

Dallas Center for Dermatology and Aesthetics

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PATIENT INFORMATION UPDATE

Name: _____ Date: _____

Address: _____
STREET CITY STATE ZIP CODE

Home Ph: (____) _____ Work Ph: (____) _____ Cell Ph: (____) _____

Email Address: _____

DOB: ____/____/____ Age: _____ Male Female Marital Status: S M D W

Employer: _____ SS# _____ - _____ - _____ DL# _____

Preferred Communication: Home Work Cell Email

OPTIONAL PATIENT INFORMATION (please circle your selection)

Race: White / Black / African American / Other : _____

Ethnicity: Not Hispanic / Latino Hispanic / Latino

Primary Language: English / Spanish / Other: _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Ph#/Address: _____

INSURANCE

Insurance Company: _____ Insured ID#: _____

Insured Name: _____ (if different from patient) DOB: ____/____/____

IN CASE of EMERGENCY

Contact Name: _____ / _____ Phone: (____) _____
RELATIONSHIP

RELEASE AND ASSIGNMENT OF BENEFITS: I hereby authorize the release of any & all medical information to my insurance carrier(s) or their representative, for purposes necessary in the adjudication or processing of any & all insurance claim(s) filed on my behalf & for which I am financially responsible. I further authorize all insurance benefits be paid to the provider rendering services on behalf of Dallas Center for Dermatology & Aesthetics.

CONSENT TO TREAT: I hereby consent to treatment by my dermatologist to include examination and treatment, prescribing medication and skin preparations.

PATIENT SIGNATURE (PARENT IF PATIENT IS MINOR CHILD)

DATE

Financial Policy

We are dedicated to providing the best possible care and service to you. Your complete understanding of your financial responsibilities is an essential element of your care and treatment. If you have any questions about the following financial policy, please do not hesitate in discussing them with us.

Your Insurance

We make every effort to follow the guidelines required by your insurance company for both **in office** and **telemedicine** appointments. However, every insurance contract is unique. If you do not inform us of any special requirements in your plan and we subsequently perform a service or test that is denied, we have no choice but to bill you directly for those charges. Every effort is made to file claims on your behalf with your insurance plan. Unfortunately, if we are unable to collect from your insurance company, you will be held financially responsible. Therefore, we encourage our patients to be pro-active in assuring that claims are paid.

If your insurance coverage changes, it is your responsibility to notify our office at least **24 hours** before your next appointment. Failure to do so may result in rescheduling of your appointment. In addition, we may not be a provider with your new insurance. You will then be treated as a cash patient and given a superbill in order to file your own claim.

You may receive a separate bill from an off-site laboratory (Ameripath, Freeman-Cockerell, LabCorp etc) for any lab tests your physician may order. Please discuss any lab billing discrepancies with that laboratory.

With the exception of our Medicare patients, we DO NOT file secondary insurance.

Cancellations and Missed Appointments

All cosmetic appointments will require a credit card number on file upon scheduling. We kindly request that you give us a minimum of 24 hours notice if you are unable to keep your appointment. Failure to do so will result in a missed appointment fee. This fee is NOT covered by your insurance plan. The missed appointment fee schedule is as follows:

Medical - \$85

Cosmetic - Minimum of \$100 for each provider on the same day. Higher fees may be applied to procedures including, but not limited to, Thermage, Fraxel Repair, Fraxel Restore, CoolSculpting, Sculptra, Fotofacial, Botox, and fillers. In the case of prepaid packages, one session will be deducted from the package.

Returned check fee

There will be a \$35 charge for all returned checks.

Collections: If your account is turned over to our collection agency, you will be responsible for the collection fee charged us by the agency in addition to your outstanding balance.

Your insurance card and driver's license will be required at check in.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

Signature of Patient or Responsible party

Today's Date

Printed Name of Patient

Date of Birth

In signing this HIPAA Patient Acknowledgement form , you acknowledge and authorize, that you hold harmless this Healthcare Facility, its employees and agents for any and all liability (including but not limited to negligence) arising out of or occurring from this authorization. I understand that my records may be subject to re-disclosure by recipient(s) and unprotected by federal or state law; that this authorization remains effective until this Healthcare Facility is in actual receipt of a signed revocation or until the records retention period required under federal and state law has expired and the records have been destroyed; that I have the right to revoke this authorization at any time, provided I do so in writing; that I have been given the opportunity to ask question; that I have received a copy of the signed authorization; that I may inspect a copy of my PHI to be used or disclosed under this authorization; that this Healthcare Facility has not conditioned provision of services to or treatment of me upon receipt of this signed authorization; and that I may refuse to sign this authorization. A copy of this signed, dated Authorization shall be as effective as the original.

Consent to release Protected Health Information (PHI)

I understand that in order to disclose my PHI, Dallas Center for Dermatology and Aesthetics, PLLC must have my consent, therefore, I authorize Dallas Center for Dermatology and Aesthetics, PLLC, to disclose my PHI as described in the above forms, to the recipients listed below:

Description of the information to be disclosed (check all that apply)

All Procedures Test Results Appointments Other Surgeries Billing/Account information

Name(s) of the person(s) authorized to obtain the above mentioned information. (e.g. Physician other than your referring doctor, family members and other specified person/persons)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Contact Information:

I authorize Dallas Center for Dermatology and Aesthetics to contact me at the following number with results or questions:

Home _____ Cell _____ Work _____

Email _____

May we leave a detailed message on your answering machine or voicemail?

Yes No Failure to check one of these boxes may delay results

By Patient: (Print and sign) _____

Date: _____

Or Patient's Representative (Print name, sign and describe authority)

Date: _____