Lake DERMATOLOGY, INC.

Patient Information

Name _____Nicknames _____

Address _____ City _____ State _____Zip _____

Mailing Address (if different) _____

Phone Number _____ Date of Birth _____Age _____

Cell Phone Number _____Social Security Number _____

Email _____

Place of Employment _____Work Phone _____

Primary Care Physician _____Address _____

Referring Physician _____Address _____

Preferred Language _____

Race: _____ White _____ American Indian or Alaskan Native _____ Asian

_____ Black or African American _____ Native Hawaiian or other Pacific Islander

Ethnic Group: _____Hispanic or Latino _____ Non Hispanic or Latino _____ Unknown

Responsible Party (for minors only)

Name _____Relationship _____

Address _____ City _____ State _____Zip _____

Telephone _____Social Security Number _____Date of birth _____

Emergency Contact Information

Name _____Phone Number _____

Privacy Policy Information

I authorize my doctor or staff to leave messages including medical information:

_____ **Yes** _____ at HOME _____ at WORK _____on my CELL PHONE

or with the following individuals: Please list

My spouse or significant other _____ My son or daughter _____

Other _____

_____ **No**

I understand that this permission is valid until revoked by me

Receipt of Notice of Privacy Practices

My signature below indicates I have received and/or reviewed a copy of the HIPPA Policy.

Patient or Responsible Party Signature _____ Date _____

Lake
DERMATOLOGY, INC.

FINANCIAL POLICY

Thank you for choosing Lake Dermatology, Inc. for your dermatology health care. Our main concern is that you receive the proper and optimal treatment needed to restore your health. If you have any questions or concerns regarding our payment policies, please do not hesitate to discuss them with us.

We do require all patients to complete their registration information, read and sign our financial policy prior to receiving your examination or treatment.

Commercial Insurance: Any deductible/copayment or 20% of services will be paid each visit. After insurance has paid, any remaining balance will be the responsibility of the patient, due within 10 days. Any balance not paid in full will incur a $5.00 per month fee.

In the event that you, as the patient, or we, as the physician, are not aware of a charge that is not covered by your plan, you will be billed after we obtain a denial from your insurance carrier payment due within 10 days.

Self-Pay: 100% of services rendered each visit.

Payments can be made by cash, check, debit or credit card (Visa & MC and Discover).
In the event of a returned check, a $35.00 service fee will be charged to your account.
Delinquent accounts will be turned over to collection 60 days past due. If your account goes to collection, you agree to be responsible for all fees involved in the collection process.

I hereby guarantee payment of all charges incurred at Lake Dermatology Inc. I hereby assign and direct to pay any and all benefits for medical services under this claim to Lake Dermatology Inc. I authorize the release of any medical information necessary to process my claim with the above assignment.

Patient/Guardian Signature_____ Date_____

MEDICARE

We are participating providers of the Medicare program. We will accept assignment on all claims. Patients are responsible for meeting their annual deductible and paying for the 20% copayment. We do file with secondary/supplemental carriers. However, in the event that the secondary does not pay within 60 days, patients will be billed.

I authorized assignment of Medicare benefits to Lake Dermatology Inc. for any services furnished by that physician/provider. I authorize the holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine those benefits payable to related services.

I understand my signature authorizes release of medical information necessary to pay the claim. If "the other health insurance" is indicated in box 9 of the HCFA 1500 form, or elsewhere on the approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, coinsurance, and non-covered services.

Patient/Responsible Party Signature _____ Date _____

Cancelation/No Show Policy

Lake Dermatology asks that you kindly provide us 24 hours notice for any canceled appointments. We reserve the right to charge a failed visit fee of $25 for any visit not canceled within 24 hours.

Signature _____ Date_____