Dermatology Treatment & Research Center, PA

Patient Information

☐New Patient ☐Established Patient

☐**Dr. Abramovits** ☐**Dr. Saxton-Daniels**

Patient Information **PLEASE PRINT LEGIBLY**

Last Name: _____ First: _____ MI: ____ DOB: ___/_____/____

Address: _____ Apt #: _____ City: _____ ST: ____ Zip: _____

Hm Ph: _____ Cell:_____ Work:_____ Pt's SS#____-_____-_____

Sex: **M F** Race _____ Ethnicity _____ Preferred Language:_____

Marital Status: **M S D W E-mail address** (Medical record accessibility)_____

Emergency contact name & number: _____

Employer name & number_____

What number may we leave detailed messages (appointment confirmation, return call needed, etc)**:**_____

Pharmacy name:_____ **Pharmacy number/fax:**_____

Insurance Policy Holder Information **Relation to Patient**☐ Self ☐Spouse ☐Other _____

Last Name: _____ First: _____ MI: ____ DOB: ___/_____/____

Address: _____ Apt #: _____ City: _____ ST: ____ Zip: _____

Hm Ph: _____Cell: _____Wk:_____ Subscriber SS#_____

Sex: **M F** Mar Status: **M S D W** E-mail address:_____

Insurance Information

Primary Insurance
Insurance Co/Network: _____

Secondary Insurance
Insurance Co/Network: _____

Referring Physician's Information

Name: _____ Phone: _____

I hereby authorize the release of any medical information required by my insurance carrier for services rendered to me in order to process claims on my behalf. I request that payments of authorized medical benefits be made to the above provider. I understand and agree that I am ultimately responsible for the balance on my account for any professional services rendered. I understand and agree that if I cannot be reached by phone or mail, my emergency contact may be called. I further understand that failure to cancel future appointments will result in a $25 fee.

Patient/Guardian's Signature:_____ Today's Date: _____

Dermatology Treatment & Research Center, P.A.

Consent to Treat

IF ADULT:
I hereby authorize the employees and agents; including physicians, of this medical office to render routine medical care to the patient indicated on this form and to fulfill the orders of the physicians; including consultants, associates, and assistants of the physicians' choice. I UNDERSTAND IT IS MY RESPONSIBILITY to verify MY insurance eligibility and deductible information. I UNDERSTAND THAT I WILL BE responsible for all co-pays, co-insurance, deductibles, and any service that is not covered by my insurance plan.

IF MINOR CHILD:
I hereby consent & authorize the employees and agents; including physicians, of this medical office to evaluate and treat my minor child, _____. I understand that this authorizes the person(s) named herein to consent to medical and surgical procedures and immunizations for the child named herein.

The duration of this consent is indefinite and continues until revoked in writing. I understand that by not signing this consent, the patient will not be provided medical care except in case of emergency.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Printed name of person signing and relationship to patient

Financial Responsibility

I hereby authorize payment of medical benefits to go directly to Dermatology Treatment & Research Center, P.A. and/or the attending physician for services rendered. Authorization is hereby granted to release information contained in my medical record as may be necessary to process and complete my information regarding communicable diseases, such as Acquired Immune Deficiency Syndrome ("AIDS") and Human Immunodeficiency Virus ("HIV"). I understand that I am financially responsible for the total charges for services rendered which may include services not covered by my insurance companies. I agree that all amounts are due upon request and are payable to Dermatology Treatment 7 Research Center, P.A. I further understand should my account become delinquent; I shall pay the reasonable attorney fees or collection expense of Dermatology Treatment 7 Research Center, if any.

The duration of this authorization is indefinite and continues until revoked in writing. I understand that by not signing this release of information, I am responsible for payment of services in full before the services are rendered.

_____ _____
Signature of Patient or Parent/Legal Guardian Date

_____
Printed name of person signing and relationship to patient

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Thank you for choosing ***Dermatology Treatment & Research Center, P.A.*** for your healthcare needs.

We are required by Texas law to provide you with a copy of our ***Notice of Privacy Practices***. To ensure that our records are accurate, please sign this form and return it to our front office to acknowledge that you have been provided with a copy of our Notice.

_____
Signature of Patient (or Legal Representative)

_____
Date

_____ _____ _____
Signature of Staff Member Title Date

I authorize the person(s) below to have access to all my records, including lab and pathology reports. (example: spouse, relative, doctor, etc.)

_____ _____
Name Relation to patient

_____ _____
Name Relation to patient