BOULEVARD DERMATOLOGY
Deirdre Wood, M.D. and Associates

Patient Demographics

New Patient____ Name Change____ Address Change____ Insurance Policy/Holder Change____

Name: ____ SS#______-______-______ Sex: M____ F____
First Last

Address: ____ Marital Status:S__M__D__W__
Street City/State Zip

Birth Date: ____/____/____ Age:____ Email: ______________________ Occupation: ______________

Work Phone#: ________________ Home #: ____________________ Cell#: __________________

Ethnicity: Hispanic/ Latino _____ Not Hispanic/Not Latino _____ Unknown _____ Declined to Specify _____

Race: American Indian or Alaskan Native _____ Asian _____ Black or African American _____
Native Hawaiian or Pacific Islander _____ White _____ Other Race _____ Declined to Specify _____

Primary Insurance: ____________________________ Policy Number: ________________________

Policy Holder Name (if not the patient): ____________________________ Birth Date: ____/____/____

Address: ____ SS#: ______-______-______
Street City/State Zip

Secondary Insurance: ____________________________ Policy Number: ____________________

Policy Holder Name (if not the patient): ____________________________ Birth Date: ____/____/____

Address: ____ SS#: ______-______-______

Primary MD/DO: ____________________________________ Phone #: ____________________

Address: ____
Street City/State Zip

Pharmacy: ____________________________________ Phone #: ____________________

Please list anyone, other than yourself, you would allow us to disclose any medical information **if needed:**

Name: ________________________ Relation: ______________ Phone #: ________________

Name: ________________________ Relation: ______________ Phone #: ________________

Please list your emergency contact person/s

Name: ________________________ Relation: ______________ Phone#: ________________

Patient Signature: ________________________________ Date: ____/____/____

Printed Name: ____________________________________

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Financial Policy

We appreciate the opportunity to serve you, and want to thank you for choosing our clinic for your Dermatology services. We are committed to your treatment success and strive for providing you excellence in service. Prior to receiving any services, we do require you to read and sign the following statement regarding our Financial Policy:

Forms of Payment We accept cash, check, Visa and MasterCard.

Patient Responsible Balances Due at Time of Service Co-pays that are required by your insurance policy are due at the time of service. If you have no insurance and are self-pay, or if having an elective non-covered service, your balance in full is required at time of service. If you or any of your family members have an outstanding balance, we may ask for payment of this balance at this time.

Insurance Billing As a courtesy to our patients, we bill most major insurance carriers directly. Your insurance policy is a contract between you and your insurance carrier. We are not a party to that contract. You are responsible for understanding how your insurance works. If your insurance denies a claim due to inaccurate or incomplete information you have provided to either us or them, we may bill you directly for the unpaid balances. We are not obligated to wait for you to resolve a dispute with your insurance company before seeking payment from you. We will ordinarily help you as best as possible to get proper and timely payment from your insurance.

Minor Patients A parent or legal guardian must accompany minors at the time of initial visit, and this person becomes the responsible party. Unaccompanied minors at subsequent visits are still expected to make co-payments and to update any changes to patient or insurance information. If parents are separated or divorced, accurate parent and insurance information is required at the time of service, and only with written consent can any parent become the responsible party. In the event of any disputes, the parent or guardian who accompanied the minor at the initial visit bears responsibility for outstanding balances.

Missed Appointment Fees If you miss, cancel or reschedule an appointment within less than 24 hours of the appointment time, there may be a $35 fee assessed to your account, depending on the circumstances and previous appointment history. Missed surgery appointment: We need 48 hour notice to change a surgery appointment or a fee of $100 will be assessed.

Returned Check Fees If your check is returned by the bank due to insufficient funds in your account, there will be a $36 fee assessed to your account.

Account Balances Please pay your bill promptly or call us at your earliest convenience if you have any questions about your balances due. Our general policy is that balances due be paid within 30 days. Outstanding balances not paid within 90 days may be turned over to a collection agency, resulting in further finance charges and reporting to national credit bureaus, such as Trans Union, Experian and Equifax. Please contact us immediately if special financial circumstances arise, as we may be able to arrange a payment plan.
Thank you for taking the time to read and understanding our Financial Policy. Please let us know if you have any questions or concerns.

Telephone Consumer Protection Act (TCPA)
You agree, in order for us to service your account or to collect monies you may owe, **BOULEVARD DERMATOLOGY**,and/or our agents may contact you by telephone or any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using prerecorded/artificial voice messages and/or use of automatic dialing device, as applicable.

I/we have read this disclosure and agree that **BOULEVARD DERMATOLOGY**, its employees and/or agents may contact me/us as described above.

My signature below indicates that I have read, understand and agree to the terms of this Financial Policy:

______________________________ ______________

Signature of Patient or Responsible Party **Date**

____

Printed Name

BOULEVARD DERMATOLOGY
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Patient Consent Form

Patient Name (Print):______________________________________ DOB: ______________

Legal guardian Name (Print); ____

Authorizations

I authorize the release of information necessary to process this claim and also authorize payment of medical benefits directly to Boulevard Dermatology. I certify that the information I furnish is true and correct. In order to establish optimal relations with our patients and to avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial payment policies of this office. Payment is required for services at the time they are rendered. We accept payment in form of cash, check, Visa, MasterCard or Discover. In the event of hospitalization or major procedures, our office will file with the appropriate insurance. However, before such claims are filed, coverage will be pre-verified and you will be asked to pay any unmet deductible, non-covered services and co-payments. Interest payments may be assessed for failure to pay bills within a reasonable time frame. Your signature below communicates your understanding and willingness to comply with this policy.

Patient or Legal Guardian Signature: ______________________________________ Date: ______________

Patient Consent For Use and Disclosure of Protected Health Information

With my consent, Boulevard Dermatology may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to Boulevard Dermatology Notice of Privacy Practices for more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Boulevard Dermatology. With my consent, Boulevard Dermatology may call my home or other designated locations and leave message on voicemail 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 among others. With my consent, Boulevard Dermatology may mail my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements as long as they are marked Personal and Confidential. With my consent, Boulevard Dermatology may e-mail my home or other designated locations any items that assist the practice in carrying out TPO such as appointment reminder cards and patient statement. I have the right to request that Boulevard 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. By signing this form, I am consenting to Boulevard Dermatology use and disclosure in reliance upon my prior consent. If I do not sign this consent, Boulevard Dermatology may decline to provide treatment to me.

Patient or Legal Guardian Signature: ______________________________________ Date: ______________

Medicare Health Insurance Form

I request that payment of authorized Medicare benefits be made either to me or my behalf to Boulevard Dermatology for any services furnished to me by Boulevard Dermatology. I authorize any holder of medical information about me to be released to the Health Care Financing Administration and its agents any information needed to determine these benefits payable for related services.

Patient or Legal Guardian Signature: ______________________________________ Date: ______________

BOULEVARD DERMATOLOGY

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Name: ____ Birth Date: _____/______/________
First Last

PLEASE LIST ALL YOUR CURRENT MEDICATIONS:

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

7. ____

8. ____

9. ____

10. ____

11. ____

12. ____