KUYKENDALL DERMATOLOGY

NEW PATIENT HEALTH INFORMATION

Name:_______________________________________ Age:_________ Today's Date:____________

Reason for Visit:____

Dr. Kuykendall offers a skin check to check for skin cancer, moles, etc.
Would you like to have a total body skin check today? Yes No

Referring Physician:____

How did you hear about us?____

Previous History of Skin Cancer? Yes No

If yes, what type and where?____

Please list all medications:____

____

Allergies to medications:____

Do you currently have any of the following?

Asthma	yes	no	History of abnormal scarring/keloids	yes	no
Allergies	yes	no	Irregular menstrual cycles	yes	no
Depression	yes	no	Itchy Skin	yes	no
Fever	yes	no	Thin skin or easy bruising	yes	no
Nausea	yes	no	Psoriasis	yes	no
Vomiting	yes	no	History of allergy to Neosporin	yes	no
Diarrhea	yes	no	History of allergy to numbing medicine	yes	no

PATIENT INFORMATION

DATE: ___/____/________

Name: ____

Last First M.I.

Date of birth: ____________ Age: ________ SSN: _____________________ Sex: Male Female

Drivers License # ____________________________________ State _____________________________

Mailing address: ____

City: _____________________________ State: ____________________ Zip: ____________________

Home phone: __________________________________Cell phone: _____________________________

E-mail:____

May we email information to you? Yes No

Place of employment: ____

Job Title: ___________________________________ Phone: ________________ ext: _____________

Referred by:____

Primary Care Physician: _____________________________ Phone: ______________________________

Emergency Contact: ________________________________ Relationship: _________________________

Cell Phone: _________________________________Home Phone:_________________________________

Do you give our office permission to discuss your medical information with family members? Yes No

If yes, please provide their name and phone number below:

Name: ____________________________________ Relationship: _____________ Phone: ____________

May we leave personal medical information on your answering machine or cell phone? Yes No

Pharmacy name AND location____

INSURANCE COVERAGE

Primary Insurance Name: ____

Name of policy holder: ____

Policy Holder DOB: _______________________ Relationship to holder: self spouse dependent

ID #: ______________________________ Group #:______________________________

Secondary Insurance Name:____

Name of policy holder:____

Policy Holder DOB: _______________________ Relationship to holder: self spouse dependent

Policy #: ______________________________ Group #:______________________________

Is patient currently enrolled in Hospice? Yes No

Responsible Party (if different from patient)

Name: ____ Date of Birth: _______________________

Last First M.I.

Address: ____

City: ______________________________ State: _______________________ Zip: _______________________

Primary phone: ______________________________ Alternate Phone: ______________________________

OFFICE FINANCIAL PAYMENT POLICY:

You will be responsible for paying your annual deductible, co-payment and other charges for any non-covered services or any cosmetic services **AT THE TIME** of your appointment.

I also understand all cosmetic items purchased are non-returnable and **non-refundable**

Patient or Responsible Party Signature: ______________________________________Date: _______________

OFFICE FINANCIAL POLICY

CO PAYS
All patients with a co pay are required to pay their co pay at the time of visit, prior to services rendered. Depending on your insurance, you could possibly **OWE A CO PAY FOR SUTURE REMOVAL.**

BALANCES
All patients with a balance are required to pay the balance plus their co pay prior to services rendered.

DEDUCTIBLE PLANS
All patients on an insurance plan with a deductible are required to pay the allowed amount each visit.

SELF PAY PATIENTS
All patients that are self pay are required to pay the full amount of the visit at the time of service.

NO INSURANCE CARD AT THE TIME OF VISIT
Any patient that does not have their insurance card at the time of service will be responsible for full payment of visit

INSURANCE UPDATES
It is your responsibility to make sure that we have your current and/or updated insurance card. If you fail to provide to us, you will be responsible for paying the full amount of the visit.

INSURANCE CHARGES
Charges are decided by your insurance, not our office. In the event we are not aware of a charge that is not covered by your plan, you will be balance billed after we obtain a denial from your insurance carrier.

INSURANCE ELIGIBILITY AND BENEFITS
Our staff does their best to verify your insurance, but ultimately you as the patient are responsible for understanding your contract with your insurance. ***We do NOT accept Medicaid/Ok Health Care Authority/Soonercare/Oepic/Tricare/Global Health/Blue Cross Medicare Advantage/Community Care Employee Plan (Black & Pink card).*** IT is YOUR responsibility to know if we are contracted with your insurance.

CANCEL/RESCHEDULE/NO SHOWING OF APPOINTMENTS
A $50 fee will be added to your account for any no-show appointments, rescheduled and cancellations not made within 1 full business day of the appointment, or $100 for surgery appointments not cancelled within 24 business hours. If you cannot keep your appointment, we ask you to please give as much notice as possible so that we may help other patients. If you cancel or re-schedule more than 2 times without giving proper notice, we will not be able to put you back on the schedule as a patient

RETURNED CHECK FEE
A $35 fee will be added to your account for all returned checks in addition to the amount of the check returned.

If you owe Kuykendall Dermatology money after the Explanation of Benefits (EOB) is received then you will receive a statement. The full balance is due in full within 30 days of the statement date. If payment is not made in full, then you will be **charged $20** for another statement. If payment is not made in full within 30 days of that statement date then balance will be forwarded to our collection service and you will be charged for any fees associated with the collection process, which includes an additional 50% added to your total bill

Signature:____Date:__________________________________

HIPAA CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for the treatment, payment, and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such a revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

1. Protected Health information may be disclosed or used for treatment, payment, and/or health care operations.
2. The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
3. The Practice reserves the right to change the Notice of Privacy Practices.
4. The patient has the right to restrict the uses of their information but the Practice does not have to agree to those restrictions.
5. The patient may revoke this Consent in writing at any time and all future disclosures will then cease.
6. The practice may condition receipt of treatment upon the execution of this Consent.

*Signature:*____*Date:*___________________________

*Print Name:*____