WESTLAKE DERMATOLOGY & Cosmetic Surgery

PATIENT INFORMATION

Patient Name: _____ **Date:** _____

Date of Birth: _____ Age: _____ Sex: ☐ Male ☐ Female

Race: ☐ *White* ☐ *Black or African American* ☐ *Asian* ☐ *American Indian / Alaskan Native* ☐ *Native Hawaiian / Other Pacific Islander*

☐ *Other* _____ ☐ *Declined*

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown Preferred Language: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____ Cell Phone: (_____)_____

Social Security #: _____ Drivers License #: _____

Employer: _____ Occupation: _____

Work Phone: (_____)_____ Do you authorize email communication pertaining to:

Email Address: _____ Appointment reminders? ☐ *Yes* ☐ *No*

Specials, events, etc.? ☐ *Yes* ☐ *No*

EMERGENCY CONTACT

Name: _____ Relationship to Patient: _____

Address: _____ Phone: (_____)_____

PRIMARY INSURANCE INFORMATION *(In order for us to file a claim on your behalf, this section must be completed in its entirety.)*

Primary Insurance Name: _____ Phone: (_____)_____

ID #: _____ Group / Account #: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____ Subscriber's Social Security #: _____

Subscriber's Address (street, city, state, zip): _____

SECONDARY INSURANCE INFORMATION *(If applicable.)*

Secondary Insurance Name: _____ Phone: (_____)_____

ID #: _____ Group / Account #: _____

Subscriber Name: _____ Subscriber's Date of Birth: _____

Relationship to Patient: _____ Subscriber's Social Security #: _____

Subscriber's Address (street, city, state, zip): _____

HOW DID YOU HEAR ABOUT WESTLAKE DERMATOLOGY & COSMETIC SURGERY?

☐ Doctor: _____ ☐ Friend: _____

☐ Insurance ☐ Internet / Website

☐ Radio Ad (which station?): _____ ☐ Billboard

☐ Magazine Ad (which one?): _____ ☐ Other: _____

WESTLAKE DERMATOLOGY & Cosmetic Surgery

ACKNOWLEDGEMENT OF OFFICE POLICIES

Patient Name: _____ **Date of Birth:** _____

Please review and initial each policy listed below.

_____ **Receipt of Notice of Privacy Practices:** I have had the opportunity to review the Notice of Privacy Practices of Westlake Dermatology. (This document is available at our front desk or on westlake dermatology.com)

_____ **Cancellation Policy:** If the patient cannot adhere to a scheduled appointment, it is the patient's responsibility to call the office to cancel within 24 hours of the scheduled appointment. **Please note: Westlake Dermatology reserves the right to charge a $50 fee if the patient does not cancel their appointment within 24 hours or a $100 fee for excision appointments not cancelled within 72 hours. Fees for cancelled cosmetic surgery appointments may vary.**

_____ **Release of Medical Information:**

I do / do not *(circle one)* authorize Westlake Dermatology and its designated representatives to release my medical information to my spouse, parent, guardian.

I do / do not *(circle one)* authorize Westlake Dermatology and its designated representatives to release my medical information to my primary care physician. If authorized, pleave provide name of physician: _____

If at any time you should need a copy of your complete medical records, we require a written release to be signed and dated. The form is available on our website. Please allow 10-15 business days to complete your request. If your request is urgent, please ask to speak with the medical records department to expedite your request. If one of your other physicians requires records for continuation of care, their office may request these specific items be faxed to them directly.

_____ **Contact Permission:** In the event that Westlake Dermatology needs to contact you (the patient) regarding an appointment, lab result, medication, or any other reason, it is permissible to:

☐ **Yes** ☐ **No** Leave a message on an answering machine.

☐ **Yes** ☐ **No** Speak with other authorized entities listed below.

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

Name: _____ **Relationship:** _____

_____ **Consent to Treatment:** I consent to the performance of diagnostic procedures, examinations, and rendering treatment by the medical provider and their designated medical office staff as it is deemed necessary in the medical provider's judgement.

_____ **Unaccompanied Minors (Under 18 Years Old):** I understand that Westlake Dermatology is unable to treat unaccompanied minors unless prior consent is obtained from parent or legal guardian. Non-emergency treatment will be denied unless we have this consent. New patient minors must have a parent or legal guardian present for the new patient exam. Existing minor patients may provide signed Minor Consent Form (available on our website). **I understand that I must make arrangements for payment of copay or other fees as needed at the time of service.**

_____ **Proof of Identity:** Westlake Dermatology requires proof of identity on file. I understand that I will be asked to provide a photo ID such as a driver's license at check-in. This will be scanned into your private medical record as a means to document who we are treating. If you are reluctant to scan your ID, we may ask to view your photo ID at each visit.

By signing this Acknowledgement of Office Policies you acknowledge that you have read, understand, and accept the above policies.

_____ _____

Signature of Patient or Guardian **Date**

WESTLAKE DERMATOLOGY & Cosmetic Surgery

FINANCIAL POLICY NOTICE

Patient Name: _____ **Date of Birth:** _____

Thank you for choosing Westlake Dermatology. Please understand that the services you elect to participate in imply a financial responsibility on your part and you are ultimately responsible for payment of your bill. If you have any financial questions about your visit, please contact our Billing Department as soon as possible, as we may have deadlines to resolve any discrepancies. We accept cash, checks, Mastercard, Visa, Discover, and American Express. CareCredit is accepted for transactions of $300 or more.

Please review and initial each policy listed below.

_____ **Private Pay (Self-Pay):** I understand that if I do not have health insurance, full payment is due at the time of service.

_____ **Policy Benefits / Non-Covered Charges:** I understand it is my responsibility to know my insurance policy coverage and benefits and to notify Westlake Dermatology of any insurance changes in a timely manner. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. Services rendered may be considered non-covered by insurance and/or may be subject to a deductible in addition to a copay. I understand I have the right to refuse any services before they are rendered if I think they are non-covered services or not payable by my insurance. *We will not become involved in disputes between you and your insurance company regarding non-covered charges, diagnoses, copays, cost-shares, or deductibles. Please refrain from asking our office to change a diagnosis or procedure code in order for the visit to be covered by your insurance company.*

_____ **Out-of-Network Insurance Plans:** I understand that full payment is required if I choose to be seen using an out-of-network insurance plan.

_____ **In-Network Insurance Plans:** I understand I must provide a copy of my current insurance card in order to file an insurance claim. If I do not have my insurance card, full payment may be due at the time of service. I authorize the release of my medical information necessary to process an insurance claim on my behalf. I understand that I am financially responsible for all charges and I understand and agree to this financial policy. I request that my medical insurance carrier make any payment to Westlake Dermatology for services rendered to me.

_____ **Copayments:** I understand that all copays are due at the time of my appointment and before I see the provider. Due to the fact that Westlake Dermatology physicians are specialists, a higher copay may be required.

_____ **Managed Care (HMO) Plans or Health Select:** I understand it is my responsibility to obtain any and all necessary referrals including referrals for follow up visits if my plan requires one. We will strive to keep you informed of how many visits are remaining on a referral and/or the expiration date, but it is ultimately the responsibility of the patient to know this information and to make the necessary arrangements through their primary care physician. If you do not have a current referral on file, you may be asked to reschedule your appointment.

_____ **Ancillary Services:** I understand it is my responsibility to know from whom my insurance company requires me to obtain any labs, X-rays, or any other ancillary services. Please let your doctor's medical staff know so that they may schedule these services accordingly.

_____ **Worker's Compensation:** I understand that Westlake Dermatology does not file worker's compensation claims. Full payment is due at the time of service.

_____ **Returned Checks:** I understand that personal checks returned for non-sufficient funds may be charged a fee of $25. Balances must be handled by cash, credit card, or money order.

_____ **Past Due Accounts:** I understand that all outstanding accounts will be turned over to a collection agency after three statements and one pre-collection letter is mailed. Please contact us before this if you would like to set up payment arrangements.

By signing this Financial Policy Notice you, the guarantor, acknowledge that you have read, understand, and accept the above policies.

_____ _____

Signature of Patient or Guardian **Date**