WESTSIDE
DERMATOLOGY

Please write clearly and carefully-
This information will be used on all of your records.
Thank you for choosing Westside Dermatology.
Our team of board-certified dermatologist look forward to caring for you and your skin.

PATIENT INFORMATION

*** Last Name:** _____

***First Name:** _____

***Middle Name:** _____

***Preferred Name:** _____

***Date Of Birth:** _____

***Address:** _____

_____

***City, State, Zip:** _____

***Cell (text) Phone:** _____

Home Phone: _____

***Preferred Reminders (circle one): CALL TEXT**

***Email:** _____

***Sex** ☐ Female ☐ Male ☐ Intersex

Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Other:_____

Race
☐ American Indian or Alaska Native ☐ Asian
☐ Black or African ☐ West Indian ☐ White
☐ Other ☐ Declined To Specify

Ethnicity ☐ Not Hispanic or Latino ☐ Hispanic or Latino
☐ Declined to Specify

Social Security Number: _____

Employer Name: _____

Emergency Contact -Name, Phone and Relation:

_____

How did you learn about Westside Dermatology?

- □ Social Media
- □ Search Engine
- □ Physician Referral
- □ Patient Referral
- □ Event
- □ Insurance Referral
- □ Mailer
- □ Advertisement
- □ Existing Patient

Document is double-sided

***Signature:**_____ ***Date:**_____ ***Staff:**_____ ***Date:** _____

Patient Agreement

WESTSIDE DERMATOLOGY

Release of Information and Assignment of Insurance Benefits

I hereby authorize the release of medical information to my primary care or referring physician, to consultants if needed and as necessary to process insurance claims, insurance applications and prescriptions. I also authorize payment of insurance benefits to the physician directly.

Receipt of Notice of Patient Rights and Responsibilities AND Notice of Private Practices (HIPAA)

My signature below indicates I have been offered a copy of BOTH my physician's Notice of Patient Rights and Responsibilities AND Notice of Private Practices (HIPAA)

Payment Policy

I certify the information I've provided for payment of services rendered for government or private health insurance is correct. I understand I am financially responsible to the physician for any balance due from any deductibles, co-payments, co-insurance, or in the event I have no insurance, or my insurance does not cover services provided to me. I understand I am financially responsible for all services incurred. Physician reserves the right to impose reasonable financing/late fees as well as reasonable costs, attorney fees and/or expenses incurred in the collection of my account should it become delinquent. The following fees apply to patient accounts: $5.00 if copayment is not made at time of service; $2.00 per month or 1% of balance (whichever is greater) on billed items 30 days past due; $18 returned check; $50.00—$150.00 missed appointment or appointment canceled within 48 hours (two business days). If I file bankruptcy and charges for services received at Westside Dermatology are written off, payment in full for services written off will be expected from me if I seek future treatments at this facility. Upon notification of a bankruptcy filing, Westside Dermatology reserves the right to cancel

Insurance Coverage

MEDICARE: Westside Dermatology is a Medicare participating provider and accepts assignment on all non-cosmetic claims. I understand I am responsible for meeting the annual $140.00+ deductible and the co-insurance balance remaining on each claim. I agree to direct any grievances regarding the method of how my claim benefits were calculated directly to Medicare. Furthermore, this office is required to keep my signature on file authorizing them to file claims to Medicare on my behalf and to release information to that payer if they require it to properly consider a claim. I authorize any holder of medical or other information about me to release it to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply.

COMMERCIAL: (Aetna, Cigna, First Choice, Great West, Premera, Regence, Uniform, United, etc.): I will be responsible for paying my annual deductible, co-payment, and charges for any service/procedure deemed not medically necessary or cosmetic by my insurance. I acknowledge I am responsible for any balance remaining after my insurance processes my claim. I agree to direct any grievances regarding the method of how my claim benefits were calculated directly to my insurance.

SECONDARY INSURANCE: I understand Westside Dermatology will bill my secondary insurance plan as a courtesy and will do so for me once per claim and is under no obligation to pursue reimbursement 30 days after the claim is originally filed. (Note: tertiary insurance is not billed by Westside Dermatology.)

NON-NETWORK INSURANCE: I understand my insurance does not consider my Westside Dermatology physician to be a preferred provider and may pay my claims at a lower rate or not at all.

UNINSURED: I understand that payment in full is due upon receiving care and I agree to ask the provider how much services will be prior to having them performed.

Signature of patient (or guardian if a minor) **Date**

Print name of patient **Print name of guardian (if patient is a minor)**