DERMATOLOGY ASSOCIATES OF KENTUCKY, P.S.C.

250 FOUNTAIN COURT • LEXINGTON, KY 40509
(859) 263-4444 • FAX (859) 254-1814

MRN_____

PATIENT INFORMATION

NAME (Last First Middle)		SSN#	BIRTHDATE	SEX
LOCAL ADDRESS		CITY, STATE, ZIP		
HOME PHONE	WORK/DAY PHONE	CELL PHONE		
MARITAL STATUS	EMAIL ADDRESS			
PRIMARY EMPLOYER	ADDRESS	CITY, STATE, ZIP		
EMERGENCY CONTACT NAME		EMERGENCY CONTACT PHONE NUMBER		

WHO MAY WE DISCUSS YOUR HEALTH INFORMATION WITH?
❑ NO ONE OTHER THAN SELF ❑ SPOUSE ❑ PARENT ❑ VOICEMAIL (Cell/Home) ❑ OTHER (NAME) _____

MAY WE LEAVE DETAILED PERSONAL HEALTH INFORMATION ON YOUR EMAIL ADDRESS OR VOICE MAIL?
THIS INFORMATION MAY INCLUDE PATHOLOGY RESULTS, LAB RESULTS, APPOINTMENTS OR BILLING INFORMATION.

HOME PHONE: yes ❑ no ❑ WORK/DAY PHONE: yes ❑ no ❑ CELL PHONE: yes ❑ no ❑ EMAIL: yes ❑ no ❑

As of 1/1/09, per Kentucky state law and the Office of Health Policy, we are required to collect the following information.

Please choose one:

Race
❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Pacific Islander
❑ White
❑ Other

Please choose one:

Ethnicity
❑ Hispanic or Latino Ethnicity
❑ Non-Hispanic or Latino Ethnicity

RESPONSIBLE PARTY INFORMATION (for minor patients)

NAME (Last First Middle)			SSN#	BIRTHDATE	SEX
ADDRESS			CITY, STATE, ZIP		
HOME PHONE	DAY PHONE	MARITAL STATUS	RELATIONSHIP TO PATIENT		

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY			NAME OF INSURED (Policyholder)	
SSN	DOB	SEX	RELATIONSHIP TO PATIENT	
ADDRESS (if different from patient)			CITY, STATE, ZIP	PHONE

SECONDARY INSURANCE

NAME OF INSURANCE COMPANY			NAME OF INSURED (Policyholder)	
SSN	DOB	SEX	RELATIONSHIP TO PATIENT	
ADDRESS (if different from patient)			CITY, STATE, ZIP	PHONE

MEDICARE PATIENTS ONLY (Required by Medicare Program)

• **ARE YOU OR YOUR SPOUSE COVERED BY ANY EMPLOYER GROUP HEALTH BENEFIT PLAN?**	**YES**	**NO**
• **ARE YOU OR YOUR SPOUSE WORKING FOR AN EMPLOYER WITH MORE THAN 20 EMPLOYEES?**	**YES**	**NO**
• **ARE YOU CURRENTLY A RESIDENT IN A SKILLED NURSING FACILITY?**	**YES**	**NO**
• **DO YOU RECEIVE BLACK LUNG BENEFITS?**	**YES**	**NO**
• **DO YOU RECEIVE WORKERS COMP BENEFITS?**	**YES**	**NO**
• **ARE YOU BEING SEEN FOR AN INJURY OR ILLNESS FOR WHICH ANOTHER PARTY COULD BE HELD LIABLE OR IS COVERED UNDER AUTOMOBILE NO FAULT INSURANCE?**	**YES**	**NO**

I hereby give my permission to Dermatology Associates of Kentucky, PSC for the evaluation and treatment of the presented dermatological condition.

I hereby authorize the above physician(s) to release information regarding services rendered by him/her and allow a photocopy of my signature to be used to file insurance.

I hereby authorize the physician(s) indicated above to furnish information to insurance carriers concerning this illness, and I hereby irrevocably assign all payments for medical services rendered. I understand that I am financially responsible for all charges whether or not covered by insurance.

I consent to receive phone calls, emails and/or text messages at any of the phone numbers/email addresses listed above for such events as appointment reminders, reschedules, and inclement weather closings. I understand I may incur charges from my cell provider and that such calls may be generated by an automated dialing system. I understand I may revoke authorization to receive further calls or messages at any time.

I have read the financial and privacy policy statements for Dermatology Associates of Kentucky, PSC on the reverse of this page and agree to the terms herein. I also understand that such terms may be amended when needed by the practice.

_____ _____

Patient or Responsible Party **Date**

See Reverse Of This Page

Dermatology Associates of Kentucky, PSC
Financial and Privacy Policy

Financial:

Our main goal is providing you the best care and service. We also recognize the need for a clear understanding of your financial obligations for the treatment you receive. In order to create a better understanding between patients and our practice, we have adopted the following policy. If you have any questions about this policy, we encourage you to contact our patient accounts department.

Patients With No Insurance Coverage:

Payment is due for all services on the day they are rendered. We offer a 15% discount for patients with accounts in good standing. We accept cash, check or credit cards.

For surgical/medical procedures full payment is due on the day the procedure is scheduled. An estimate of cost will be provided prior to your surgery.

Patients With Out of Network Coverage:

Effective 1/07/07 DAK will no longer file claims on your behalf. Upon request, appropriate documentation will be provided to you for claim submission.

Cosmetic Procedures and Non-Covered Services:

Patients are responsible for payment for all Cosmetic Procedures and Non-Covered Services. Pre-payment is required for all cosmetic consultations and procedures.

Returned Checks:

Due to the expense of processing checks returned by the bank, we charge a $25.00 service fee. Any returned check must be paid within ten days or it may be turned over to a collection agency or the County Attorney's Office.

Outstanding Balances:

Delinquent balances must be paid in full before additional services can be provided, unless other arrangements have been made through our billing office. Delinquent balances over 60 days old will be referred to an outside collection agency. An additional 35% surcharge will be placed on the account. *DAK reserves the right to dismiss patients with delinquent accounts.*

Insurance Claims:

Co-payments are due on the day of service. In the event that your insurance card does not state your co-payment amount and you do not know the amount, we require a $25.00 co-payment. For your convenience, we have telephones available in our waiting areas if you would like to contact your insurance company to verify the correct amount.

Surgical services: Co-insurance and deductibles are due on the day that services are rendered. Our office will contact your insurance company to determine the amount. We recognize that your insurance policy may indicate your deductible is not due until after your insurance has paid. However, our financial policies require these amounts up front. Our billing office will contact you prior to your procedure to discuss this obligation.

Insurance Plans Requiring Referrals:

Please check your insurance plan to see if a referral or pre-authorization is necessary from your primary care doctor to see our specialists. It is your responsibility to obtain the necessary referral in order for your insurance company to pay for your services. We will be happy to assist you in any way possible to obtain your required referral. If you arrive for your appointment without the required referral, you can either reschedule the appointment when a referral can be secured or sign a waiver stating you do not have the necessary referral form and assume total financial responsibility for services that day.

Adult Students Covered by Parents Insurance:

We will gladly file your claim for you. However, if you are over the age of 18, you are responsible for your bill. All co-payments are due on the day of service. We will need your current address and your permanent billing address for our files.

Minors:

A parent or legal guardian must accompany all children under the age of 18. In the case of divorced parents, the parent bringing the child in for service is responsible for the bill.

Other:

Dermatology Associates of Kentucky, Inc. has my consent to use photographic images for educational or promotional purposes. As well, Dermatology Associates of Kentucky, Inc. has my consent to allow students in clinical areas to observe my visit. It is my responsibility to advise my physician in the event I ***do not*** consent to the use of photographic images for educational or promotional purposes and/or to allow students to observe my visit

We will treat you and your family with respect and consideration and request that you treat our staff in the same manner. Failure to do so may result in termination of services.

Privacy:

I have been offered and/or received a copy of Dermatology Associates of Kentucky's Notice of Privacy Practices.