PEDIATRIC DERMATOLOGY OF DALLAS

PATIENT INFORMATION

Please complete the following information: TODAY'S DATE _____

PATIENT'S NAME_____
Last First Middle

HOME ADDRESS_____
Street Apt City State Zip Code

DATE OF BIRTH _____/_____/_____ AGE _____ MALE_____ FEMALE _____ SOCIAL SECURITY# _____

PHONE # HOME _____ CELL _____WORK _____

PARENT'S INFORMATION

FATHER _____DOB _____SSN_____

Father's Employer_____ _____
Name Phone: Work or Cell (circle one)

MOTHER_____DOB_____SSN _____

Mother's Employer_____ _____
Name Phone: Work or Cell (circle one)

PATIENT'S PRIMARY CARE MD _____
Name City/State Phone

PHARMACY# _____ EMERGENCY CONTACT: _____PHONE_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? _____
Name Phone

INSURANCE COVERAGE

Policy Holder's Name _____Relationship to Patient _____

Address _____
Street Apt City State Zip

Social Security Number _____ Date of Birth: Month _____ Day _____ Year _____

Insurance Company: _____ Phone No. _____

Policy No _____Group No_____

Address: _____
Street Apt City State Zip

I hereby state that the above information is current and correct, and authorize the release of any information required to complete this or any future claim and also authorize payment of medical benefits to me, for professional services to K. Robin Carder, MD of Pediatric Dermatology of Dallas, PA. I further authorize a copy of this authorization to be used in place of the original.

BY SIGNING BELOW, I AGREE TO PAY ALL EXPENSES REGARDLESS OF INSURANCE RESPONSIBILITY.

_____
Signature Date

PEDIATRIC DERMATOLOGY OF DALLAS, PA

INSURANCE POLICY

Your medical insurance is designed to assist you, the policyholder, with your medical fees. However, few policies provide complete coverage. Payment of our fee is your responsibility and is due in full at the time of service. As a courtesy to you, we will file insurance for medical care with the following understanding:

1. Patient agrees to pay any portion of our fee that the insurance company will not cover. This would include deductibles, uncovered expenses and co-payment. ***It is the patient's responsibility** to ensure that all necessary referrals/authorizations are obtained for medical care. If these are not obtained, the patient is responsible for all charges.

2. **As a courtesy to you**, we will file your claim(s) with the sufficient information given. If for any reason, you are unable to provide us the insurance within a timely manner with all necessary and correct information, you will be billed for the services rendered to you. It is the patient's responsibility to provide the office correct/current information.

3. **Patient agrees to monitor his or her own claims** filed with the insurance company, by calling and checking the status of claims until the claim has been paid.

4. **Assignment of benefits is accepted for a period of 60 days** from the date our office submits the initial claim to your carrier. Should your insurance company fail to provide benefits within this period of time; your remaining balance will become due and payable.

5. If payment is not received within a timely manner your account could be turned over for collection with possible interest and collection fees added to your balance due. **If payment arrangements are needed,** please call the office immediately so that we may assist you and avoid in further action.

6. **A returned check fee of $25.00** will be posted to your account and will be automatically turned over for collection.

7. **A $25.00 administrative fee** will be charged to your account if you **"No show"** or fail to cancel your appointment within 24 hours (one full business day) prior to your visit. **Surgery "no shows"** will be charged a $50.

8. Some insurance plans consider any procedure (such as skin scrapings, wart or molluscum treatment) to be a surgery. As such, these procedures may be subject to a separate deductible.

We appreciate the opportunity to participate in your care and hope this explanation of policy will eliminate any misunderstandings associated with your insurance benefits.

As the responsible party, I accept the terms of this insurance office policy and authorize payment of insurance benefits to the doctor in charge of my care.

Signature: _____ Date: _____

PEDIATRIC DERMATOLOGY OF DALLAS, P.A

PATIENT HIPAA AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this form. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you acknowledge our use and disclosure of protected health information about you for treatment payment health care operations. You have the right to revoke this disclosure, in writing, signed by you. However such a revocation shall not affect any disclosures we have already made in reliance on your prior Acknowledgement. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The patient or their parent or guardian understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations

- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice
- The Patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
- The patient may revoke this authorization in writing at any time and all future disclosures will then cease
- The Practice may condition receipt of treatment upon the execution of this Authorization.

I acknowledge that I have read the above authorization and have had access to read Pediatric Dermatology of Dallas' full Notice of Privacy Practices:

_____ _____
Printed Name – Patient or Representative Relationship to patient

_____ _____/____/_____
Signature Date

_____ ____/____/____
Signature – Practice Representative Date

PRACTICE POLICIES:

In order to serve your needs better, we ask that you read our policies and signed below.

1. We request a 24 hour (1 full business day) cancellation notice. Failure to call or "no shows" will be charged a $25 administrative fee that is not billable to insurance. Surgery "no shows" will be charged $50.
2. Prescription refills may take 24-48 hours to be processed. Please call your pharmacy to request refills.
3. If a patient loses their lab requisition form, there is a $5 administrative fee.
4. Co pays and deductibles are due at the time services are rendered.
5. Patients are responsible for verifying insurance coverage.
6. We attempt to make courtesy phone call to remind you of your appointment but are unable to provide this service at all times. If you do not receive a reminder phone call and forget to come to your appointment, this does not cancel our "no show" policy above.
7. All returned checks will be charged a $25 administrative fee.
8. If past bills are sent to collections, there will be a surcharge to cover the cost of the collection agency.
9. Some insurance plans consider any procedure (such as skin scrapings, wart or molluscum treatment) to be a surgery. As such, these procedures may be subject to a separate deductible.
10. We are happy to see any and all children in your family, but a separate appointment is required for each child.

I have read, understand, and agree to adhere to the practices policies above.

_____ _____
Printed Name – Patient or Representative Relationship to patient

_____ ____/____/____
Signature Date