

**PATIENT INFORMATION**

Date \_\_\_\_\_

**COMPLETE FAMILY  
DERMATOLOGY**

WWW.COMPLETEFAMILYDERMATOLOGY.COM

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Sex: M / F    Marital Status: S M D W    Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Email Address \_\_\_\_\_

Student / Retired    Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Primary Physician (First and last name) \_\_\_\_\_

Referring Physician (First and last name) \_\_\_\_\_

**PARENT OR RESPONSIBLE PARTY**

(If different from patient or patient is under 19 years of age.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Sex: M / F    Marital Status: S M D W    Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Email Address \_\_\_\_\_

Student / Retired    Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SUBSCRIBER INFORMATION**

(If different from above.)

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ M.I. \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Sex: M / F    Marital Status: S M D W    Birth Date \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Email Address \_\_\_\_\_

Student / Retired    Employer \_\_\_\_\_

Employer Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Patient Name \_\_\_\_\_

## EMERGENCY CONTACT/MEDICAL RELEASE

I authorize *Southpointe Dermatology Clinic* to release information concerning any and all diagnostic studies and findings contained within my clinic files (whether performed here or elsewhere) to the family members or parties listed below:

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Phone \_\_\_\_\_

Patient or responsible party signature \_\_\_\_\_

Date \_\_\_\_\_

## MEDICAL CONSENT

I voluntarily consent to treatment which may include procedures such as: shave removal biopsy, surgical excision or Mohs surgery. This office visit may include routine, diagnostic procedures including lab/pathology and medical treatment. I also consent to exams, tests, diagnostic and other medical procedures such as blood tests that my physician or physician's assistant may order. I understand that the procedures and treatments at *Southpointe Dermatology* may be performed by medical staff. I also understand that my physician may request that other health care providers care for me if my physician thinks it's necessary and I consent to their providing such care. I consent to the visual recording of my care if internal purposes to improve health care provider performance and for health care provider education.

Patient or responsible party signature \_\_\_\_\_

Date \_\_\_\_\_

## INSURANCE AND ASSIGNMENT OF BENEFITS AUTHORIZATION INFORMATION

I hereby authorize treatment of the above named patient and agree to pay all charges for treatment regardless of insurance coverage or the pendency of insurance claims.

I authorize the release of all medical information to insurance carriers that are pertinent to the above patient's medical care and are necessary to process my insurance claims. I will assign all medical and surgical benefits to *Southpointe Dermatology Clinic*. A photocopy of this form shall be a valid as the original. I understand that I can withdraw this assignment at any time by notifying this office in writing.

I also acknowledge that I have received a copy of *Southpointe Dermatology Clinic's* "Notice of Privacy Policies."

### I HAVE READ THIS INFORMATION THOROUGHLY AND UNDERSTAND IT

Signature of patient or responsible party \_\_\_\_\_

How did you first hear about our clinic? \_\_\_\_\_

## MEDICAL CONSENT

I voluntarily consent to treatment which may include procedures such as: shave removal biopsy, surgical excision or Mohs surgery. This office visit may include routine, diagnostic procedures including lab/pathology and medical treatment. I also consent to exams, tests, diagnostic and other medical procedures such as blood tests that my physician or physician's assistant may order. I understand that the procedures and treatments at *Southpointe Dermatology* may be performed by my physician, physician's assistant or nursing staff who are members of the *Southpointe Dermatology* medical staff. I also understand that my physician may request that other health care providers care for me if my physician thinks it is necessary and I consent to their providing such care. I consent to the visual recording of my care for internal purposes to improve health care provider performance and for health care provider education.

## PRIOR AUTHORIZATION / REFERRAL FOR INSURANCE

It is my responsibility to obtain prior authorization and /or physician referrals if required by my insurance carrier. I understand that if I am treated without authorization, I will be responsible personally for all or part of the cost of professional services.

## AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I authorize the release of all or part of the contents of my medical record to the following: 1) To persons, corporation or other entities providing health care services and supplies to me in cooperation with *Southpointe Dermatology*, its staff and employees whose services are deemed necessary and requested by my treating physician. 2) To persons, corporation or other entities responsible for payment of all or part of my clinic or physician charges including but not limited to insurance companies and government agencies. 3) To persons, corporations or other entities providing accounting, billing, credit, payment or collection services to, for, or in cooperation with *Southpointe Dermatology*. 4) To any health care provider assuming responsibility for my care or treatment immediately following my appointment. I further authorize the disclosure of my medical record and any written communications, reports, or other data concerning my treatment to my insurance carrier.

## FINANCIAL AGREEMENT AND RELEASE

I agree to pay for services rendered to me at the rates now in effect or to become effective during the course of my treatment. I understand that all billings for services are due and payable at the time of service. I agree that should my account go unpaid for more than 30 days from the date of service, that I will pay interest at the rate of fifteen (150 percent per annum from the date of service, computed monthly on the unpaid balance of my account. If there is an overpayment by me or on my behalf, or by my insurance carrier, I direct *Southpointe Dermatology* to apply the overpayment to any other unpaid account I may have with *Southpointe Dermatology*. I understand that *Southpointe Dermatology* is unable to finance patient account balances and may at its option, contract with independent agencies, finance companies and/or financial institutions to make financial information and services available for patients with outstanding account balances. I authorize the disclosure of patient demographic and financial information, including but not limited to the amount of my outstanding account balance from my record for the purpose of making such financial information and services available to me.

## AGREEMENT OF INSURANCE BENEFITS

I assign to *Southpointe Dermatology* all insurance benefits to which I may be entitled to the extent of charges owed to *Southpointe Dermatology*. I hereby authorize direct payment of all such insurance benefits to *Southpointe Dermatology* and I agree to pay for any and all charges not paid pursuant to this agreement.

Notice of Privacy Practices (same version) previously given.

\_\_\_\_\_  
Patient or Person Authorized to Consent for Patient / Relationship / Date

\_\_\_\_\_  
Reason Patient was Unable to Consent / Date

\_\_\_\_\_  
*Southpointe Dermatology* Representative - Witness to Signature / Date