CLEAR
Dermatology & Aesthetics Center

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? (please circle): YES or NO

E-Mail: _____

❑ Please check the 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:_____ Fax: _____

Address: _____

STREET SUITE CITY STATE ZIP

Referring 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_____

Preferred Language *(check one)*
❑ English ❑ Spanish ❑Other_____

Ethnicity*(check one)*
❑ White ❑ Hispanic or Latino ❑ Unknown ❑ Other Race: _____

How much do you weigh? _____lbs. What is your height? _____ft. _____in

OFFICE POLICIES

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, coinsurance 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 $50 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 APPOINTMENT

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. **$100.00 "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 the 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 $175 will be applied to cosmetic charges when services are rendered. Deposit will not be refunded if the appointment is cancelled or rescheduled with less than 24 hour notice.

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: _____

Patient or Guardian Signature: _____ Date: _____

If Guardian representative, describe relationship:_____

RECEIPT/REVIEW OF HIPAA 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.

AUTHORIZATION OF USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI).

This notice describes how health information about you as a patient of this practice may be used and disclosed and how you can get access to your Protected Health Information. Please review this notice carefully.

Our practice is dedicated to maintaining the privacy of your Protected Health Information (PHI). In conducting our business, we will create records regarding you and the treatment and services we provide to you. We are required by law to maintain the confidentiality of health information that identifies you. We are required by law to provide you with this notice of our legal duties and privacy practices that we maintain in our practice concerning your PHI. We must provide you with the following important information:

- How we may use and disclose your Protected Health Information (PHI).
- Your privacy rights in your PHI.
- Our obligations concerning the use and disclosure of your PHI.

OUR PRACTICE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION (PHI) IN THE FOLLOWING WAYS:

Treatment: Our practice may use your PHI to:

- Write a prescription for you and disclose it to a pharmacy when we order a prescription for you.
- Assist people who work for our practice including, but not limited, to doctors and assistants to treat you or to assist others in your treatment.
- Along with health care providers for purposes related to your treatment.

Health Oversight Activities: Our practice may disclose your PHI to a health oversight agency. Oversight activities can include investigations, inspections, audits, surveys, licensure or other activities necessary for the health care system in general.

Payment: Our practice may use and disclose your PHI in order to bill and collect payment for services you receive from us.

- For example, we may contact your health insurer to certify that you are eligible for benefits and what range of benefits. We may provide your insurer with details regarding your treatment to determine if your insurer will cover your treatment.

Appointment Reminder Calls: Our practice may use and disclose your PHI to contact you and remind you of an appointment.

Disclosure Required by Law: Our practice will use and disclose your PHI when we are required to do so by federal, state, or local agencies for the following:

- Response to a discovery request, summons, subpoena, court order or similar legal process.
- Law enforcement regarding a crime victim, identifying or locating a suspect, material witness, fugitive, or missing person.
- In an emergency to report a crime including the location or victim(s) of the crime or the description, identity or

locations of the perpetrator.

Serious Threats to Health or Safety: Our practice may disclose your PHI when necessary to prevent a serious threat to your health and safety of another individual or the public.

Military or National Security: Our practice may disclose your PHI if you are a member of the U.S. or foreign military forces and if required by the appropriate authorities. We will also cooperate with federal officials for intelligence and national security matters.

Other PHI Uses and Disclosures: You may be contacted to raise funds and have the right to opt out of receiving such communications; Most uses of and disclosures of PHI for marketing purposes and sales of PHI require the individual's authorization. Uses and disclosures not described in the Privacy Notice will be made only with authorization.

YOUR RIGHTS REGARDING PHI:

You have the following rights regarding the PHI that we maintain about you:

1. **Confidential Communications:** You have the right to request that our practice communicate with you about your health and related issues in a particular manner or certain location. For example, you may ask to be communicated with at home rather than work.
2. **Requesting Restrictions:** You have the right to request a restriction in our use or disclosure of your PHI for treatment, payment of healthcare operations. Additionally, you may request the right to restrict disclosure to certain individuals involved in your care or the payment of your care such as family members and friends.
3. **Breach:** You have the right to be notified following a breach with your PHI.
4. **Restrictions:** You have the right to restrict certain disclosures of PHI to a health plan when the individual (or any person other than the health plan) pays for treatment at issue out of pocket in full.
5. **Inspection and Copies:** You have the right to inspect and obtain a copy of the PHI including patient medical records and billing records. You must submit your request in writing to:

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Clear Dermatology

Attn: Practice Manager

20201 N. Scottsdale Healthcare Dr. ;Suite 260 Scottsdale, AZ 85255

Amendment to your PHI: You may ask in writing for an amendment to your Private Health Information. Any agreed amendment will be included in your patient records. We are not required to agree to your request, however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies or when the information is necessary to treat you.

You must request and describe clearly to the Practice Manager at Clear Dermatology & Aesthetics Center:

1. The information you wish is restricted.

2. Whether you are requesting to limit our practice's use, disclosure or both
3. To whom you want the limits to apply.

If you believe that your privacy rights have been violated, you have the right to file a written complaint with Clear Dermatology and Aesthetics Center. You will not be penalized for filing a complaint.

The terms of this notice apply to all records containing your PHI that are created or retained by our practice. We reserve the right to revise or amend this Notice of Privacy Practices. You may request a copy of our most current notice at any time.