PATIENT INFORMATION

Last Name ___________________________ First Name _________________________M.I. ______

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Social Security No.:______-_______-______ Birth Date: ______/______/______ Sex: ☐M ☐ F

City/State of Birth: _____________________Driver's License # and State:___________________

Preferred Language: _____________________________ Race: _____________________________

Mailing Address: ____

City: ____________________________________ State: _______________ Zip: ________________

Employer: _________________________________ Occupation: ____________________________

Emergency Contact Name: _____________________________ Relationship: _________________

Emergency Contact Phone: (_____)____________ Primary Dr.: _____________________________

Please check preferred contact number

☐Home Phone: (_____)______________ ☐Work Phone: (_____)_______________

☐Cell Phone: (_____)________________ ☐Other Phone: (_____)_______________

Do you authorize Dermatology Specialists, Inc. to leave detailed messages?

☐YES, you have my consent to leave detailed messages.

☐NO, you do not have my consent to leave detailed messages.

Email Address: ____

☐ **Yes,** I would like to receive emails which may include practice and physician updates, marketing materials / promotions from third parties or our practice, information on medical advancements and / or information on our clinical trials.

INSURANCE INFORMATION

Primary Insurance Carrier: ____________________Policy Holder Name:______________________

Birth Date of Policy Holder: _____________ID Number: ___________ Group Number: _________

Secondary Insurance Carrier:_________________ Policy Holder Name: _______________________

Birth Date of Policy Holder: _____________ID Number: ___________ Group Number: _________

↓ **PLEASE TURN OVER** ↓

You have my authorization to release detailed information including results to:

(please list the names of who you would like to have access to your information)

My Spouse: ___________________________ Family Member: _______________________

My Doctor: ___________________________ Other: _______________________________

I understand I have the right to revoke this authorization in writing. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. To revoke an authorization I may fill out a revocation form available at Dermatology Specialists, Inc. or write a letter to Dermatology Specialists, Inc.

By ✓ checking below I acknowledge that I have received, understand, and am in agreement with the ALL of the following:

____ FINANCIAL POLICY

____ CHECK POLICY

____ HMO PLANS

____ COSMETIC PROCEDURES

____ RECORD RELEASE

____ NOTICE OF PRIVACY POLICY

____ NO SHOW/ CANCELATION POLICY

RESPONSIBLE PARTY(only complete if different than self)

Last Name __________________________ First Name ________________________M.I. ______

Birth Date ___ /____/_____ Social Security No.:______-______-______ Sex: ☐M ☐ F

Mailing Address: ____

City: ____________________________________ State: _______________ Zip: ________________

☐Home Phone: (_____)______________ ☐Work Phone: (_____)________________

☐Cell Phone: (_____)________________ ☐Other Phone: (_____)________________

NOTICE TO PATIENTS: The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at **https://openpaymentsdata.cms.gov.**

MINOR TREATMENT CONSENT

I give the doctors and staff at Dermatology Specialists, Inc. permission to treat ____________________________________in my absence for all future appointments.

(Minor's name)

____ Date: _________________

(Signature of parent or legal guardian of minor)

PATIENT/GUARDIAN SIGNATURE

____ Date: ________________

Patient or legal guardian Name (PRINT) Patient or legal guardian Signature

For Your Records

FINANCIAL POLICY

Since your insurance policy is a contract between you and your insurance company, you are responsible for the cost for services you receive from Dermatology Specialists, Inc. If our office has a contract with your insurance company, we will bill your insurance for you. It is your responsibility to know whether prior authorization is required by your insurance company prior to any office visits or surgery. This requirement may affect your benefits and amounts paid by your insurance. Please inform this office if such authorization is required before services are rendered. You must have your insurance card or you will be required to make a payment at the time of service.

It is your responsibility to notify us if your insurance type, primary physician, primary medical group, termination or any other changes have occurred that could affect your insurance coverage for services about to be provided. If we are not informed prior to rendering services, you may be responsible for the cost of the services.

We accept assignment for all Medicare and Tricare patients. Co-payments and deductibles are due and payable at each visit. A $15.00 processing fee will be added to your account if it is submitted to our collection agency for non-payment or if your check is returned to us by your bank.

CHECK POLICY

Dermatology Specialists, Inc. will electronically debit your account for the amount of the check plus a processing fee of $25.00 on checks that are returned by the bank as unpaid. This fee represents the cost of handling and collecting the dishonored check.

HMO PLANS

You understand that payment of these services is dependent on prior authorization secured from your primary care physician or health plan and your current eligibility of benefits from your insurance carrier. Should either requirement not be met, you are financially responsible for the service rendered.

COSMETIC PROCEDURES

Cosmetic procedures are cash only and cannot be billed to insurance. These procedures include but are not limited to: Botox, Collagen, Restylane, Hair Removal, Facial Veins, Spider Veins, and Skin Tags or benign growths.

RECORD RELEASE AND ASSIGNMENT OF BENEFITS

I hereby authorize Dermatology Specialists, Inc. to release relevant information regarding my care to other physicians involved in my case and / or insurance companies holding policies on me. I authorize my insurance company to directly remit payment to Dermatology Specialists, Inc. for medical or surgical services provided and billed by Dermatology Specialists, Inc.

NOTICE OF PRIVACY POLICY

I hereby acknowledge this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be available to me in writing upon my request. Any amended Notice of Privacy Practices will be available to me at each appointment upon my request.

NO SHOW / LATE CANCELLATION POLICY

No Show Policy:

If you do not arrive to your appointment, it will be recorded in your chart and considered a "no show". If you no show, you will be charged a No Show / Late Cancellation Fee. Late cancellations (less than 24 hours notice) are considered a "no show" and will be charged the No Show / Late Cancellation Fee. Exceptions may be made in some circumstances, but are determined by the provider. Cancellations made more than 24 hours in advance of your scheduled appointment time will not receive a No Show / Late Cancellation Fee.

Cancellation of an Appointment:

Please call the office promptly if you are unable to attend an appointment, so this time can be given to another patient in need of treatment. If it is necessary to cancel your appointment please contact us at least 24 hours in advance. We appreciate your attention to this matter as our appointments are in high demand.

No Show / Late Cancellation Fees:

- Medical and Cosmetic Appointment: $50.00
- Surgery Appointment: $150.00
- Mohs Surgery Appointment: $300.00

If you no show to an appointment, you are **required** to pay any No Show / Late Cancellation Fees before scheduling any further appointments.

I understand this policy and authorize Dermatology Specialists, Inc. to assess No Show / Late Cancellation Fees according to the above outlined policy.