

PATIENT INFORMATION

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

PRIMARY INSURANCE

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

SECONDARY INSURANCE

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

PRIMARY CARE PHYSICIAN

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

EMERGENCY CONTACT INFORMATION

Full 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.

Financial Policies

- 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.
- Payment is required at the time services are rendered. The amount collected is **estimated** based on benefit information available. Specific policy information is often limited or unavailable until after a claim has been filed.
- I understand I am responsible for any remaining balance not covered by my insurance. It is my responsibility to contact my insurance if I have questions regarding my benefits and coverage.
- 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 may have a preferred lab for blood work. It is my responsibility to know which preferred lab I can use, and to inform my provider at the time of service.
- I understand that a \$25 returned check fee will be assessed for returned checks.

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 Photos

I understand that during 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.

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 Appointment Reminders

I authorize *U.S. Dermatology Partners* to contact me by automated SMS text message, phone call, or email for appointment reminders. I understand that message/data rates may apply to messages sent by *U.S. Dermatology Partners* under my cell phone plan. I understand that I am under no obligation to receive automated notifications and may opt-out of these communications at any time by following the prompts in the reminder.

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, as indicated 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.

<input type="checkbox"/> 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:	



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:
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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:	