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:		**PO Box/Apartment Number:**	
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/Legal 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/LEGAL GUARDIAN RESPONSIBLE FOR PAYMENT (IF OTHER THAN PATIENT)

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

_____ _____

Signature of Person Responsible for Payment *Date*

DERMATOLOGY ASSOCIATES OF LINCOLN POLICIES AND CONSENT TO TREAT

Financial Responsibility Policy:
I understand that my copay/self-pay balance is due at the time of service. I understand that I am responsible for charges not covered by my insurance plan. I agree to pay for services rendered including any co-pays, deductibles, coinsurance, and non-covered services. I am responsible for knowing and understanding my insurance benefits and coverage. If I am concerned about coverage for any service, I will contact my insurance company prior to the visit. I understand that my coverage is a contract between me and my insurance company and/or my employer and my insurance company. As a courtesy, Dermatology Associates of Lincoln will submit my insurance claims, so I receive full benefit of my medical coverage. I understand that they will make a good-faith effort to collect on the claim, but they cannot force my insurance company to pay. If my insurance denies coverage, or payment is not received 60 days from filing the claim, I understand that I become responsible for payment.

No Show Policy:
I understand that if I am not able to keep my appointment, I will call at least 24 business hours before my appointment time to avoid a No Show fee. I understand that a cancellation/reschedule with short notice does not allow another patient to take the appointment time. I understand that the No Show fees are as follows: (i) missing an office visit - $50; (ii) missing a 30-minute appointment - $100; (iii) missing a surgery - $150.00. I understand that the fee must be paid in full before another appointment is scheduled.

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

- During my visit, my provider may recommend a procedure. Such procedures include but are not limited to: 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 prior to the procedure(s).
- Any and all procedures are optional. I may choose to decline a procedure for any reason.
- If I refuse to have a cancerous lesion removed, I will be asked to sign an Informed Refusal form.
- **Photos may be taken of me and kept in my medical file. Photos will not be used in any other manner without my express written consent.**
- There is no guarantee of results. Medicine is not an exact science.
- Some procedures may need to be performed more than once to achieve optimal results.
- Procedures are not included in the copay amount. I am responsible for payment of any additional charges.
- If a procedure is deemed cosmetic, and therefore not covered by my insurance, I am responsible for payment.
- For more invasive procedures and certain cosmetic procedures, a separate consent may be required.
- If I have a biopsy, the specimen will be sent for evaluation by a pathologist. I understand I will receive a separate bill from the pathologist and am responsible for any amount not covered by my insurance.

Assignment and Release
I authorize payments to be made directly to Dermatology Associates of Lincoln by my insurance company. I authorize the release of any demographic and medical information requested by my insurance company 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 the "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 and Release statement, as well as the Notice of Privacy Practices. These statements describe how my health information may be used or disclosed to receive benefits. I understand that I should read it carefully. I am aware that the Notice may change 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 (i) provide my express consent to medical treatment and minor procedures, (ii) acknowledge the terms of the Dermatology Associates of Lincoln Assignment and Release statement, as well as the Notice of Privacy Practices, and (iii) agree 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*

Updated 04/11/2025