MODERN DERMATOLOGY

Last Name	First Name	Middle Name

Birth Sex M / F	Gender Identity	Birth Date	Email	Social Security #

Billing Address	Unit	City, State	Zip Code

Home Phone	Work Phone	Cell Phone

Emergency Contact Name	Emergency Contact Number	Relationship

Primary Care Physician Name	Primary Care Physician Phone #	Were you Referred? Yes/ No	Referred By

Guarantor/ Legal Guardian (COMPLETE ONLY if different than above)

Last Name	First Name	Middle Name

Sex	Date of Birth	Social Security #

Street Address	Unit	City, State	Zip Code

Home Phone	Work Phone	Cell Phone

Financial Policies:

Medical appointments: Up-to-date insurance information is required to schedule appointments. Modern Dermatology participates in most commercial insurance plans. If you are uninsured or have a plan that Modern Dermatology is not contracted with, payment in full is expected at the time of service.

Co-pays are due at the time of service. You agree to assign payment directly from your insurance to Modern Dermatology. You are financially responsible to Modern Dermatology for the charges not paid by insurance and understand that those charges are due within 30 days of invoice. In addition to the bill from your provider at Modern Dermatology, you may also receive separate bills from the pathology laboratory and/or other specialized services.

Aesthetic appointments: Credit card on file is required to schedule appointments.

Referral Policy: You are responsible for all referrals/ authorizations required to comply with your insurance plan. When required, you must obtain this prior to your scheduled appointment. If your claims are denied for lack of referral/ authorization or if the referral/ authorization is rejected by your insurance company, it is possible that you may not be able to be seen at Modern Dermatology. *In some cases, you may have the option to pay out of pocket on the day of service and will be responsible for all charges incurred.*

(Over)

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Missed Appointment Policy: The purpose of this policy is to ensure that any cancellations or appointment modifications are made with adequate time for other patients to be seen during the time we had reserved for you.

Medical: Modern Dermatology requires a 48-hour notice of any changes or cancellation of any medical appointments. If you reschedule, no show or cancel your appointment within 48 hours, you will be required to pay $50.00. If a third late cancellation, reschedule or no show should occur, within the same calendar year, you will either be discharged from the practice or the cancellation fee will increase to $150.00. This amount is due before scheduling any future appointments.

Aesthetic: Modern Dermatology requires a 48-hour notice of any changes or cancellation of any aesthetic appointments. If you make changes to your treatment plan, reschedule, no show or cancel your appointment within 48 hours, you will be required to pay $250.00. If a third late cancellation, change to your treatment plan, reschedule or no show should occur, within the same calendar year, you will be required to pay 50% of the service you are requesting to reserve any future appointments. This amount is non-refundable should you fail to show up or cancel within 48 hours of your appointment.

_____ Initials

Consent to Care:
I consent to the plan of care proposed by the providers in this clinic. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse this plan of care. I will ask for any information I want to have about my medical care and will make my wishes known.

Notification of Release of Payment:
I understand that Modern Dermatology will disclose any diagnosis and pertinent information to the extent required to assure payment from insurance companies. I understand that this disclosure, unless expressly limited by me in writing, will extend to all aspects of treatment including testing and/or treatment of HIV/ AIDS, sexually transmitted diseases, substance abuse, or mental health conditions.

Receipt of Notice of Privacy Practices:
I have received a copy of the Modern Dermatology Notice of Privacy Practices which provides additional information about how my health information may be used and disclosed.

I have read the above and understand its contents:

Signature of Patient or legally authorized individual: _____ Date: _____

Printed name *if signed on behalf of the patient*: _____Relationship: _____
(parent, legal guardian, personal representative)