skc DERMATOLOGY

TELEHEALTH INSTRUCTIONS

We are looking forward to scheduling your telehealth visit with Dr. Chun! This page will explain how to complete your documents to get your visit scheduled.

- ☐ You should have received an email called "Patient Portal".
- ☐ Verify the email address and create a password you will remember.
- ☐ The email address is your username.

STEP 1: Completing the registration and health history information:

- ☐ Enter the portal – once you are in, you will see your name in the top left side of the screen
- ☐ Click on "My Health" and you will be taken to the Contact Info screen.
- ☐ Complete all fields, scrolling to the bottom and click Save and Continue
- ☐ Click save and continue- we will enter your pharmacy information at the visit
- ☐ Click save and continue on the next page- we will enter your medications at the visit
- ☐ Add any allergies and the reaction you had – click save and continue
- ☐ Enter medical, social and family history on the following pages – click save and continue to move to the next page.
- ☐ When you have completed the Family History page, you are finished in the portal.

STEP 2: PRINT THIS DOCUMENT FOR ADDITIONAL SIGNATURE PAGES

INSURANCE INFORMATION

- ☐ Please complete all fields and all signature lines. .
- ☐ Please make sure the GUARANTOR INFORMATION on the registration page is complete- this is asking WHO the insurance policy is under – name, date of birth and relationship is needed to submit your claim.
- ☐ Please take a photo or make a copy of the front and back of your insurance card/ cards
- ☐ Please take a photo or make a copy of your drivers license or other photo ID

FORMS TO SIGN

- ☐ Please be sure to review, complete and sign all pages.

STEP 3: SEND INFORMATION TO THE OFFICE

- ☐ Scan your completed paperwork, insurance card and photo ID pages into your computer and label them SKC registration and Insurance cards
- ☐ From the portal, click "Messages"
- ☐ Click "Compose Message"
- ☐ Click "Choose Recipient" and a drop-down menu will appear
- ☐ Select "Telehealth Registration"
- ☐ Subject line type "Telehealth Visit info"
- ☐ Please indicate the patient name, and best number to reach you in order to schedule your telehealth visit.
- ☐ Scroll to the bottom and click " Add attachments"
- ☐ Double click on the saved paperwork you completed to upload the paperwork to the email
- ☐ Double click on the insurance cards/ drivers license to upload them to the email
- ☐ Click "Send" and all of your documents will be sent through a HIPAA secure portal to our office.

STEP 4; YOUR APPOINTMENT

Scheduling

- ☐ We will contact you to schedule your appointment within 24 business hours of receiving your registration documents.

Day of Your Appointment

- ☐ Dr. Chun will contact you through either Face time or Zoom. Your preference has been indicated in the email we sent to you.
- ☐ As with office appointments, the amount of time a patient requires is sometimes unpredictable and may cause a brief delay in remaining on time. Please give Dr. Chun 15 minutes of wait time before contacting the office regarding a delayed telehealth call. We apologize for any inconvenience.
- ☐ If you have not used these formats before, you may need to download it or create an account.
- ☐ Please make sure you do this before your appointment as it may take several minutes.
- ☐ If you have not heard from Dr. Chun within 30 minutes of your scheduled time, please contact our office.

Please call the office with any questions you may have at 201-879-0303

Paperwork to Print and complete is below

PATIENT INFORMATION

PATIENT NAME:____**D.O.B:** ____________________________

Pharmacy Name: ________________________________ Town: _____________________________________

Primary Doctor Name: ____________________________ Town: _____________________________________

Phone#:______________________________________

Referring Physician ______________________________ Town: ______________________________________

Phone#:____________________________________

New Patients: How did you hear about SKC Dermatology? ____

Primary Insurance Plan:____

Primary Insurance Plan Holder's Name:__________________________________ DOB:___________________________

Relationship to patient:____

Mailing address of Plan Holder if different from patient: ____

____

Home Phone of Plan Holder: _____________________________Cell phone of Plan holder:________________________

Secondary Insurance Plan:____

Secondary Insurance Plan Holder's Name:__________________________________ DOB:______________________

Relationship to patient:____

4 Forest Avenue Suite 205, Paramus, NJ 07652 | Office: (201) 879-0303 | Fax: (201) 880-6369
Email: infor@skcdermatology.com | www.skcdermatology.com

TELEMEDICINE CONSENT/ REFUSAL FORM

PATIENT NAME:____**D.O.B:** ____________________

PURPOSE: The purpose of this form is to obtain your consent to participate in a telemedicine consultation in connection with the following medical services:
TELEDERMATOLOGY services with Dr. Sunny K. Chun is for consultation, evaluation, treatment and management of dermatological conditions.

1. NATURE OF TELEMEDICINE CONSULT: During the telemedicine consultation:
   - Details of your medical history, examinations, x-rays, and test will be discussed with other health professionals through the use of interactive video, audio, and telecommunication technology.
   - A physical examination of you may take place.
   - Video, audio and/or photo recordings may be taken of you during the services.
   - In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s).
2. MEDICAL INFORMATION & RECORDS:
   - All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine consultations.
   - Please note, not all telecommunications are recorded and stored. Additionally, dissemination of any patient-identifiable images or information for this telemedicine interaction to researchers or other entities shall NOT occur without your consent.
3. CONFIDENTIALITY:
   - Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine consultation, and all existing confidentiality protections under federal and New Jersey state law apply to information disclosed during this telemedicine consultation.
4. RIGHTS:
   - You may withhold or withdraw consent to the telemedicine consultation at any time without affecting your right to future care of treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.
5. DISPUTES:
   - You agree that any dispute arriving from the telemedicine consult will be resolved in New Jersey, and that New Jersey law shall apply to all disputes.
6. RISKS, CONSEQUENCES & BENEFITS:
   - You have been advised of all the potential risks, consequences and benefits of telemedicine. Your health care practitioner has discussed with you the information provided above.
   - You had the opportunity to ask questions about the information presented on this form and the telemedicine consultation.
   - All your questions have been answered, and you understand the written information provided above.

I agree to participate in a telemedicine consultation for the medical service(s) described above.

CIRCLE the platform of your choice: FaceTime Google Duo Zoom Skype

Phone # or Email address or ID for the above platform is: ______________________________________
Patient/ Legal Guardian Signature: ____

I refuse to participate in Telemedicine consultation for the medical service(s) described above.

Signature: ____
DATE:______________________________TIME: ______________________________

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ADDENDUM TO FINANCIAL POLICY FOR TELEHEALTH SERVICES

PATIENT NAME:____**D.O.B:** ________________

Payment in full may be required for telehealth services. If you are unsure whether or not we are in-network with your insurance plan, please discuss this with your insurance plan or with our staff before your visit. Being in-network and having a contract with your insurance company does not guarantee payment for telehealth or any other medical service/procedure. There can be specific plans within an insurance company with which we do not participate. You need to inquire with your insurance company if we participate with your specific plan.

Telehealth for Medical Dermatology

If you choose to be seen via secure FaceTime, Google Duo, ZOOM, Skype or other video/audio platform/application, email with photographs, or telephone call appointment, rather than being seen in the office, SKC Dermatology will submit to your insurance plan the visit as a Telehealth visit. Due to the COVID-19 pandemic, Medicare/Medicaid and most (if not all) commercial insurance plans are now participating in reimbursing Telehealth visits.

For *self-pay* patients and plans that do *not* participate with Telehealth, SKC Dermatology will charge as follows:

New patient visit: $150 - $250 (depending on the complexity of the visit)
Established patient: $99 - $150 (depending on the complexity of the visit)
The above fees are payable prior to the visit.

All copays and deductibles that apply to your plan for regular in-office visits will also apply for telehealth visits.

If you have any questions/concerns about SKC Dermatology's financial policy, please ask prior to the telehealth service/visit so you can make an informed decision that is best for you.

I agree to participate in a telemedicine consultation for the medical service(s) described above.

Signature:____

If signed by someone other than the patient, indicate relationship: _______________

Print Name:_____________________________________Date: ____________________

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skc DERMATOLOGY

PATIENT POLICES

Patient Name:____DOB: _______________________

Our goal is to provide you and your family with the very best care in a warm, supportive environment. We wish to provide you with information that helps us to maintain this goal and through our Patient Policies. These Policies manage expectations and assure understandings to develop a long-lasting relationship. We remain available for any questions you may have.

Appointment Cancellations and No Shows

- I understand late cancellation or missing an appointment keeps other patients from being seen.
- I understand failure to give 24-hours' notice of cancellation for a medical appointment will result in a charge of $100 and $300 for a surgical appointment. Failure to provide 48-hours' notice for a surgical or cosmetic procedure may result in a charge of $100 or forfeit of my cosmetic deposit or a treatment in my laser package.
- These charges cannot be billed to my insurance company.

Late Arrivals for Appointments

- I understand SKC Dermatology will do its best to accommodate me should I arrive late for an appointment. I understand arriving late means I have forfeited my appointment time and will need to wait to be worked back into the schedule if possible or be placed with another provider who may have availability. I also understand that there may be times when these accommodations are not available, and I will be asked to reschedule my visit.

Co-Payments, Deductibles and Co-insurances and Balances

- Copayments are due and collected at check in on the day of the appointment. I understand I may be charged a $25.00 administrative billing fee for each co-payment that is not paid at the time of service.
- Insurance Deductibles, including Medicare, will be verified prior to your visit. All unmet deductibles will be collected at the time of service.
- Medicare patients without a secondary insurance will be charged their 20% co-insurance at the time of service.
- All balances are due in full within 30 days of my first billing.
- Any balance left unpaid after 60 days without attempt at resolution will be considered for collections.
- Should my account be sent to collections, I understand I will be responsible for an additional 15% administrative collection fee plus any attorney / court fees which may be added to my account during efforts to obtain payment.
- I am responsible for any bank fees associated with returned check fees plus a $35.00 administrative processing fee. Any returned check must be paid in full via credit card or cash within 15 days of notice or legal efforts to collect balance will be instituted.

Referrals

- *It is my responsibility to know if my insurance plan requires a referral to see a specialist and it is my responsibility to obtain initial referrals track usage, obtain additional referrals as needed and verify SKC Dermatology has these referrals in their office prior to my visit.*
- I understand that should I fail to have a valid referral for my visit, SKC is not authorized to see me. I will either need to reschedule my appointment or pay in full at the time of service for my visit.
- If I decide to see the provider without my referral my insurance company will not reimburse me, and I will be considered a self-pay patient for that visit and be responsible for the balance at the time of service.
- I understand trying to contact the referring office to obtain or inquire about my referral at the time of my visit with SKC will not allow enough time to maintain my scheduled appointment and doing so will forfeit my scheduled time at SKC.

Insurance Policies

- I will confirm my insurance is current at each visit. If there is a change to my insurance I will provide a valid insurance card or temporary print out at the time of my visit or will be responsible for all charges.
- If I am unable to produce this documentation I will either need to reschedule my appointment or pay in full at the time of service for my visit. I will be responsible for submitting my receipts to my insurance company should I wish to be reimbursed for my visit.
- My insurance carrier may consider certain routine services in dermatology to be surgical in nature or considered an uncovered benefit; and separate co-insurances, deductibles or co-payments or payments in full may apply. Each insurance plan is different, and I understand it is my responsibility to understand my policy and what will be covered.
- I understand in signing below that I am responsible for notifying SKC Dermatology of any changes to my insurance or contact information. If insurance or referral information I present at the time of my visit is not correct, I will be responsible for all charges incurred.

SKC DERMATOLOGY

Minor Patients

As a practice specializing in Pediatric and Adolescent Dermatology, we recognize the stress a family may encounter navigating the healthcare of the children under the best of circumstances. We also recognize this may be even more difficult in families where the parents are not together. We are here to provide treatment and support to you and your children, not to be incombered in the legal issues and responsibilities of the family.

- I understand a ***legal guardian*** MUST ACCOMPANY my child under the age of 18 to their initial appointment.
- I understand a ***legal guardian*** MUST ACCOMPANY my child under the age of 18 to subsequent appointments where an additional consent will be required.
- I understand as significant information is needed at the initial visit and treatment plans are created, it is essential for a parent/ legal guardian to be present at the initial visit. ***Children without legal guardian at their initial visit will be rescheduled***. Notes from legal guardians with permission to treat is not acceptable.
- I acknowledge that Grandparents, older siblings, step-parents etc. are not considered legal guardians without a court document that must be presented at the time of service.
- I understand that unless documents are provided showing otherwise, both parents are assumed to make appointment and treatment decisions for their child. Disagreements on approach to treatment is between the parents to discuss.
- I understand Payment (co-pays, deductibles, etc.) are due at the time of service regardless of which parent is responsible for medical coverage. We are not a party to your divorce agreement. **We will collect payment due from the parent who brings the child to the visit.** If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.
- I understand there may be times when I may allow my adolescent child to be unaccompanied for a follow-up visit and all payments that are due at the time of service will be handled by me either prior to the visit or with the credit card on file for my child.

Insurance Inquiries

- From time to time I may receive a request from my insurance company requesting information about my coverage.
- I understand that claims will not be paid without my providing this information
- I will reply to all insurance inquiries within 10 days of receipt or will be responsible for the entire balance.

Credit Card on File

- We have implemented a policy requiring a credit card held on file for touchless transactions.
- Similar to hotels and car rental agencies, you are asked for a credit card number at the time you check in and the information will be held securely until your insurances have paid their portion and we have received an EOB. At that time, your credit card will be run for the amount indicated
- This in no way will compromise your ability to dispute a charge or question your insurance company's determination of payment.
- Additional information will be explained with our Credit Card on File policy form

Cosmetic Deposits

A significant amount of time is reserved for our patient's cosmetic appointments, and therefore a deposit of $200 is required for all injectable and laser appointments, payable at the time of scheduling. Aesthetician services require a 50% deposit to schedule your appointment. Your deposit will be charged immediately and will be noted as a credit on your account. The deposit will be applied to the total charges on the day of your treatment. Cancellations/ reschedules with greater than 48-business-hours notice will be refunded or applied to the new appointment in full. Changes made with less than 48-business hours notice may forfeit the deposit in total.

Patient or Legal Guardian Signature:______________________________________Date: ______________________

Name of Legal Guardian:____Relationship: _________________

Credit Card on File

Dear Patients,

Like many businesses, SKC Dermatology has implemented a credit card on file for all transactions. With the changing environment in healthcare, 90% of our patients now have deductibles and/ or co-insurances in addition to their copayments. Simply put, this means their insurance companies are placing more responsibility of payment on our patients. Covid-19 has reinforced our plan with providing for contactless transactions.

How it Works

- Similar to hotels and car rental agencies, you will be asked for a credit card.
- The information will be held securely in an encrypted system; No one will be able to see your full credit card number and it will be accessed by your name and SKC account number.
- I understand I will receive an Explanation of Benefits (EOB) from my insurance company after my claim has processed. The EOB will outline any financial responsibilities such as deductibles or coinsurance
- ***I understand I will not receive a separate statement from SKC Dermatology*** and my EOB will be used to determine my financial responsibilities.
- I understand I may also request this card be used for copayments, products or cosmetic treatments,
- In signing below, I authorize and request SKC to charge my credit card for my copayment and/ or balances due for services rendered that my insurance company identifies as my financial responsibility.
- This authorization relates to all payments not covered by my insurance company for services provided to me/ my child/ spouse for whom I provide this credit card.
- This authorization will remain in effect until I cancel this authorization. To cancel, I must give a 60-day notification to SKC in writing and with no open or pending balances.
- I agree to provide an alternate card prior to the expiration date and will provide an alternate method of payment within 5 days should my card not contain enough credit/ monies to cover my balance.
- I understand failure to provide alternate payment methods as outlined above may result in my account being sent to collections and discharge from the practice.

Patient Name: ______________________________

Signature of Patient/ Guardian: ____________________ ***Date:*** ____________________

Credit Card Holder Name: ____________________ ***Relationship:*** ____________________

Card type:_Visa___MC____Discover______AMEX_HSA Last 4 digits: ____

COMPLETE THE FOLLOWING INFORMATION FOR TELEHEALTH

Billing address associated with the card:

Address: ______________________________

City: ____________________ State: ______________ Zip code: ______________