Kirkland Dermatology Associates

Please complete all forms and return to the Front Desk.

Full Name: _____ **DOB:** _____ Preferred Name: _____
First *MI* *Last*

Birth Sex: ☐ M ☐ F ☐Unknown Preferred Pronoun: ☐ He, Him, His ☐ She, Her, Hers ☐ They, Them, Their

Gender Identity: ☐ Male ☐ Female ☐ Transgender Male/Trans Man ☐ Transgender Female/Trans Woman
☐ Genderqueer (neither exclusively male nor female ☐ Other ☐ Choose not to disclose

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Other: _____

Preferred Language: ☐ Decline to specify ☐ English ☐ Spanish ☐ Other: _____

Ethnic Group: ☐ Decline to specify ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown

Race: ☐ Decline to specify ☐ White ☐ American Indian or Alaska native ☐ Asian ☐ Black or African American ☐ Other

Emergency Contact/Full Name: _____ Phone: _____

Home Phone: _____ **Work Phone:** _____ **Mobile Phone:** _____

Preferred Phone: ☐ Home ☐ Work ☐ Mobile **Is it okay to leave detailed messages?** ☐ YES ☐ NO

Email Address: _____

Mailing Address: _____
Street *City* *State* *Zip*

Employer: _____ **Occupation:** _____

Release of my Protected Health Information: ☐ Decline
I give permission to the following person(s) to speak with anyone from Kirkland Dermatology Associates, PLLC about my confidential health, billing, and/or any other relevant information.
Name: _____ Phone: _____ Relation to Patient: _____
(Any authorizations given will automatically expire after 3 years from date of signature)

Insurance Policy Holder (*if different from patient*): Patient relationship to subscriber: (Circle one): Spouse Child Other
Primary Insurance Policy Holder Name: _____ DOB: _____

Secondary Insurance Policy Holder Name: _____ DOB: _____

Preferred Pharmacy Name: _____
Address or street
Phone#: _____ City or Zip code: _____

Primary Care Doctor: _____
Full name *Location*
Referring Doctor (if applicable): _____
Full name *Location*

Please see next page for Policies and Signature--->

Insurance Information:
I authorize any holder of medical or other information about me to release to the insurance company(s) any information needed for this or a related insurance claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or the party who accepts assignment.

Payment Policy:
Medicare, HMO, PPO, or Other managed care patients: You will be responsible for paying your annual deductible, copayment, and charges for any non-covered, cosmetic services at the time of service.

Patient Financial Responsibilities
Kirkland Dermatology Associates is committed to providing you with the highest quality medical care. Because patients are ultimately responsible for the charges associated with their care, even when insurance is in place, you may find the following information helpful.

You can help ensure an efficient experience by assisting with the following:
- Providing us with your picture identification and insurance cards
- Knowing your insurance benefits and limitations
- Obtaining authorization for your visit if it is required by your insurance, including obtaining a referral.
- Providing us with at least 24 hours' notice should you need to cancel or reschedule an appointment.

Patient Responsibilities
- You are responsible for payment of services you receive in our office. Please understand that your medical insurance is a contract between you and your insurance company. You are responsible for any unpaid balance.
- We will gladly bill your insurance company with the appropriate charges and diagnosis codes. If your insurance carrier does not pay for the services, please do not ask us to change codes. We follow strict coding guidelines by the American Medical Association as well as those established and covered by federal and state programs.
- Your copay is due at the time of your visit.
- Without insurance coverage, you will be considered self-pay and your balance will be collected in full at the time of service.
- **Please note that co-payments, co-insurance, and deductibles are a contractual agreement between you and your insurance carrier. We cannot change or negotiate these amounts.**

Insured Patients- We will bill your primary and secondary insurance carrier in a timely manner. If you are disputing payment with your insurance carrier or have a balance with us, you must notify our business office and make payment arrangements.

- **Co-Pays/Deductibles/Co-Insurance** – Please be prepared to pay for your portion of the charges on the date of service. Office procedures (e.g., tests, labs, etc.) will be billed separately from the office visit.
- **Non-Participating Insurance** – If we do not participate with your insurance, you will be required to pay for your visit in full on the date of service. We will file a claim with your insurance as a courtesy. If your insurance pays a portion of the claim we submit, we will refund you the amount they paid.

Uninsured Patients-

- **Office Visits** – We ask that you pay the full amount of your visit on the date of services. Office procedures (e.g., labs, tests, etc.) will be billed separately from the office visit.
- **Other Charges- No Show** – Please provide us with at least 24 hours' notice if you need to cancel or reschedule an appointment. We may charge a fee for missed appointments.
- **Payment Options** – We accept cash, checks, major credit/debit cards and money orders for payment (no post-dated or third-party checks). We charge a $40.00 NSF fee for any returned checks.
- **Delinquent Accounts** –We may assign an account to collections if balances are unpaid after 90 days. Patients assigned to collections may be denied additional service.
- **Bankruptcy/ Bad Debt** – Patients who have previously filed for bankruptcy or never satisfied their payment obligations for prior episodes of care with Kirkland Dermatology Associates may be required to pay for their portion of new charges at the time of service.

Receipt of Notice of Privacy Practices and Financial Policy:
My signature below indicates that I have received and/or reviewed a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (Notice of Privacy Practices) and the Financial Policy.

Patient or Responsible Party Signature: _____ **Date**_____/_____/_____