PATIENT INFORMATION

Patient's Name: Last: _____First:_____MI:_____ **Suffix**:_____

Date of Birth:_____/_____/_____ **Gender:** Male / Female / Other **Marital status:** Child / Single / Married / Divorced / Widowed

Parent/Guardian: Name: _____Relationship:_____Date of Birth:_____/_____/_____

Address: Street: _____Apt #_____City: _____State: _____Zip Code: _____

Primary Phone #: (_____)_____ **Alternate phone #**: (_____)_____

Email: _____ ***Would you like to subscribe to our email list to receive announcements and exclusive offers on cosmetic services and product discounts? Yes ☐ No ☐***

(***Be advised our office will communicate with you and notify you of upcoming appointments with the contact information you provide.)***

INSURANCE INFORMATION ** ONLY COMPLETE THIS SECTION IF YOU ARE UNABLE TO PROVIDE A VALID INSURANCE CARD**

Primary medical insurance policy:_____Is a referral required? **Yes ☐ No ☐**

Group #: _____ Member/Subscriber ID #: _____

Claims Address: _____ Customer service #: _____

Subscriber information (if different from patient): Name: _____ Date of Birth: _____

Relation to Patient: _____ Gender: Male / Female / Other

Secondary medical insurance policy: _____ Is a referral required? **Yes ☐ No ☐**

Group #: _____ Member/Subscriber ID #: _____

Claims Address: _____ Customer service #: _____

Subscriber information (if different from patient): Name: _____ Date of Birth: _____

Relation to Patient: _____ Gender: Male / Female / Other

RELEASE OF INFORMATION

Employees of this office must have your permission to relay your medical information to someone you authorize us to communicate with via phone/text/email. If you do not give us permission to speak to a specific person on your behalf, we will be unable to relay any information to anyone other than the patient or legal guardian. Please list below anyone you authorize our office to discuss your medical care and test results with, we will keep this authorization on file and it will remain in effect until you revoke authorization by written notice.

1) Name: _____ **Relationship:** _____ **Number: (** **)** _____ **Emergency contact: ☐**

2) Name: _____ **Relationship:** _____ **Number: (** **)** _____ **Emergency contact: ☐**

COMMUNICATION PERMISSIONS

May we leave a message with benign pathology results and normal laboratory results? **Yes ☐ No ☐**

PRIVACY ACKNOWLEDGEMENT

I acknowledge that The Woodlands Dermatology/ Montgomery Dermatology Associates has provided me with a written copy of his/her Notice of Privacy Practices. I also acknowledge that I have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.

Patient / Legal Guardian initial to acknowledge: ☐

ASSIGNMENT AND RELEASE

I hereby assign, transfer, and set over to the Woodlands Dermatology/Montgomery Dermatology Associates all of my rights, title, and interest to my medical reimbursement benefits under my insurance policy in regards to all services performed in our office. I authorize the release of any medical information needed to determine these benefits. This authorization will remain valid until I revoke it by written notice. I understand that I am financially responsible for all charges whether it is a covered benefit by my insurance or not.

Patient / Legal guardian Signature:_____ **Today's date:**_____

Office & financial policies

Welcome and thank you for choosing The Woodlands Dermatology/Montgomery Dermatology Associates for your dermatology care. We are committed to providing you with the highest quality medical care, in an efficient, and cost-effective manner. We hope that by providing you with our policies in advance, we can prevent any misunderstanding or frustration at the time of your visit.

Insurance: When making an appointment with one of our physicians, it is your responsibility to confirm with your insurance company that our physician is currently under contract with your plan.

Self pay/No insurance: If you have no medical insurance or you are not using your insurance, you will be responsible for the entire cost of the visit upon checking-out.

Patient Payments/Refunds policy: Please be prepared to pay for your estimated cost of today's visit as well as any previous balances unless alternate arrangements are made prior to your visit. Our insurance department will make every effort to obtain your insurance benefits based on the information you have provided us prior to your appointment. Although we try very hard to obtain true and accurate information, your insurance carrier's database may not always be updated at the time of your visit. Therefore, some/all benefit information we obtain may not be factual. We recommend contacting your insurance company to determine your benefits, such as deductible/specialist copay/referral requirements prior to your appointment so you are aware of your requirements and potential out of pocket costs. We will determine and collect the estimated amount due from you at the end of your visit. For your convenience, we accept the following methods of payment: cash, check (VALID ID IS REQUIRED), MasterCard, Visa, Discover, and American Express. In the event you have overpaid or we mistakenly overcharged you for any reason we will promptly refund you by the method in which you paid. (If paid by cash you will receive a check by mail)

Referrals: Some insurance plans require you to obtain a referral prior to seeing a specialist; if your insurance requires a referral to see a specialist, you will be responsible for contacting and obtaining a referral from your primary care physician. Please do this well in advance of your scheduled appointment so you will have it at the time of your appointment. You are responsible for verifying that our office has received your valid referral prior to your appointment. You will also be responsible for obtaining a new referral as needed for additional visits or if your referral expires.

Late arrivals: We normally allow a 15-minute grace period following your scheduled arrival time at **your provider's discretion**. In the event we are able to see you, there may be a longer than usual wait time to allow patients arriving on time to be seen first. In the event that you arrive more than 15 minutes past your scheduled appointment time, you will be asked to reschedule.

No shows/Late cancellations: We require a 24-hour advance notice for all canceled appointments; this is to allow other patients needing an appointment sufficient time to use the canceled appointment slot. As a courtesy, we offer an automated reminder call or text approximately 48 hours prior to your appointment that will allow you to cancel your appointment at that time. When canceling your appointment less than 24 hours in advance (Non-emergent) you will be a considered a NO SHOW for that visit. You will then be required to provide a $50.00 deposit (*Surgical procedures will require a $150 deposit)*, to make a future appointment with our office. In the event you no show or cancel your appointment with less than 24 hours' notice, your deposit will not be refunded to you. Please note: If you have excessive no shows/late cancellations you will be dismissed as a patient in TWDA/MDA practice.

Non-covered procedures: A waiver may be required to acknowledge understanding of your responsibility for paying the entire cost for non-covered services. In dermatology, many procedures are considered cosmetic or medically unnecessary by Medicare and private insurers. These procedures include but are not limited to removal of skin tags, seborrheic keratosis, spider veins, etc. When you have non-covered services performed in our office, be prepared to pay for the service in full on the date the procedure is performed.

Cosmetic procedures: We require a $75.00-$150.00 deposit (depending on the procedure and length of your appointment) for all cosmetic procedures. This includes, but is not limited to chemical peels, laser treatments, sclerotherapy, fillers, Botox injections, etc. Cosmetic treatments are not covered by insurance; therefore, we will not file a claim to your insurance company for any treatment deemed as a cosmetic procedure. In the event that you NO SHOW or cancel your appointment with less than 24 hours' notice, we will then keep the deposit used to secure your appointment. In addition, you will also be required to provide a new $75.00-$150.00 deposit to schedule a future appointment.

Parent/Legal guardian of minor's: The parent(s) or legal guardian(s) accompanying a minor are responsible for providing current information as well as any payments due on the day of the visit.

Unaccompanied minor: Minors must have a written authorization on file for us to provide treatment for medical conditions. The parent/legal guardian must sign a waiver before any treatment can be rendered. Any unaccompanied minor must also provide any payments due on the day of the visit.

Outside Labs: Please be advised that our office uses an outside lab for processing and diagnosing specimens. Any lab fees and bills you receive are unrelated to your physician charges incurred at the visit. The lab will file your insurance, if applicable and bill you directly for any balances.

By signing below, I am acknowledging that I have read, understand, and have agreed to The Woodlands Dermatology/Montgomery Dermatology Associates office and financial policies. I hereby attest that I have given and agree to provide current demographics, current insurance information, and authorize TWDA/MDA the release of my information necessary for filing claims to my insurance companies and obtaining pre-certification, when necessary, by signing this statement.

Print patient name:_____ **Date of birth:** _____

Patient / Legal guardian signature:_____ **Today's date:** _____