dermatology associates OF LINCOLN

6969 South St | Lincoln, NE 68506 | 402-413-7460

Casey D Bowen, MD ● Gina L Weir, MD ● Jay Arthur, PA-C ● Christina Meyer, PA-C ● Meredith McManaman, PA-C

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*

Updated 04/20/2026

dermatology associates OF LINCOLN

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*

Updated 04/20/2026

dermatology associates OF LINCOLN

POLICIES AND CONSENT TO TREAT

Financial Responsibility Policy:

☐ I understand that payment is due at the time services are provided, including any applicable copay or self-pay balance. I agree to pay for all services rendered, including copays, deductibles, coinsurance, and any services not covered by my insurance plan. ☐ I understand that it is my responsibility to know and understand my insurance benefits and coverage. If I have questions about whether a service is covered, I will contact my insurance company prior to my visit. ☐ I acknowledge that my insurance coverage is a contract between me and my insurance company (and/or my employer). As a courtesy, the Practice will submit claims to my insurance company on my behalf. However, I understand that they cannot guarantee my insurance company will pay. ☐ If my insurance denies coverage, or if payment is not received within 60 days of claim submission, I agree that I am responsible for the remaining balance.

No Show Policy:

☐ If I am unable to keep my appointment, I agree to notify the office at least 24 business hours in advance to avoid a No Show fee. ☐ I understand that late cancellations or missed appointments prevent other patients from using that time. The following fees apply: 1) Missed office visit: $50; 2) Missed 30-minute appointment: $100; 3) Missed surgery: $150. ☐ I understand that any No Show fee must be paid in full before scheduling another appointment.

Consent for Medical Treatment and Minor Procedures:

I understand that:

- During my visit, my provider may recommend medical treatments or minor procedures. These may include but are not limited to: liquid nitrogen treatment (freezing), biopsies, shave removals, excisions, incision and drainage, scissor snip excision, curettage (scraping), electrodessication (heat/cautery), and steroid injections. The risks include but are not limited to scarring, infection, bleeding, scabbing, incomplete removal, nerve damage, and allergy to anesthesia.
- I will have the opportunity to ask questions and receive answers before consenting to any procedure.
- All procedures are voluntary, and I may decline any treatment at any time.
- If I decline recommended treatment for a cancerous lesion, I may be asked to sign an informed refusal form.
- Photographs may be taken for medical documentation and included in my medical record. They will not be used for any other purpose without my written consent.
- I understand that there are no guarantees of specific results, as medicine is not an exact science.
- Some conditions or treatments may require multiple procedures to achieve the best outcome.
- Procedures are not included in the standard copay and may result in additional charges for which I am responsible.
- If a procedure is considered cosmetic and not covered by insurance, I agree to pay for it.
- Certain procedures may require a separate, additional consent form.
- If a biopsy is performed, the specimen will be sent to a pathologist. I understand I may receive a separate bill for these services and am responsible for any balance not covered by my insurance.

Assignment and Release:

☐ I authorize my insurance company to pay benefits directly to Dermatology Associates of Lincoln for services provided. ☐ I also authorize the release of necessary demographic and medical information to my insurance company for the purpose of processing claims. ☐ I accept financial responsibility for any charges not covered by my insurance. I acknowledge that I have read and understand the “No Show Policy” and the “Consent for Medical Treatment and Minor Procedures.”

Acknowledgment of Receipt of 1) Notice of Privacy Practices and 2) Patient Rights and Responsibilities:

☐ I acknowledge that I have received and reviewed the Notice of Privacy Practices as well as the Patient Rights and Responsibilities documents. The first document explains how my health information may be used and disclosed for treatment, payment, and healthcare operations. The second document provides an overview of my Rights and Responsibilities as a patient. ☐ I understand that these notices may be updated at any time and that I may request a current copy at the clinic or view it on the Practice’s website.

By signing below, I:

1. Consent to medical treatment and minor procedures as described above,
2. Acknowledge the Assignment of Benefits and Release of Information,
3. Confirm receipt of the Notice of Privacy Practices and Patient Rights and Responsibilities, and
4. Agree to all policies outlined in this document.

_____ _____

Signature of Patient or Parent/Legal Guardian *Date*

_____ _____ _____

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

Updated 04/20/2026