KNOXVILLE INSTITUTE OF DERMATOLOGY

Pt #: _____
(Internal use only)

PATIENT INFORMATION

Social security #: _____

First Name: _____ MI: _____

Last Name: _____

Sex: _____ Date of Birth: _____

Address: _____

_____

City: _____ State: ____ Zip: _____

Primary Phone #: (_____)_____

Cell Phone #: (_____)_____

Email Address: _____

Marital Status *(circle one)*: Single Married Divorced Widowed

Race/Ethnicity: Asian Native American White
Black/African American Hispanic/Latino
Non-Hispanic/Latino Other

Language: English Spanish Other

Employment: Full-time Part-time Retired Student Other

Employer: _____

Primary Care Physician: _____

Referring Physician: _____

How did you hear about us? _____

PRIMARY INSURANCE

Card Holder's Name: _____ Date of Birth: _____

Relationship: _____ Employer: _____

SECONDARY INSURANCE

Card Holder's Name: _____ Date of Birth: _____

Relationship: _____ Employer: _____

EMERGENCY CONTACT

First Name: _____ Last Name: _____

Relationship: _____ Phone #: (_____)_____

GUARANTOR INFORMATION

(If patient is disabled or a minor)

First Name: _____ MI: _____ Last Name: _____

Relationship: _____ Phone#: (_____)_____

Social Security #: _____ Sex: _____ Date of Birth: _____

RELEASE (Signature Required)

Authorization to release information and pay benefits to physician: I hereby authorize the physician to release any information acquired in the course of my treatment necessary to process insurance claims. I also authorize payment directly to the physician or the surgical and/or medical benefits, if any, otherwise payable to me for his/her services as described, responsible to pay non-covered services.

X_____

Patient Signature (parent signature if minor) *Date*

KNOXVILLE INSTITUTE OF DERMATOLOGY

PATIENT NAME: _____ DOB: _____

HIPAA CONSENT: AUTHORIZATION TO REVEAL MEDICAL AND BILLING INFORMATION

I authorize Knoxville Institute of Dermatology, PLLC and staff to reveal to the following individuals, as needed, information regarding my protected health information and billing information. I understand that once this information is disclosed to these individuals, Knoxville Institute of Dermatology, PLLC will not have responsibility over to whom these individuals reveal this information. I may revoke this authorization by giving written notice to Knoxville Institute of Dermatology, PLLC.

Name: _____ Relationship: _____

LAB/BIOPSY RESULTS: I authorize the staff of Knoxville Institute of Dermatology, PLLC to notify me of my ***normal*** labs and/or ***benign*** biopsy results via (*check all that apply*):

- ☐ Voicemail of primary phone number
- ☐ HIPAA contact (listed above)

NO SHOW POLICY: Our physicians and staff work very hard to meet the needs of our patients. We kindly ask that you give **24-hour notice** if you need to cancel your appointment. As a courtesy, we attempt to make confirmation calls 48 hours in advance of your scheduled appointment, and we will attempt to leave a reminder message on your answering machine if there is no answer. However, you are responsible for notifying us if you will not be able to make it. A one time consideration will be made for failure to show up for your appointment. Any no shows thereafter will be charged as follows:

- Routine office appointments: $20
- Cosmetic appointments: $75
- Surgeries: $100

Payment must be made before another appointment may be scheduled. Thank you for your understanding in this matter.

FINANCIAL POLICY: We have contracts with many insurance companies to accept assignment of benefits for our services, but we must have a valid insurance card on file in order to do this. If you cannot present a valid insurance card at the time of the visit, you will be charged as a private-pay patient. You are responsible for knowing your insurance. **Your co-pay is expected at the time of your visit**. As a service to you we will file your insurance claim following your visit. You will be billed for any amount not covered by the insurance company, including deductibles, surgical/pathology deductibles, and co-insurance. Payment is due upon receipt of your statement.

I understand that each time I am seen in the office for evaluation and/or treatment, an office visit can be charged in addition to any other charges. We accept cash, check, Visa, MasterCard, and Discover. I request that payment of Medicare or other insurance company benefits be made to Knoxville Institute of Dermatology, PLLC for services provided. I authorize the release of any information needed for processing of this or and related claim(s). I will permit a copy of the authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. I understand that all outside laboratory testing will be billed from the specific laboratories to me and/or my insurance company. I accept payment responsibilities if my insurance denies payment.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES: I acknowledge that I have been given the Notice of Privacy Practices for Knoxville Institute of Dermatology, PLLC and understand the policies. I am aware that I may request a copy at any time.

SIGNATURE: _____ DATE: _____
(patient or guardian)