U.S. DERMATOLOGY partners

PATIENT INFORMATION

PATIENT INFORMATION

First Name:				Last Name:	
Nick Name:				Date of Birth:	
Birth Sex:		Current Gender:		Marital Status:	
Address:					
City:		State:		Zip Code:	
Phone:	( )			Cell Phone:	( )
Email:					
How did you hear about our office?					

PRIMARY CARE PHYSICIAN

First Name:		Last Name:	
City:		Phone:	( )

PRIMARY INSURANCE

Insured's Full Name:			Insurance Company:	
Insured's DOB:		Sex: M / F	Member No:	
Relationship to Patient:			Group No:	
Insured's Address:				

SECONDARY INSURANCE

Insured's Full Name:			Insurance Company:	
Insured's DOB:		Sex: M / F	Member No:	
Relationship to Patient:			Group No:	
Insured's Address:				

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PATIENT INFORMATION

RESPONSIBLE FINANCIAL PARTY (fill out if other than self)

Printed Name:		Relationship:	
Address:			
Home Phone:	( )	Cell Phone:	( )

EMERGENCY CONTACT INFORMATION

Printed Name:		Relationship:	
Home Phone:	( )	Cell Phone:	( )

By signing below, I certify that the information above is true and correct to the best of my knowledge.

Patient Printed Name:	
Patient DOB:	
Parent/Legal Guardian Printed Name:	
Relationship to Patient:	
Signature:	
Date:	

Notice of Privacy Practices
I have read the Notice of Privacy Practices which explains how my medical information will be used and disclosed. I authorize the release of any medical information necessary to evaluate and/or treat my condition. I further authorize the release of any medical information necessary to process insurance claims on my behalf. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

Cancellation Policy for Appointments
It is my responsibility to call the office to cancel at least 24 hours prior to the scheduled appointment. *U.S. Dermatology Partners* reserves the right to charge a fee if the appointment is not cancelled at least 24 hours in advance. Additionally, the office reserves the right to reschedule appointments for which I am more than 15 minutes late. Some types of appointments require a deposit to reserve the appointment date. *U.S. Dermatology Partners* reserves the right to charge a fee or retain the deposit if the appointment is not cancelled at least 72 hours in advance.

Cosmetic Services and Retail Sales
Payment for cosmetic services is required in full at the time of service. All retail sales are final. Due to the nature of the cosmetic products, no exchanges/refunds are allowed.

Payment is required at the time services are rendered
I understand that I am financially responsible for all charges for services rendered on my behalf or on behalf of my dependent, regardless if they are covered by my insurance.

- I understand I will be responsible for any remaining balance not covered by my insurance company, Medicare and/or my supplemental policy. Please contact your insurance company if you have questions regarding your benefits and coverage information.
- I understand that if I have a surgical procedure or biopsy performed, there are two charges: (1) a charge by the provider for collecting the Biopsy; and (2) a charge to examine the specimen by a Pathologist (who is chosen by my Rendering Provider). I understand that I will be billed separately by the Pathologist (also a medical doctor) who performs the reading.
- I understand that my insurance company may have a preferred laboratory for blood work. It is my responsibility to know which preferred laboratory I need to use. It is also my responsibility to inform my provider of this at the time services are rendered.
- I understand that a $25 returned check fee will be assessed to my account for any checks returned by my financial institution.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Patient Printed Name:	
Patient DOB:	
Parent/Legal Guardian Printed Name:	
Relationship to Patient:	
Signature:	
Date:	

Consent for Treatment
I authorize *U.S. Dermatology Partners* to provide any healthcare services that my provider deems necessary for diagnosis and/or treatment. If a biopsy is performed, I authorize the Pathologist to send my specimen for a second opinion and/or obtain special tests, if medically necessary to ensure an accurate diagnosis. I understand that additional costs may result and that I will be responsible for any remaining balance that is not covered by my insurance company, Medicare and/or supplemental policy.

Consent for Filing Insurance Claims
I understand that to file claims and release medical information to any insurance companies, *U.S. Dermatology Partners* is required to keep my signature on file. I hereby authorize *U.S. Dermatology Partners* to receive benefits directly from my insurance company when an assigned claim is filed. I also authorize *U.S. Dermatology Partners* to appeal any denials to my insurance companies on my behalf and authorize the release of any medical information to my insurance companies that is necessary for the processing of claims.

Consent for Electronic Prescription History
I understand that to offer the best patient care, *U.S. Dermatology Partners* will retrieve my prescription history that has been ordered and filled through Surescripts. I authorize *U.S. Dermatology Partners* to import the prescription history obtained through Surescripts into my electronic chart.

Consent for Photos
I understand that in the course of treatment, photographs may be taken for clinical and educational purposes. No audio taping, videotaping, or photography is allowed by non-staff members.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Patient Printed Name:	
Patient DOB:	
Parent/Legal Guardian Printed Name:	
Relationship to Patient:	
Signature:	
Date:	

PHI COMMUNICATION PREFERENCES

I authorize *U.S. Dermatology Partners* to disclose any and all details of my medical diagnoses, treatment, and billing/claims information to the individuals listed below. This authorization is voluntary and I understand that I have the right to revoke this authorization by submitting a written request to the office. I understand that the information disclosed under this authorization may be disclosed again by the person or organization to which it is released. I understand that the below list may not be exhaustive and that my protected health information (PHI) may be disclosed to additional individuals based on my written authorization or as indicated in our Notice of Privacy Practices. This authorization shall remain in effect indefinitely unless revoked in writing by me.

☐ **I elect not to authorize disclosure to any individuals at this time**

			Check all that apply	
First and Last Name:	**Relationship:**	**Telephone Number**	**Medical**	**Billing**
		( )		
		( )		
		( )		

Communication for benign (non-cancerous) test results	**Telephone Number**
I hereby allow all benign (non-cancerous) test results to be put in a voice message on the phone number indicated in the box.	( )

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Patient Printed Name:	
Patient DOB:	
Parent/Legal Guardian Printed Name:	
Relationship to Patient:	
Signature:	
Date:	

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CONSENT TO TREAT MINORS

We cannot legally treat a minor child without a signed consent form. You must be present at your child's **initial visit** to sign the parental consent below.

Minor Information

Patient Name:	Patient DOB:

Parent/Legal Guardian Information

Name:	SSN#:
DOB:	Work Phone:
Relationship to Patient:	Cell Phone:

If you are not the parent, you will need to provide legal documentation that you are the legal guardian. This information will be kept in the patient's file.

Special Permissions: This agreement is required in order for the minor child to be seen and treated without the parent/legal guardian present.

_____(Initials) **Unaccompanied:** I grant permission to treat and provide any healthcare services to my child that the provider deems necessary for treatment, if my child arrives at the office unaccompanied.

_____(Initials) **Accompanied by Others:** If I am unable to accompany my child to the appointment, the below listed individuals have my permission to accompany my child and make medical decisions regarding my child.

Other Individuals Allowed to Accompany Minor:

Name:	DOB:	Relationship to Patient:
Name:	DOB:	Relationship to Patient:

Consent to Treat Minor: I authorize *U.S. Dermatology Partners* to treat and provide any healthcare services to my child deemed necessary for treatment and/or diagnosis. I also understand that, in the course of that treatment, photographs may be taken for clinical or educational purposes. I acknowledge that this consent will remain in effect until I revoke it in writing and present this document to the office or the minor reaches the age of 18 years.

By signing below, I certify that I have read the above information and have had any questions answered. My signature also certifies my understanding and agreement with the above information.

Parent/Legal Guardian Signature:	
Date:	