DATE _____ **COMPLETE FAMILY DERMATOLOGY** MR# _____

PATIENT LAST NAME _____ FIRST _____ MI ____ BIRTH DATE _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

SEX M F MARITAL STATUS S M D W SEP RACE _____ ETHNICITY _____ LANGUAGE _____

SELF PAY Y N EMAIL ADDRESS _____ SS# ____/____/____

STUDENT / RETIRED / PART-TIME/ FULL-TIME EMPLOYER _____

EMPLOYER ADDRESS _____ CITY _____ STATE _____ ZIP _____

REFERRING PHYS. _____ PRIMARY PHYS. _____

PRIMARY INSURANCE _____ SECONDARY INSURANCE _____

SUBSCRIBER LAST NAME _____ FIRST _____ BIRTH DATE _____ SEX M F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

RELATIONSHIP TO PATIENT SPOUSE / PARENT/ CHILD/ OTHER SPONSOR SS# (IF MILITARY) ____/____/____

EMPLOYER _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

GUARANTOR/RESPONSIBLE PARTY (if under 19 years of age)

LAST NAME _____ FIRST _____ BIRTH DATE _____ SEX M F

ADDRESS _____ CITY _____ STATE _____ ZIP _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

RELATIONSHIP TO PATIENT PARENT / RELATIVE/ OTHER (SPECIFY) _____ SS# ____/____/____

EMPLOYER _____ ADDRESS _____ CITY _____ STATE _____ ZIP _____

EMERGENCY CONTACT _____ RELATIONSHIP _____ PHONE _____

ADDRESS _____

CITY/STATE/ZIP _____

MEDICAL CONSENT

I voluntarily consent to treatment which may include procedures such as: shave removal biopsy, surgical excision or MOHS surgery. This office visit may include routine diagnostic procedures including lab/pathology and medical treatment. I also consent to exams, tests, diagnostic and other medical procedures such as blood tests that my physician or physician's assistant may order. I understand that the procedures and treatments at Complete Family Dermatology may be performed by my physician, physician's assistance, or nursing staff who are members of the Complete Family Dermatology medical staff. I also understand that my physician may request that other health care providers care for me if my physician thinks it is necessary, and I consent to their providing such care. I consent to the visual recording of my care for internal purposes to improve healthcare provider performance and for healthcare provider education.

Signature/Date _____

HEALTH INFORMATION RELEASE

I authorize Complete Family Dermatology to release information concerning any and all diagnostic studies and findings contained with my clinic files (whether performed here or elsewhere) to the family member or parties listed below.

NAME _____ RELATIONSHIP _____ PHONE _____

INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above-named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to insurance carriers that are pertinent to the above patient's medical care and are necessary to process my insurance claims. I will assign all medical and surgical benefits to Complete Family Dermatology. I understand that my insurance carrier may pay less than the actual bill for services. I understand I am responsible for all copays, deductibles, co-insurance, and balances. I understand and agree that I am ultimately responsible for any unpaid balances. A photocopy of this form shall be as valid as the original. I understand that I can withdraw this assignment at any time by notifying this office in writing.

I also acknowledge that I have received a copy of Complete Family Dermatology's "Notice of Privacy Policies."

Signature/Date _____

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT

Due to the hundreds of different insurance companies and plan provision, we at Complete Family Dermatology are unable to know specific details of each patient's plan. It is the responsibility of the patient to know their deductible and co-insurance.

In many instances, deductibles and co-pays have increased without your knowledge. If you are unsure about your coverage, please call your insurance company or agent. It is their obligation to explain the provisions of your plan. Although most insurance plans cover one annual exam, most insurance plans do not consider a skin cancer screening to be a covered preventative service.

Signature/Date _____

NO-SHOW / CANCELLATION POLICY

Complete Family Dermatology is dedicated to providing the best, most comprehensive care for our patients in a timely and efficient manner. To better achieve this, we have implemented a policy regarding no-show appointments and cancellations with 24-hour prior notice as follows:

NO-SHOW APPOINTMENTS

- A patient who fails to show up for their scheduled appointment without prior notice will be considered a "no-show".
- A patient having three (3) no-show appointments will be considered for dismissal from the practice.
- Patients who no-show appointments for 2 or more family members will be unable to schedule future double-appointments.

CANCELLATIONS

- Our office requires 24-hour prior notice for cancellations to allow the appointment slot to be available to another patient.
- Late "same-day" cancellations will be considered a "no-show" appointment.
- Patients cancelling three (3) times without 24-hour notice will be considered for dismissal from the practice.

LATE APPOINTMENTS

- Patients arriving 15 or more minutes late will be rescheduled unless the provider has available time to see the patient.
- Patients continually arriving late for three (3) or more times will be considered for dismissal from the practice.

**This policy may not apply in instances of emergency, illness, or weather conditions.

I have read and understand this policy.

Signature/Date _____