for any additionally charges that may occur. Also, it is your responsibility to notify us as soon as possible of any insurance plan changes or home address information etc.

Patient Name: _____

_____

Signature of patient, parent or guardian Date:

Dr. Lydia M. Evans
229 King St.
Chappaqua, N.Y. 10514
914-238-1500

I, _____ (please print clearly) request that payment of authorized Medicare benefits be made on my behalf to Dr. Lydia M. Evans for services furnished to me by the provider. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

_____

Patient Signature Date