Patient Information Sheet

Welcome to Dermatology Physicians of Dallas and Frisco. We appreciate your time in completing these forms.

Date: _____ **Email Address**: _____

Phone Numbers(check preferred): _____ _____ _____
Home Cell Work

Patient's Name: _____
Last First Middle

Mailing Address:_____
Street

_____
City State Zip

Marital Status: Single Married Divorced Widowed **Sex**: Male Female

Social Security #: _____ **Date of Birth**: _____

Occupation of Patient: _____

Employer: _____ Employer's Phone: _____

Responsible Party, if different from patient (billing statements will be addressed to the responsible party):

(For minor patients, the responsible party will be the individual signing this form)

Name: _____ Date of Birth: _____

Address: _____

Phone: _____ Relationship to Patient: _____

Referral to/Patient of/Appointment with: (X on all applicable)

__ Dr. Betty Park __ Dr. Miriam Singer__ Dr. Anne Tuveson__ Dr. So Yeon Paek__ Elaina Ricci, PA-C__ Sheryl Gyr, PA-C__ April Wiseman, PA-C

Were you referred by another physician? If yes, complete below:

Doctor's Name: _____ Phone: _____

Address: _____

Were you referred by someone other than a physician? If so, name: _____

Are other members of your family patients with us? If so, name: _____

Do you have a primary care physician? If so please list below.

Doctor's Name: _____ Phone: _____

Address: _____

Do you give permission to disclose relevant medical information to your primary care physician: YES ____ NO ____

Do you have an Advanced Directive: YES ____ NO ____

PRIMARY INSURANCE INFORMATION

Name of Primary Insurance Policy Holder if other than self. If self, please write "self."

_____
Last First Middle

Primary Insurance Company: _____ DOB:_____

ID #: _____ Group #: _____ Relationship to Patient:_____

SECONDARY INSURANCE INFORMATION

_____

Last First Middle

ID #: _____ Group #: _____

Signature: _____ Date: _____

WE REQUIRE AN EMERGENCY CONTACT FOR ALL PATIENTS.

Name of person to contact in case of an emergency (must be at least 18 years of age):

_____

Last First Middle

Relationship to Patient: _____

Phone: _____ _____ _____

Home Work Cell

DISCLOSE OF INFORMATION

I allow Dermatology Physicians of Dallas and Frisco to share my medical or billing information with the individuals listed below:
(Please list any PHYSICIANS, family, or other individuals)

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

Name: _____ Relation: _____ Phone: _____

PHARMACY INFORMATION:

I consent to have the office electronically access my medication record from my pharmacy (when possible).

Signature: _____ Date: _____

ACCURACY OF INFORMATION: I have read the above information and corrected and/or completed any incorrect or missing information. I represent to Dermatology Physicians of Dallas and Frisco that all of the information is complete and accurate.

OUR FEE POLICY: To control costs, we ask our patients to pay for their office visit at the time services are rendered.

ASSIGNMENT OF BENEFITS: I hereby authorize Dermatology Physicians of Dallas and Frisco to furnish information to insurance carriers concerning my or my dependents illness and treatments. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all co-payments, co-insurance, deductibles, and any non-covered services. I hereby authorize said assignee to release all information necessary to secure the payment.

I UNDERSTAND that I am responsible for co-payments, co-insurance, deductibles, and any non-covered services. I understand it is my responsibility to know my benefit and whether or not the services I am to receive are a covered benefit. I will notify Dermatology Physicians of Dallas and Frisco of any changes in my health status or health insurance.

Signature: _____ Date: _____

FOR MINOR PATIENTS (if applicable):

I give permission for you to see and treat _____, my minor child in your office.

_____ _____

Parent/Guardian Signature Date

Our Office Policies

Cell Phones

- Please turn your cell phone off in the exam rooms so that we can focus on your health.

Payment

- We collect co-payments, deductibles, and/or co-insurances for **every visit** at the time of the visit.
- If you have a pre-existing waiting period on your insurance plan policy, then you will be responsible for the charges for the visit.
- If you have any questions regarding your co-pay, deductible, or co-insurance, please call your insurance company.
- In the event we are forced to submit a delinquent account to a collection agency, the collection fee or percentage charged by the agency, will be added to that account.

Labs

- Please note that lab charges, including pathology charges for skin specimen analysis, are separate and that you may receive a statement from the lab if a payment is due. Lab charges are determined by your insurance plan benefits. Please contact your insurance company for further information.

Referrals

- It is the responsibility of the patient to obtain referrals from your primary care physician if one is required under your insurance plan policy. If you are seen and treated in our office without obtaining a required referral then you will be responsible for the charges of the visit.

No Shows

- If you do not show up and so not call us 24 hours in advance to reschedule or cancel your appointment, we reserve the right to charge a $25.00 fee, $75.00 for surgery appointments, for the scheduled time that we are unable to give to other patients.
- After three consecutive no shows, cancellations, or reschedules, we will require a non-refundable deposit to make another appointment for you.
- Continuously missed appointments may result in termination of services.

Medical Records/Copies

- First copy of your records is free of charge. Thereafter, a fee of $25.00 for up to 20 pages and $0.15 (15cents) for each additional page will be charged for any additional copies requested for any reason.
- Please allow 10 business days for records to be sent.
- Please call us in advance so that we can have them ready when you arrive. **We do not fax reports to patients unless specifically stated**.

Emergency Visit/Hospital Visits

- In case of emergency, please call 911 or go to the nearest emergency facility/hospital.

We thank you for understanding our office policies. Our goal is to make your visit pleasant and professional. If you have any questions, please feel free to contact our office.

We thank you again for choosing us for your care. Please sign below to acknowledge that you have read our office policies.

_____

Patient

_____ _____

Signature/Authorized Signature Date

Dermatology Physicians of Dallas and Frisco
7777 Forest Ln., Ste. C-755
Dallas, TX 75230
255 W Lebanon Rd., Ste. 112
Frisco, TX 75036

Acknowledgement of Review of Notice of Privacy Practices

I have reviewed this Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

_____

Date

_____

Name of Patient

_____

Signature of Patient, Parent or Personal Representative

_____

Name of Parent of Personal Representative

_____

Relationship to Patient