GEORGE DERMATOLOGY

PATIENT INFORMATION - PLEASE PRINT

LAST NAME	FIRST NAME	M.I.	TODAY'S DATE	
			HOME PHONE	CELL PHONE
STREET ADDRESS			WORK PHONE	
CITY	STATE	ZIP	SEX ☐M ☐F	MARITAL STATUS ☐S ☐M ☐W ☐DIV ☐SEP
				DATE OF BIRTH
EMPLOYER			SOCIAL SECURITY #	
OCCUPATION			HOBBIES	
IF MINOR - CONSENTING ADULT:				

INSURED SUBSCRIBER (OR SPOUSE)

RELATIONSHIP TO PATIENT:

LAST NAME	FIRST NAME	M.I.	HOME PHONE	CELL PHONE
STREET ADDRESS			WORK PHONE	
CITY	STATE	ZIP	SEX ☐M ☐F	DATE OF BIRTH
EMPLOYER				SOCIAL SECURITY #

EMERGENCY INFORMATION

RELATIONSHIP TO PATIENT:

NAME		
HOME PHONE	WORK PHONE	CELL PHONE

PRIMARY CARE PHYSICIAN

PHONE

NAME	
STREET ADDRESS	CITY/STATE/ZIP

REFERRING PHYSICIAN

PHONE

NAME	
STREET ADDRESS	CITY/STATE/ZIP

I authorize the release of medical information necessary to process my claim and also authorize payment of medical benefits to George Dermatology. I understand that I am responsible for any and all balances left after insurance pays. I will be responsible for all balances if I do not have insurance.

I further authorize release of medical information to my designated Primary Care Physician and/or Referring Physician.

_____ _____

PATIENT / GUARDIAN SIGNATURE *DATE*

GEORGE DERMATOLOGY

Patient Name: _____ Date of Birth: _____

Reason for Today's Visit: _____

MEDICATIONS:

List any medications you currently take:

_____

_____

_____

_____

_____

Do you have an Allergy to any medications? ☐ No ☐ Yes

If YES, please list them: _____

_____

Completed by: Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

George Dermatology

MARY NOËL GEORGE, MD, FAAD
ALEXIS NEAL, PA-C

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, George Dermatology may use and disclose protected health information(PHI) about me to carry out treatment, payment and healthcare operations (TPO)(available upon request). Please refer to the George Dermatology Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing the consent. George Dermatology reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the Privacy Officer at 8888 Ladue Rd., #120, St. Louis, MO 61324.

With my consent, George Dermatology may e-mail, fax, mail or verbally send to my home or other designated location any items that assist the practice in carrying outt TPO, such as appointment card reminders, financial or medication information. I have the right to request that George Dermatology restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does it is bound by this agreement.

E-Mail Address:_____

I authorize the release of medical information necessary to process my claim and also authorize payment of medical benefits to George Dermatology. I understand that I am responsible for any and all balances left after insurance pays. I will be responsible for all balances if I do not have insurance.

By signing this form, I am consenting to George Dermatology's use and disclosure of my PHI or carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, George Dermatology may decline to provide treatment to me. With my consent, Dr. George and/or staff may call my home or other designated locations and leave a message on voicemail.

If I am unavailable, I give Dr. George and/or staff consent to discuss my medical or financial status with:

_____

(include names, relationship and phone number)

_____

Signature of patient or legal guardian Date

8888 Ladue Road, Suite 120
St. Louis, MO 63124
www.georgedermatology.com

phone 314.344.0004
fax 314.344.0631
info@georgedermatology.com

George Dermatology

MARY NOËL GEORGE, MD, FAAD
ALEXIS NEAL, PA-C

Thank you for choosing George Dermatology. We are dedicated to providing the best possible care and services for you. Knowing your financial responsibility is an essential element of your care. With healthcare costs shifting more to patient responsibility, it is essential that you understand your deductible and details of your plan. **Please read the following carefully and sign at the bottom to confirm your understanding.**

1) Insurance: Your visit is filed with the carrier with whom our practice has a valid contract. It is the responsibility of the patient to provide accurate insurance and personal information. If your insurance requires a referral, it is your responsibility to provide the referral ***prior to*** your visit. You will be responsible at the time of service for the payment of copays, unpaid deductibles, and past due balances.

2) Self-pay and cosmetic: Payment is expected in full at the time of services.

3) On occasion, pathology is ordered by physicians to properly diagnose certain skin disorders. To provide quality care for our patients, we utilize an independent licensed lab with analysis performed by a board-certified Dermatopathologist who specializes in the microscopic diagnoses of skin disorders. *Charges for these services are **in addition** to your office visit charge and procedure charge.*

4) Cancellation and Missed Appointments: We understand that unexpected events, illnesses, etc occur. When this happens, call our office as soon as possible to inform us of such issues. In the case of missed appointments or cancellations within 24 hours of the appointment:

- Office Visit - I understand that it is my responsibility to cancel my appointment at least 24 hours in advance of my appointment time and date; otherwise, a $50 fee will be billed to my account which is not covered by my insurance plan. All outstanding balances must be paid in full before your next visit.
- Surgical appointments - I understand it is my responsibility to cancel or change my appointment at least 24 hours in advance of appointment time and date; otherwise, a $200 fee will be billed to my account which is not covered by my insurance plan. All outstanding balances must be paid in full before your next visit.

5) Requests for Medical Records/ Forms (FMLA): Fee for medical records is $25 plus the cost of mailing and/or electronic device. FMLA, medical and other such policy forms to be filled out will be charged $10 fee.

6) Methods of payment accepted are: Cash, Visa, Mastercard, Discover, and personal checks with proper identification (valid Driver's license or photo ID). A $30.00 overdraft charge will be added to the insufficient funds amount of any returned checks.

7) I have read the above financial policies and understand my financial responsibilities as a patient. I understand that failure to make payment when due is the basis for legal action and agree to pay all costs of collection, including court costs and attorney fees.

8) Recent changes in healthcare markets and payment processes have altered insurance coverages to shift more of the cost of care to our patients. *Many policies have large deductibles and/or copayments that won't be known until after your services are submitted to your insurance carrier. Even if a procedure is covered by insurance, you may still receive a bill.* These external factors make it necessary for George Dermatology to maintain a credit card on file for all patients. The card information is stored in a confidential, secure merchant account. Once your insurance company notifies us how much of the bill is your responsibility, we will mail one statement to obtain payment. After 30 days, we will charge your credit/debit card and provide you with the confirmation of the charge. If the balance is over $200, you will receive one courtesy call from our billing office regarding the payment a few days prior to charging the card. By signing this form you authorize George Dermatology to bill your card on file that are determined to be the patient's responsibility by the insurance company.

Name as it appears on credit card _____ Cardholder Signature _____

Patient (Guardian) Signature / Name of patient Date

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