

Welcome to the office of Dr. Peter Accetta. Our practice is committed to providing you with the highest quality care, service and access. In order to help accomplish these goals, we would like to provide you with the following information.

Office Hours

Monday - Thursday 7:30 a.m. - 4:15 p.m.
Friday - Office is closed

Phone Hours (716-675-7000)

Monday - Thursday. 7:30 a.m. to 5:00 p.m.

Appointments – Option 1

Billing Office – Option 4

Monday - Thursday 8:00 a.m. - 4:00 p.m.

A medical provider is on call seven (7) days a week to take urgent calls outside normal business hours. (Bleeding, Pain, Infection)

For emergencies, call 911

Our phone message and website is updated as needed to report any closings; weather related, emergency or otherwise.

Prescription Refills

If you need a prescription refill, contact your pharmacy and the pharmacy will fax your request to us. You will receive a call only if there is a question or delay in filling your request.

716-675-7000 Option 3

Form Completion

A \$25 fee is required to complete any forms. Please allow seven (7) business days for us to complete the forms.

Test Results

Please allow up to fifteen (15) business days for biopsy results. We will review test results as they become available and we will contact you with all results. Extension 212 or Option 2

Appointments

Please arrive 15 minutes prior to your appointment time to register. For your benefit and the benefit of all our patients, we try to stay on schedule (though emergencies sometimes occur). As a courtesy, you will receive an *automated* pre-appointment reminder call 3 to 5 business days before your appointment.

Please specify if you prefer to be reached by home phone, cell phone, text or e-mail. *Let us know if you would like to be added to our cancellation list for a sooner appointment.*

BRING THE FOLLOWING ITEMS WITH YOU

- **New patient forms printed from our website, filled out in full.**
- **Current *INSURANCE CARDS, PHOTO ID* and *CREDIT CARD*.**
- **Some insurance companies require a *REFERRAL* to see a dermatologist. Please contact your primary care physician to verify whether you need a referral.**
- **CO-PAYMENTS are required at the time of visit.**

If you arrive 15 minutes beyond your scheduled appointment time we may need to reschedule your appointment.

Address and/or Phone Number Change

It is important that the practice has your correct address and phone number on file. Please advise the practice anytime there is a change to your address, phone number, or other contact information.

Participating Insurances

The practice accepts most insurance plans, however, participation in insurance plans may change. It is your responsibility to verify that our providers are participating with your plan. It is also your responsibility to know which labs participate with your plan and advise us of any lab restrictions. **We do not participate with Medicaid or any Medicaid product.**

Referrals and Pre-authorizations

If the patient's insurance company requires a referral and/or preauthorization (for specialist visit), the patient is responsible for obtaining one for each visit. Failure to obtain the referral and/or preauthorization may result in no payment from the insurance company and the balance will be the patient's responsibility.

Medicaid, Workers' Compensation

Our office does not participate with these plans, or any variation thereof.

Co-Pay, Deductibles, POS Plans, Self Pay and Unpaid Balances

All co-payments and past due balances are due and payable at the time of service. Self pay accounts shall exist if a patient has no insurance coverage. Payment in full is expected at the time of service. If your insurance is a High Deductible Plan, you will be required to pay a \$50 deposit for an office visit and a \$250 deposit for a surgical procedure prior to services being rendered. The deposit will be applied to your total cost. You will be billed for the balance owed or issued a refund for an overpayment. Should you need to discuss this payment policy, you may contact our Patient Financial Service Representative at 716-675-7000, ext. 214 prior to your appointment.

Insurance Claims

The practice will bill the patient's primary insurance company as a courtesy. In order to properly bill the insurance company, the practice requires that the patient disclose all insurance information including primary and secondary insurance. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill. It is the insurance company that makes the final determination of the patient's eligibility and benefits. The patient should verify that services are covered and that appropriate pre-authorization or referral is obtained when necessary. The patient is responsible for knowing which labs their insurance policy covers. Patient is responsible for non-covered services provided. The insurance company is not contracted with the patient, the patient agrees to pay any portion of the charges not covered by insurance. We cannot bill insurance for cosmetic or non-covered services, therefore, full payment is required at the time of service.

Missed Appointments

Our office requires 24 hour notice of appointment cancellations. Patients that miss appointments and do not cancel within 24 hours notice are charged a fee of \$75.00 for regular appointments and \$150.00 for cosmetic appointments.

Returned Checks

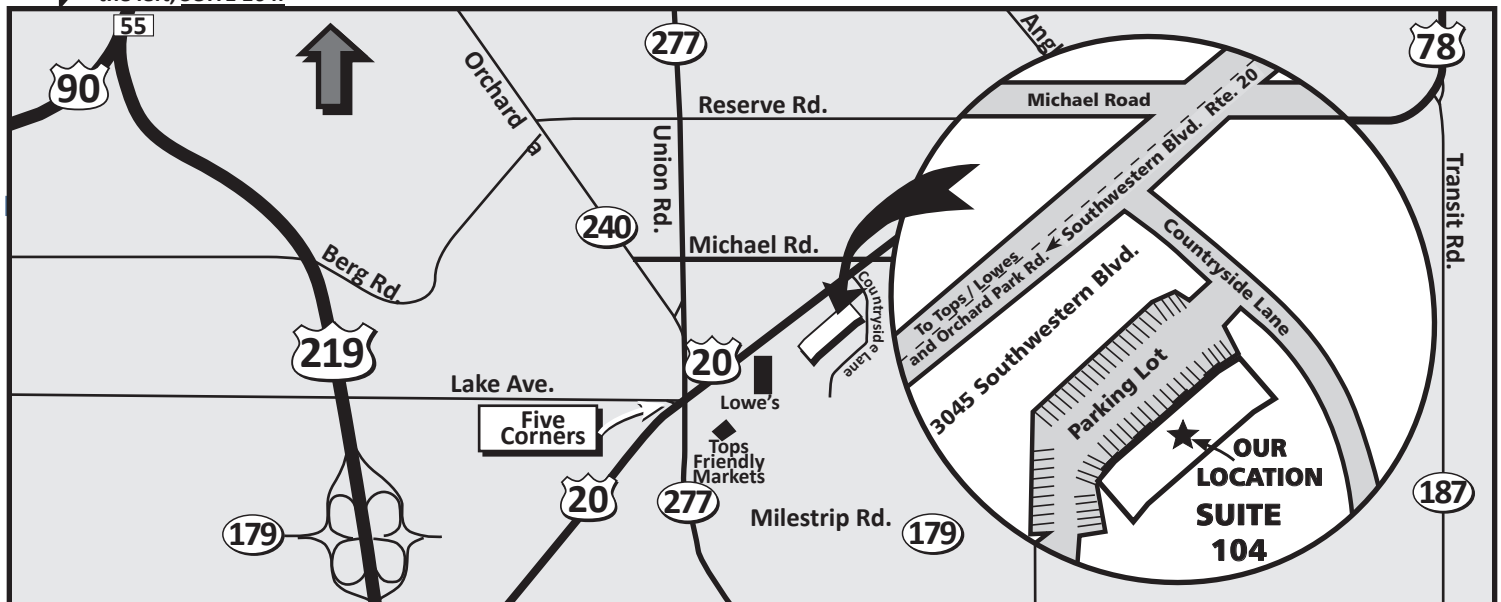
The charge for a returned check is \$50.00.

Medical Records

Patients requesting copies of medical records are charged \$.75 per page.
Please call 716-675-7000 Option 6

DIRECTIONS TO ORCHARD PARK DERMATOLOGY LOCATED IN PARKLAND PROFESSIONAL PARK

➔ Access to our office from all points is most convenient via Countryside Lane. Turn right at the 1 drive. Building 3045 is the 1st building on the left, SUITE 104.



From Buffalo and points north

Take NY State Thruway (90 West) to exit 55. Follow the signs to Orchard Park Route 219. Take 219 to Milestrip Rd. EAST. Proceed to the second traffic light and make a left on to U.S. Route 20 (Southwestern Blvd.). Go straight through the next light past the Tops/Lowes Plaza and make a right on Countryside Lane.

From Springville, Ellicottville, Gowanda, Boston

Take the 219 NORTH to the Milestrip Rd EAST exit. Make a left turn at the second light (Rt 20) which is Southwestern Blvd. Go straight through the next light past the Tops/Lowes plaza and make a right on Countryside Lane.

From Westfield, Dunkirk, Fredonia, Silver Creek, Angola

Take the NYS Thruway (90 East) to exit 56 (Milestrip Rd) and make a left turn at the light onto Milestrip Rd. Make a left turn at the 7th signal (Rt 20). Go straight through the next signal past the Tops/Lowes plaza and make a right on Countryside Lane.

From Cheektowaga, Depew, Lancaster, Elma, East Aurora

Take Transit Rd (Rt. 78) SOUTH. Transit Rd leads into Southwestern Blvd. (Rt 20) WEST. Just past the signal at Michael Rd. you will make a left on Countryside Lane.

**2018 Patient Registration
Orchard Park Dermatology
Peter Accetta, M.D.
3045 Southwestern Blvd. Suite 104 Orchard Park, NY 14127**

Please bring completed forms to our office

Patient Information (Please Print)

Last Name _____ First Name _____ MI _____
SSN _____ Birth Date _____ Age _____ Sex M F
Street Address _____ City _____ State _____ Zip _____
Home Phone ____ - ____ - _____ Cell Phone ____ - ____ - _____ E-Mail _____
Employer _____ Employer Phone No. _____

Primary Care Physician

Name _____ Address _____
Phone No. ____ - ____ - _____ Fax No. ____ - ____ - _____

Preferred preference for appointment confirmation:

Home Phone Cell Phone Cell Text E-Mail

Would you like to be contacted about special offers? Y N

INSURANCE INFORMATION

Primary Insurance (Insurance to be billed 1st)

Insurance Carrier _____ Patient ID No. _____

Subscriber or person who holds policy information:

Name _____ Birthdate _____ Relationship to Patient _____
Subscriber ID No. _____ Employer _____

Secondary Insurance (Insurance to be billed 2nd)

Insurance Carrier _____ Patient ID No. _____

Subscriber or person who holds policy information:

Name _____ Birthdate _____ Relationship to Patient _____
Subscriber ID No. _____ Employer _____

Signature _____ Date _____ Office _____
Signature _____ Date _____ Office _____
Signature _____ Date _____ Office _____
Signature _____ Date _____ Office _____

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PATIENT PRIVACY INFORMATION (HIPPA)

Please list any family members or other persons, if any, whom we may inform about your general medical condition and your diagnosis:

Name and Relationship to Patient

Phone Number

Name and Relationship to Patient

Phone Number

Can messages be left on your home answering machine/voicemail or with family member? Yes__ No__

I hereby give express consent to receive dialed, autodialed, pre-recorded or SMS Text calls from or on behalf of Orchard Park Dermatology at the telephone number(s) provided above. I understand that consent is not a condition of purchase or services received.

Office Policies and Financial Agreements

Please remember that insurance is considered a method of reimbursing the doctor and is not a substitute for payment. It is your responsibility to pay any co-pays, deductibles, co-insurance, and also any non-covered or denied services.

*You agree to reimburse us the fee of any collection agency, which may be based on a percentage at a maximum **25%** of the debt and all costs and expenses, including reasonable attorney fees and court costs we incur in such collection efforts. The agency or law office may report to one or more credit reporting agencies.*

Patients should be aware that we only send one billing statement. Additional statements, if necessary, will incur a \$35.00 late fee.

PLEASE REMEMBER - to bring your Insurance Card(s), Medicare Card, Drivers License, co-pay, and credit card.

- We expect full payment for co-payments at the time services are rendered.
- You are responsible for the entire balance on your account at the time service is rendered unless we have a special contractual relationship with your insurance company. Please discuss this with us in advance to avoid misunderstandings.
- You are responsible for cosmetic or non-covered services. Full payment must be made at time of service.
- If you need to cancel an appointment, we require 24 hour notice.
- If you no show for an appointment there is a **\$75.00** fee for a regular visit, or a **\$150.00** fee for a cosmetic visit.
- I understand that I am responsible for any and all referrals required by my insurance company.

I authorize the release of medical information to my primary care or referring physician and as necessary to process insurance claims or prescriptions.

I understand that I am responsible for presenting a copy of correct and current insurance information prior to, or at the time of service. If the insurance information presented is incorrect, I am responsible for all charges incurred at the time of service.

I authorize payment of medical benefits be made to Dr. Peter Accetta for all services furnished to me.

I understand that Orchard Park Dermatology, the office of Peter Accetta, M.D., may share my health information for treatment and billing.

My signature constitutes my acknowledgement that I have been offered an opportunity to review the Notice of Privacy Practices from Orchard Park Dermatology containing a more complete description of the uses and disclosures of my health information. This signature states an understanding of the above information and authorization for our medical personnel to examine and treat this patient as well as authorizes release of medical information to the insurance company. **I UNDERSTAND THAT THIS IS A LIFETIME SIGNATURE AUTHORIZATION.**

SIGNATURE: _____

PRINT: _____

DATE: _____

DERMATOLOGY MEDICAL HISTORY

Patient Name: _____

Date: ____/____/____

Reason for today's visit: _____

CURRENT OR PAST PROBLEMS WITH: (Review of Systems)

Check Yes or No, explain as necessary	Yes	No	Please Explain:
General Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Liver	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding/Hepatitis/HIV	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____

FAMILY HISTORY: Check following conditions that have occurred in your family.

- | | |
|------------------------------------|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Lung Disease |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Malignant Melanoma |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Skin Cancer |

SOCIAL HISTORY:

Flu Vaccine Yes (Date: _____) No (Why: _____) Pneumovax Yes No

Do you use Tobacco? Yes No Do you drink alcohol? No Yes (Drinks per week _____)

(Women) Are you pregnant? Yes No Due Date ____/____/____

What is your occupation? _____ Hobbies? _____

Understanding your Insurance

What is a Deductible and How Does It Affect Me?

An annual deductible is the dollar amount you must pay out of pocket during the year for medical expenses before your insurance coverage begins to pay.

For example, if the policy has a \$500 deductible, you must pay the first \$500 of medical expenses before the insurance company begins to pay for any services.

When does a deductible begin?

Most plan years begin January 1st, check with your insurance plan.

When do I have to pay for services?

Any time you receive medical care, you are expected to pay in full for the services until your deductible is met.

How will I know when my deductible has been met?

Call your insurance company at any time to check on how much of your deductible has been met; some insurance companies have this information available online. Every time you receive medical services, you will receive notification from your insurance company with how much they paid or did not pay.

What is Coinsurance and How Does It Work?

Coinsurance is your share of the costs of a health care service.

It is the percentage of the bill your health insurance requires you to pay first and then they will pay the remainder of the bill. You start paying coinsurance after you've paid your plans deductible amount.

For example: You have a \$1000 deductible. You have already met that deductible and need to have a skin cancer removed. The cost of removing the cancer is \$500. If your coinsurance is 20 percent, you will pay \$100 and your insurance will pay \$400.

What is a Dermatopathologist and What do I need to know?

A Dermatopathologist is a medical doctor who specializes in looking at skin samples under a microscope.

When a biopsy is taken it is sent to a Dermatopathology Lab and the biopsy is interpreted by a Dermatopathologist. You will get a separate bill directly from them. The bill you receive is not from our office, and you are responsible for all charges owed to them.