CLEAR Dermatology & Aesthetics Center

VALLEY OF THE SUN Dermatology

Date:_____

PATIENT DEMOGRAPHICS

Name _____Patient Goes By "_____" SS#_____

Date of Birth: _____ Gender: ❑ Male ❑ Female Marital Status: ❑Single ❑Married ❑Divorced ❑Widowed

Address: _____
STREET CITY STATE ZIP

Phone *(check ☑ preferred contact number)* Home❑ _____ Cell❑_____ Work❑_____

May we leave a detailed message?
❑Yes ❑No

E-Mail: _____

❑ Please check box if you would like to receive future cosmetics promos and our monthly newsletter.

Clear Dermatology & Aesthetics Center may discuss my medical information with the following people:

Name: _____ Phone: _____ Relationship:_____

Name: _____ Phone: _____ Relationship:_____

EMERGENCY CONTACT

Name: _____ Phone: _____ Relationship:_____

PHYSICIAN INFORMATION

Primary Care Physician: _____ Phone:_____

Address: _____Fax: _____
STREET SUITE CITY STATE ZIP

Referring Physician ❑Primary Care Physician
Physician Name:_____ Phone: _____ Fax:_____

If not referred, how did you hear about us? ❑ Website ❑ Google Ad ❑ Current Patient ❑Other _____

PHARMACY INFORMATION

Preferred Pharmacy: _____ Phone: _____ Fax: _____

Pharmacy Address: _____
CROSSROADS CITY STATE ZIP

GUARANTOR/LEGAL GUARDIAN IF PATIENT IS UNDER 18 YEARS OF AGE

Last Name: _____ First: _____ MI: _____ Date of Birth: _____/_____/_____

Address: _____City:_____ State: ____ Zip: _____

Home Phone: _____ Work Phone: _____ SS#: _____

Sex: ____ Relationship: ❑Spouse ❑Parent ❑Legal Guardian

INSURANCE *Please present insurance card(s) with this completed form*

Primary Insurance Subscriber: _____ Date of Birth: ____/____/_____

Insurance:_____ Policy #:_____ Group #_____

Secondary Insurance Subscriber: _____ Date of Birth: ____/____/_____

Insurance:_____ Policy #:_____ Group #_____

DEMOGRAPHICS

These questions are included to comply with new Federal Health guidelines -- we are required to ask every patient for this information.	Race *(check one)*	❑ American Indian/Alaskan Native	❑ Asian	❑ Native Hawaiian/Other Pacific Island
		❑ Black/African American	❑ White	❑ Other Race_____
	Ethnicity *(check one)*	❑ Hispanic or Latino	❑ Not Hispanic or Latino	❑Unknown
	Preferred Language *(check one)*	❑ English	❑ Spanish	❑Other_____
	How much do you weigh? _____lbs.		What is your height?	_____ft. ____in

RECEIPT/REVIEW OF HIPPA PRIVACY PRACTICE

By signing below, I acknowledge that I have been offered a copy of the Clear Dermatology & Aesthetics Center Notice of Privacy Practices. I have been advised of my rights, and how my health information may be used and disclosed by Clear Dermatology & Aesthetics Center.

Print Name: _____

Patient or Guardian Signature: _____ Date: _____

If Guardian representative, describe relationship:_____

This acknowledgement will be filed in your records.

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but it could not be obtained because:

❑ Individual refused to sign

❑ An emergency situation prevented us from obtaining acknowledgement

❑ Communication barrier prohibited obtaining the acknowledgement

❑Other (please specify)_____

OFFICE POLICY ON PAYMENTS AND INSURANCE

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with our billing manager. We are dedicated to providing the best possible care and services to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either yourself or your health coverage carrier(s), full payment is due at the time of service. For your convenience, we accept cash, all major credit and debit cards, traveler's check, money orders and personal checks.

YOUR INSURANCE

We are providers for many health insurance plans so please verify with your insurance carrier that Clear Dermatology and Aesthetics Center is a contracted provider with your insurance. We will be happy to submit to most insurance carriers if you provide us with policy numbers, address, and other pertinent information. If you require a referral, it is the insured's responsibility to obtain the referral authorization from your insurance carrier and provide that information to our billing department on the date of service. Your insurance plan booklet should explain the details of your plan. You are responsible for all co-payments, co-insurance, deductibles and any unpaid or denied services not covered by insurance. Please note that all copays, coinsurances and deductibles will be due at the time services are rendered. It is the policy of our office to collect any copays, coinsurance and balances due before services are rendered.

CREDIT CARD ON FILE POLICY

We require all patients to maintain a valid credit or debit card on file with us. It is the policy of Clear Dermatology & Aesthetics Center to follow all federal and state laws regarding identity theft and financial privacy. Our staff will scan your card with a card reader, which will store your card number in a secure, compliant location in your electronic medical record. For security reasons, only the last four digits will be visible to our staff. Credit and debit cards on file will be used to pay account balances, after your insurance processes your claim.

If we do not receive payment for the amount listed on your statement within 30 days, we will run the credit card on file for the full amount owed. If your payment is declined, we will call you. If we are unable to reach you, we will leave you a message, and if our reminder call is not returned within one week, a $35 declined payment fee will be applied and another statement will be mailed.

By signing below, I give Clear Dermatology & Aesthetics Center permission to charge my credit or debit card on file for any patient balance due on my account. If I have insurance coverage, my card will be charged after my insurance has paid their portion.

COLLECTION POLICY

Any unpaid balance will accrue a 1.5% finance charge monthly, after the account has lapsed for 60 days. In the event any balance due hereunder is not paid as agreed, the undersigned jointly and separately agrees to pay all costs charged by the collection company. The costs will not exceed 33% of said balance, including a reasonable attorney's fee, court costs, etc. Any balance due must be paid in full before any further services are rendered.

CHECK POLICY

Your check must include your name, address, home and work phone number. There will be a fee of $50.00 for all returned checks.

LATE ARRIVAL

With the purpose of maintaining a prompt schedule for all of our patients, if you are going to be more than 10 minutes late, please contact our office as you will be required to reschedule your appointment.

MISSED APPOINMENT

In order to provide the best possible services and availability to all of our patients, please contact our office as soon as possible to cancel or reschedule your appointment. We will attempt to contact you by phone with a courtesy reminder 1-2 days prior to your appointment. A $50.00 "no-show" fee will be applied to your account if you fail to call or cancel your appointment with less than a 24 hour notice.

RECORDS REQUEST

Charges may apply when medical records are requested. Please see front office for details.

NON INSURANCE AND/OR COSMETICS PATIENTS

Payment in full is expected at the time of service for all services performed by Clear Dermatology & Aesthetics Center.

MINOR PATIENTS

For all services rendered to minor parties, we will look to the adult accompanying the patient and the parent or guardian with custody for payment.

COSMETIC DEPOSITS

A non-refundable deposit may be required when scheduling cosmetic appointments. The $50 will be applied to cosmetic charges when services are rendered. Deposit will not be refunded if appointment is cancelled or rescheduled with less than 24 hour notice.

OVER FOR SIGNATURE

AUTHORIZATION, ACCEPTANCE OF TERMS AND CONSENTS

I authorize the release of any medical information necessary to process any claim.

I certify that I have read and fully understand the office policies on payment and insurance of Clear Dermatology & Aesthetics Center. I realize that I am responsible for my charges and that any collection of legal fees will be charged to me in the event that my account is not paid in full as described in the terms and conditions above.

I authorize benefits amounts payable by the insurance company to be assigned directly to the provider.

Print Name:_____ Date:_____

Patient or Guardian Signature: _____

If Guardian representative, describe relationship: _____