LAS COLINAS DERMATOLOGY

ALISON A. BLACK, M.D. ~ BROOKE SMART, FNP
DERMATOLOGY AND DERMATOLOGIC SURGERY

PATIENT INFORMATION

(ANSWER ALL QUESTIONS• CIRCLE CHOICES THAT APPLY• PRINT CLEARLY)

NAME OF PATIENT_____
LAST FIRST MIDDLE

HOME ADDRESS_____
STREET APARTMENT #

_____
CITY STATE ZIP

SSN_____-_____-_____ **EMAIL**_____

HOME #: (_____) _____-_____CELL #:(_____) _____-_____ WORK#:(_____)_____-_____

WHICH PHONE NUMBER WOULD YOU PREFER WE USE TO CONTACT YOU?_____

With your permission, we can leave detailed messages on your phone of choice for any medical information such as biopsy or lab results. YES_____ Home_____ Cell_____ NO_____

SEX M F MARITAL STATUS S M W BIRTHDATE_____AGE_____

RESPONSIBLE PARTY/INSURED

NAME_____**RELATIONSHIP TO PATIENT**_____
LAST FIRST MIDDLE

HOME ADDRESS_____
STREET CITY STATE ZIP

CELL PHONE(___)____-_____EMPLOYER_____WORK PHONE(___)____-_____

SS#_____**DATE OF BIRTH**_____

PAYMENT FOR OFFICE VISITS IS EXPECTED AT THE TIME OF SERVICE. INSURANCE FOR WHICH DR. BLACK IS A PROVIDER WILL BE FILED FOR COVERED SERVICES. YOU ARE RESPONSIBLE FOR REFERRAL APPROVAL FROM YOUR PRIMARY PHYSICIAN IF REQUIRED BY YOUR PLAN, PAYMENT OF COPAYMENTS, CO-INSURANCE, AMOUNTS APPLIED TO YOUR DEDUCTIBLE, AND SERVICES NOT COVERED OR APPROVED BY YOUR INSURANCE COMPANY. SIGN HERE TO AUTHORIZE PAYMENT TO DR. BLACK AND TO AUTHORIZE US TO RELEASE FINDINGS OF OUR EXAMINATION TO YOUR PHYSICIAN OR YOUR INSURANCE COMPANY AS NECESSARY TO PROCESS YOUR CLAIM.

SIGNATURE_____**DATE**_____

PLEASE PRESENT YOUR INSURANCE CARD TO THE RECEPTIONIST

LAS COLINAS DERMATOLOGY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, Las Colinas Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Las Colinas Dermatology's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent.
Las Colinas Dermatology reserves the right to revise its Notice of Privacy Practices at any time.
A revised Notice of Privacy Practices may be obtained by forwarding a written request to Las Colinas Dermatology at 440 W. IH 635, Suite 365, Irving, TX 75063.

With my consent, Las Colinas Dermatology may call my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others. I understand that Las Colinas Dermatology may occasionally be offering special promotions, events, discounts, or the announcement of new cosmetic treatments, services, or products that I may find of interest.

With my consent, Las Colinas Dermatology may also mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards, patient statements and/or information regarding special promotions, events, discounts, or the announcement of new cosmetic treatments, services, or products that I may find of interest.

With my consent, Las Colinas Dermatology may e-mail to me any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Las Colinas Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I understand that Las Colinas Dermatology may occasionally be offering special promotions, events, discounts, or the announcement of new treatments, services, or products that I may find of interest, and consent to receiving this information by e-mail.

By signing this form, I am consenting to Las Colinas Dermatology's use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Las Colinas Dermatology may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Patient's Name Date

_____
Print Name of Patient or Legal Guardian

LAS COLINAS DERMATOLOGY

Disclosure and Consent

PATIENT AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION OVER THE TELEPHONE, BY EMAIL OR FACSIMILE

I authorize **Las Colinas Dermatology, P.A.** to disclose my medical information pertaining to my diagnosis and/or treatment, laboratory test results, medical history or any other such related information to those listed below.

(Example: Referring Physician, Family Physician, Mother, Father, Spouse, Children, etc.)

1._____/_____/_____
Name of Entity Telephone Number Relationship

2._____/_____/_____
Name of Entity Telephone Number Relationship

3._____/_____/_____
Name of Entity Telephone Number Relationship

4._____/_____/_____
Name of Entity Telephone Number Relationship

5._____/_____/_____
Name of Entity Telephone Number Relationship

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand and authorize release of this information to other health care providers associated with my care to facilitate further health care treatment. I further understand that requests for medical information from persons' not listed above will require a specific authorization prior to the disclosure of any medical information.

_____/_____
Name of Patient Date of Birth

_____/_____/_____
Signature of Patient/Legally Authorized Representative Date Relationship

_____/_____
Witness Date

LAS COLINAS DERMATOLOGY FINANCIAL POLICY

Thank you for choosing Las Colinas Dermatology. Dr. Alison Black and Brooke Smart, FNP are committed to providing excellent dermatology services to you, our patient. As a part of our professional relationship, it is important that you have an understanding of our financial policy.

All patients must read and sign this form prior to receiving services.

- **It is your responsibility to provide us with your most current insurance information.**
  - If you fail to provide accurate insurance information in a timely manner, your insurance company may deny the claim. If the claim is denied, you will be financially responsible for services rendered.
  - We must emphasize that, as medical providers, our relationship is with you, the patient, and not your insurance company. Your insurance is a contract between you, your insurance company and possibly your employer. It is your responsibility to know and understand the level of services covered by your insurance company.
  - We may accept assignment of insurance after verification of your coverage, Please be aware that some or perhaps all of the services provided may not be covered in full by your insurance company. **You are financially responsible for services not covered by your insurance company.**
  - We charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.
  - Copayments, coinsurance and/or deductibles are due at the time of service. We will estimate the amount you owe based on information we receive from your insurance company. However, you are responsible for paying the full amount determined by your insurance company once they have paid your claim – regardless of our estimation.

- **It is your responsibility to provide us with your most current billing information.**
  - You must provide your most current billing address, all available telephone numbers and any other important contact information. If your address or contact information changes, it is your responsibility to contact us with the updated information.
  - We will send a statement (to the billing address you provide) notifying you of any balances you may owe. If you have any questions or dispute the validity of this balance, it is your responsibility to contact our business office within 30 days after receipt of the initial statement. You can call (972)432-0300.
  - **Payment in full is due upon receipt of the statement.** Patient balances not paid in full within 30 days of the statement issue date are deemed past due. **Past due account may be subject to a $5.00 monthly late fee and may be referred to a professional collection agency and/or attorney for further collection activity.** You will be responsible to pay all collection costs incurred, including attorney's fees and court costs if applicable.
  - If you are not able to pay the balance due in full, you must contact our billing office to discuss a payment schedule. Any late fees already incurred on past due balances will be included in any mutually agreed upon arrangements. If you fail to make payments as agreed upon, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred, including attorney's fees and court costs if applicable.
  - In the event you submit payment by check and the bank returns the check unpaid for any reason, we will add $25.00 to your original balance. In addition, we may seek all additional legal remedies provided to us under Texas law.
  - We may charge you a "No Show" fee of $25 if you fail to cancel or reschedule your appointment at least 24 hours prior to the appointment. You may leave a non-emergency message on our after-hours phone service if needed for a cancellation.
  - Full payment is due at the time of service. We accept cash, checks and credit cards.

I have read and understand this Financial Policy.

Signature of Responsible Party	**Date**

PATIENT NAME:_____ **PATIENT DATE OF BIRTH:**_____