

**Dermatology Specialists, LLC**

Patient's Full Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Age \_\_\_\_\_

Patient Soc. Security #: \_\_\_\_\_

Best Phone # (\_\_\_\_) \_\_\_\_\_ Preferred contact method \_\_ Call \_\_ Text

Best E-Mail Address: \_\_\_\_\_ @ \_\_\_\_\_

Address \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Employer: \_\_\_\_\_

Has this patient ever been known by any other name? (list) \_\_\_\_\_

**Name of Insurance Company** \_\_\_\_\_ **Policy ID #** \_\_\_\_\_

Group # \_\_\_\_\_

Policy Holder's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Policy Holder Social Security Number: \_\_\_\_\_ Relationship to patient \_\_\_\_\_

**Emergency Contact (other than relative already listed on this form):**

Name \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Address \_\_\_\_\_ Phone # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**If patient is less than 18 years of age, please complete the following:**

Patient Lives with:  Both Parents  Mother  Father  Other: \_\_\_\_\_

**Father's Name:** \_\_\_\_\_ **Soc. Security #** \_\_\_\_\_ **DOB** \_\_\_\_\_

Employed by: \_\_\_\_\_ **Work #** \_\_\_\_\_ **Cell #** \_\_\_\_\_

Address (if different from child) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Mother's Name:** \_\_\_\_\_ **Soc. Security #** \_\_\_\_\_ **DOB** \_\_\_\_\_

Employed by: \_\_\_\_\_ **Work #** \_\_\_\_\_ **Cell #** \_\_\_\_\_

Address (if different from child) \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**RELEASE OF INFORMATION**

The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes any physician of Dermatology Specialists, LLC to submit claims for benefits, for services rendered or for services to be rendered, without obtaining my signature on each claim to be submitted for me or my dependents and that I am bound by this signature as though the undersigned had personally signed the particular claim.

**ASSIGNMENT OF BENEFITS**

I authorize my insurance company to pay and assign directly to Dermatology Specialists, LLC all benefits, if any, payable to me for services as described on the attached forms. I further acknowledge that any insurance benefits received by Dermatology Specialists, LLC will be credited to my account.

**PAYMENT AGREEMENT**

I give my consent for the examination and treatment of the above named patient including injections when indicated and properly authorized. If the patient is less than 18 years of age or incapable of caring for him/herself, I certify that I am a legal guardian or have been authorized by a legal guardian of the above named patient to consent for examination and treatment. I understand that it is my responsibility to provide Dermatology Specialists, LLC with the current insurance information. I am aware that payment remains my personal responsibility regardless of insurance or other third party involvement (including court orders). I understand that if at any time a collection agency is employed to collect fees that I am responsible for the fees incurred up to 50% of the balance due. **I am aware of Dermatology Specialist, LLC's financial policy. A copy is available for my review upon request if unable to view online at [www.dermgvl.com](http://www.dermgvl.com). All copays, coinsurance, and deductibles are to be paid at time of service.**

**REFERENCE LABORATORY SERVICES & SPECIALTY REFERRALS**

I understand that Dermatology Specialists, LLC utilizes the service of an outside lab to perform some of the lab tests requested by its physician(s). I further understand that I will receive a separate bill from the reference laboratory for its services. I consent to Dermatology Specialists, LLC providing demographic information as necessary for billing purposes. **I also recognize that I am responsible for going to a laboratory or specialty referral within my insurance provider's network.**

**CANCELLATION OF APPOINTMENTS**

I understand that I must give a 24-hour notice to cancel my appointment or there will be charge as outlined in financial policy. I further understand that future services may be denied if I fail to keep my scheduled appointments.

**NOTICE OF PRIVACY PRACTICES**

I acknowledge by signing below that the Notice of Privacy Practices, Notice of Individual Rights are available to me and are posted for my review in the waiting room.

By signing this form, I am consenting to treatment and agreeing to these policies. I understand this authorization will remain in effect until I revoke it in writing.

**MEDICATION REFILLS AND NON-URGENT PHONE CALLS**

I understand that Dr. Miller is available by phone after hours for non-life threatening issues that need urgent medical attention (eg, bleeding from procedure site not responding to pressure). I understand that medication refills need to occur during business hours and will not be handled after hours. I understand that if my loved one or I have a medical condition that is life threatening, I will immediately call 911. I understand that the office email is not to be used for issues that need an urgent response.

**I have read the above information and agree to comply with the policies of Dermatology Specialists, LLC:**

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	<i>Signature of Patient or Parent (patient &lt;18) or Legal Guardian</i>	
	(PRINTED NAME)	

