dermatology associates OF LINCOLN

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PATIENT INFORMATION

Last Name:	First Name:	Middle Initial:	Preferred Name:
Marital Status: □ Single □ Married □ Separated □ Divorced □ Widowed	Social Security #:	Date of Birth:	
Birth Sex: □ Female □ Male	Language:	Ethnicity: □ Hispanic □ Non-Hispanic □ Declined to specify	
Gender Identity (optional):	Race:	Preferred method of contact: □ Phone □ Patient Portal □ e-mail	
Emergency Contact Name:		Phone:	
Spouse/Partner Name:		Phone:	
Caretaker Name:		Phone:	
Patient Home Phone:	Patient Work Phone:	Patient Mobile Phone:	
Preferred Phone Number: □ Mobile □ Home □ Work			
Is it OK to leave a detailed message? □ Yes □ No			
Which phone numbers can we leave a message for you to return our call? □ Mobile □ Home □ Work			
e-mail address:	Would you like to opt in to email notifications? □ Yes □ No		
Patient Address:			
City:	**State:**	**Zip:**	
Patient Employer:			

MEDICAL INFORMATION RELEASE *(Notice of Privacy Practices are located at the front desk)*

The following people (family/friends) are allowed access to my medical records:

Name:	Relationship:	Phone:
Name:	Relationship:	Phone:
Name:	Relationship:	Phone:

_____ _____

Signature of Patient or Parent/Guardian *Date*

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INSURANCE INFORMATION

How will this visit be paid for? □ Insurance □ Self-Pay	
Does your insurance require a referral? □ Yes □ No If yes, list referring physician information below.	
Physician's Full Name:	Phone:

PRIMARY INSURANCE

Insurance Name:	Insurance Phone:
Policy Number:	Group Number:
Patient's Relationship to Policy Holder:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Birth Sex:
Policy Holder Social Security Number:	

SECONDARY INSURANCE

Insurance Name:	Insurance Phone:
Policy Number:	Group Number:
Patient's Relationship to Policy Holder:	Policy Holder Name:
Policy Holder Date of Birth:	Policy Holder Birth Sex:
Policy Holder Social Security Number:	

PARENT/GUARDIAN RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT)

Responsible Person Name:		Responsible Person Phone:
Date of Birth:	Social Security Number:	
Relationship to Patient:		
Responsible Person Address:		
City:	State:	Zip:
Employer:		Employer Phone:

_____ _____

Signature of Person Responsible for Payment *Date*

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DERMATOLOGY ASSOCIATES OF LINCOLN POLICIES AND CONSENT

Financial Responsibility and Policy:
Know that your copay and/or patient self-pay balance is due at the time of service. As a courtesy to our patients, we will gladly file the forms necessary so that you receive the full benefit of your medical insurance coverage. We ask that you read and understand your insurance policy to be aware of coverage benefits and limitations. If you are concerned about coverage for any of our services, please contact your insurance company prior to your visit. If your insurance company denies coverage, or we otherwise do not receive payment 60 days from filing your claim, the amount will then become due and payable by you. Remember that your coverage is a contract between you and your insurance company and/or your employer and your insurance company. Although we will make a good faith effort to assist you in obtaining your benefits, we cannot force your insurance company to pay for the services we have provided to you. Ultimately, you are responsible for knowing and understanding your coverage. Any balance left after insurance benefits have been paid is the responsibility of the patient.

No Show Policy:
If you are not able to keep your appointment, please call us at least 24 business hours before your appointment time. Cancellations and reschedules with short notice do not allow us to offer the appointment to another patient. If you do not show up for your appointment, cancel or reschedule without a 24-business hour notice, you will be billed $50.00 for the missed appointment time. The fee must be paid in full before another appointment can be scheduled.

Consent for Medical Treatment and Minor Procedures:
I understand that:

- During the course of my visit, my provider may recommend that a procedure be performed. Such procedures are not limited to but include: liquid nitrogen destruction (freezing), biopsies, shave removals, excisions, incision and drainage, scissor snip excision, curettage (scraping), electrodessication (use of cautery/heat), and steroid injections.
- The risks, benefits, and alternatives to these procedures will be explained to me at the time of my visit, prior to my provider performing the procedure(s).
- I will be allowed to ask any questions that I have.
- Any and all procedures are optional. I may choose to decline a procedure for any reason.
- **Photographs may be taken of me and kept in my medical file. Photographs will not be used in any other manner without my express written consent.**
- There is no guarantee of results; as medicine is not an exact science.
- Some procedures may need to be performed more than once to achieve optimal results.
- Procedures may incur additional charges and I will be responsible for payment.
- If a procedure is deemed cosmetic, and therefore not covered by my insurance, I will be responsible for payment.
- For more invasive procedures and certain cosmetic procedures, a separate consent may be required.
- If I have a biopsy done, the specimen will be sent out of the office for pathologic evaluation and I will be billed for any amount not covered by my insurance.

Assignment and Release
I authorize payments to be made directly to Dermatology Associates of Lincoln, LLC by my insurance company. I authorize the release of any demographic and medical information requested by my insurance company in order to pay on the claim. I accept financial responsibility for all services not covered by my insurance. I acknowledge and understand the No Show policy. I have read "Consent for Medical Treatment and Minor Procedures" and I consent to routine minor procedures and medical treatment.

Acknowledgment of Receipt of Notice of Privacy Practices
I acknowledge that I have read the Dermatology Associates of Lincoln Assignment, LLC and Release statement, as well as the Notice of Privacy Practices. These statements describe how my health information may be used or disclosed in order to receive benefits. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the clinic location where I receive health care services as well as on their website.

By signing below, I am (i) providing my express consent to medical treatment and minor procedures, (ii) acknowledging the terms of the Dermatology Associates of Lincoln Assignment, LLC and Release statement, as well as the Notice of Privacy Practices, and (iii) agreeing to the policies contained in this document.

_____ _____
Signature of Patient or Parent/Legal Guardian *Date*

_____ _____ _____
Patient Name (Printed) *Parent/Legal Guardian Name (Printed)* *Relationship to Patient*

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